Prescription Drug and Healthcare Spending (RxDC) Reports

Instructional Guide for Completing the CareFirst RxDC Survey

FULLY-INSURED GROUP HEALTH PLANS

Table of Contents

Introduction **2**

CareFirst Submission **4**

- Fully Insured Small Group Market 4
- Fully Insured Large Group Market (51+) 4
- Aggregation Restriction 4

Providing Data to CareFirst **5**

- States where the plan is offered 5
- PBM Name & PBM EIN (if applicable) 5
- TOTAL Premium Paid by Members 5
- TOTAL Premium Paid by Employers 5

Introduction

Under Section 204 of the Consolidated Appropriations Act (CAA) of 2021, health insurers offering group or individual health coverage and self-funded (ASO) group health plans are required to report data annually on prescription drugs and healthcare spending to the Departments of Health and Human Services (HHS), Labor (DOL) and Treasury (USDT).

The Centers for Medicare & Medicaid Services (CMS) within HHS is collecting Section 204 data submissions on behalf of the Departments and has published guidance and resources on their website at https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/prescription-drug-data-collection.

The Section 204 reporting is commonly referred to as "RxDC" where the "Rx" stands for Prescription Drug and "DC" stands for Data Collection. It is important to note that the RxDC reports require data that is not related to prescription drugs. This including premium, enrollment, and other spending related to medical costs.

The RxDC report consists of three different types of files – plan lists (or P files), data files (or D files), and a Narrative Response file. The P files are designed to act like a mapping tool for CMS to reconcile the data being reported in the D files. Any entity submitting a D file, must also submit the appropriate P file that indicates what plans are included in the population of data in the D file. The P2 is the only P file that is applicable to employer sponsored health plans.

Subject	Plan Lists	Data Files
File Names	**P stands for Plan** 1. P1 Individual and student market plan list 2. P2 Group health plan list 3. P3 FEHB plan list	**D stands for Data** 1. D1 Premium and Life-Years 2. D2 Spending by Category 3. D3 Top 50 Most Frequent Brand Drugs 4. D4 Top 50 Most Costly Drugs 5. D5 Top 50 Drugs by Spending Increase 6. D6 Rx Totals 7. D7 Rx Rebates by Therapeutic Class 8. D8 Rx Rebates for the Top 25 Drugs
Purpose	The plan list identifies the plans in a submission. The plan list also collects plan-level information required by statute, such as the beginning and end dates of the plan year, the number of	The data files collect premium and spending information at an aggregate level.

	members, and the states in which the plan or coverage is offered.	
Requirement	• P1 is required for plans in the individual or student market • P2 is required for employer-based group health plans that are not FEHB plans • P3 is required for FEHB plans	• D1-D8 are required for plans with medical and pharmacy benefits • D1 and D2 are required for plans with only medical benefits • D1 and D3 – D8 are required for plans with pharmacy benefits only
Narrative Response File	A Narrative Response applicable to each plan is required. Different reporting entities may be responsible for different parts of the Narrative Response.	

The RxDC reporting is due by June 1st of each year for the applicable reference year data and is required to be uploaded in the Health Insurance Oversight System (HIOS). The term “reference year” refers to the previous calendar year plus a three-month runout for spending tied to that calendar year.

This allows for payments made in January through March of the current year for claims incurred in the previous calendar year to be included in the data. Any payments made after March 31st would not be included in the data, even if the associated claims were incurred in reference year.

CareFirst Submission

This section provides information about which files CareFirst will include in our submission for fully insured clients for the benefits we administered in the applicable reference year.

Fully Insured Small Group Market

CareFirst will submit the following files:

- **P2** Group Health Plan List
- **D1** Premium and Life Years
- **D2** Spending by Category
- **D3-D8** Pharmacy Reports generated by CVS Caremark
- **Narrative Response**

Fully Insured Large Group Market (51+)

Employer Groups with CareFirst Medical and Pharmacy Benefit Plans

CareFirst will submit the following files:

- **P2** Group Health Plan List
- **D1** Premium and Life Years
- **D2** Spending by Category
- **D3-D8** Pharmacy Reports generated by CVS Caremark
- **Narrative Response**

Employer Groups with Pharmacy Carve-Out and CareFirst Medical

For clients that do not have pharmacy benefits included in their CareFirst agreement, CareFirst will submit the following files:

- **P2** Group Health Plan List
- **D1** Premium and Life Years
- **D2** Spending by Category
- **Narrative Response**

Clients will need to work with their contracted PBM for submission of the D3-D8 files.

Aggregation Restriction

CareFirst is submitting the RxDC reports to CMS in aggregate under **CareFirst, Inc.** for all clients of CareFirst, CareFirst Administrators (CFA), and National Capital Area Services (NCAS). This includes the **D2 Spending by Category** file.

Files that are submitted by an entity other than CareFirst can therefore be aggregated at the **Issuer, TPA, or Group Health Plan** level to be compliant with the required aggregation restriction.

Providing Data to CareFirst

This section provides additional detail about the information you are being asked to provide in the RxDC survey.

States where the plan is offered

Select the states and territories in which the plan or coverage is offered. If a plan is offered in every state and in DC, select "National". If a plan is offered nationally and in one or more territories, select "National" and the applicable territories.

For purposes of RxDC reporting, a plan is considered "offered" in a state if a person living or working in that state would be eligible to obtain coverage under the plan. Plans may enter "National" if a person living or working in *any* state and DC would be eligible to obtain coverage under the plan.

Only one reporting entity is required to enter this information for a given plan, therefore if CareFirst will not be submitting the RxDC D1 – Premium and Life Years file, you will need to include this data on the P2 file that is submitted with the D1.

PBM Name & PBM EIN (if applicable)

If you have Pharmacy coverage that is NOT part of the CareFirst CVS Caremark contract (Pharmacy carve-out), you will be prompted to enter the Pharmacy Benefits Manager (PBM) name and Employer Identification Number (EIN).

Enter the 9-digit EIN of the PBM. Do not use dashes. (Ex: 012345678.)

TOTAL Premium Paid by Members

Enter the total dollars paid by members for coverage administered in the reference year, including COBRA coverage (premiums and the 2% administrative fee) and any surcharges or wellness differentials assessed on the member (e.g., tobacco or spousal surcharges).

Note: Premiums and COBRA administrative fees paid by COBRA enrollees should be included in the Total Premium Dollars Paid by Members as indicated above. **If the employer pays a portion of COBRA premiums** (e.g., 20% in an 80/20 split), those amounts should be included in the Total Premium Dollars Paid by Employers as applicable.

TOTAL Premium Paid by Employers

Enter the total dollars paid the employer for the coverage administered in the reference year, excluding the amount paid be members from the previous question. Include any portion of COBRA premiums paid by the employer (for example, with an 80/20 split).

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc., which are independent licensees of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.