

# PRESCRIPTION DRUG AND HEALTHCARE SPENDING (RXDC) REPORTS

## INFORMATIONAL GUIDE FOR THE CAREFIRST ANNUAL RXDC SUBMISSION

FULLY-INSURED AND SELF-INSURED GROUP HEALTH PLANS

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# INTRODUCTION: WHAT IS RXDC?

Under Section 204 of the Consolidated Appropriations Act (CAA) of 2021, health insurers and self-insured plan sponsors must report annual data on prescription drugs and healthcare spending to HHS, the Department of Labor and the Department of the Treasury.

CMS collects these **RxDC (Prescription Drug Data Collection)** reports. Their guidance is posted at: **https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/prescription-drug-data-collection**.

| Subject | Plan Lists | Data Files |
|---|---|---|
| **File Names** | **P stands for Plan**<br>■ P1: Individual and student market<br>■ P2: Group health plans<br>■ P3: FEHB plans | **D stands for Data**<br>■ D1: Premium and Life-Years<br>■ D2: Spending by Category<br>■ D3: Top 50 Most Frequent Brand Drugs<br>■ D4: Top 50 Most Costly Drugs<br>■ D5: Top 50 Drugs by Spending Increase<br>■ D6: Rx Totals<br>■ D7: Rx Rebates by Therapeutic Class<br>■ D8: Rx Rebates for the Top 25 Drugs |
| **Purpose** | The plan list iIdentifies the plans in a submission and collects other data, such as plan year effective dates. | The data files cCollects premium and spending information at an aggregate level. |
| **Requirement** | ■ P1 is required for plans in the individual or student market.<br>■ P2 is required for employer-based group health plans that are not FEHB plans.<br>■ P3 is required for FEHB plans. | ■ D1–D8 are required for plans with medical and pharmacy benefits.<br>■ D1 and D2 are required for plans with only medical benefits. |
| **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. | |

## TIMING

RxDC reporting is due **June 1 each year** in HIOS. "Reference year" includes:

- The previous calendar year
- A three month runout (January–March) for payments tied to that year

Payments made after March 31 are excluded, even if tied to prior year claims.

# GETTING STARTED: WHAT YOU NEED TO KNOW

CareFirst submits RxDC reporting for all benefits we administer. To complete the reports accurately, we collect certain information from clients each year.

## IN GENERAL

CareFirst submits all RxDC reporting under CareFirst, Inc. (EIN of 52-2069215) in aggregate.

- **Clients who do not submit required information by CareFirst's deadline will be excluded from our D1 Premium and Life Years submission.**
  - You may revise and resubmit the form anytime before the deadline. CareFirst uses the most recent submission.

## ACCESSING AND COMPLETING THE ANNUAL RXDC SUBMISSION FORM

Access the form through the secure CareFirst Employer Portal.

- **Financial data must be total dollar amounts for the calendar year.**
  - Do not enter percentages or averages.
  - Include decimals for non-whole-dollar amounts.
  - CareFirst aggregates submitted totals before calculating averages.
- Submissions that contain clearly inaccurate values will be excluded from our D1 file.
  - Example: Premium Equivalents Paid by Member + Employer = $0 for the year.
- If another entity is submitting a D1 file for your plan, still complete the form by selecting Opt Out.
- Retain your own record by taking a screenshot of the Submission Successful pop-up.

## MARKET SEGMENT CHANGES AFTER JANUARY 1

If a client renewed with CareFirst after January 1 and the renewal caused a market segment change, review the "Mid-Year Market Segment Changes" section of the CareFirst Portal User Manual.

**Examples of mid-year market segment changes**

- Moving from Small Group to 51+ market
- Moving from Self-Insured to Fully Insured

**Not considered a market segment change**

- Choosing different benefit plans
- Changing cost-share amounts
- Moving between CFA and CareFirst Self-Insured (unless situs state also changed)

# CAREFIRST SUBMISSION: SELF-INSURED

CareFirst submits all required files for benefits we administer.

## SELF-INSURED CLIENTS WITH NO CARVE-OUTS

CareFirst submits:

- **P2** Group Health Plan List
- **D1** Premium and Life-Years
- **D2** Spending by Category
- **D3–D8** Pharmacy files (through CVS Caremark)
- **Narrative Response**

## SELF-INSURED CLIENTS WITH CARVE-OUTS

### Pharmacy Carve-Out

CareFirst submits:

- **P2** Group Health Plan List
- **D1** Premium and Life Years
- **D2** Spending by Category
- **Narrative Response** (excluding PBM components)

The PBM must submit D3–D8 and any premium data tied to the carved-out pharmacy benefits.

### Clients with Additional Carve-Outs for Stop Loss, Behavioral Health, etc.

CareFirst reports only data for benefits we administer. Other vendors must report their own components.

## AGGREGATION RESTRICTION

CareFirst submits RxDC files in aggregate under CareFirst, Inc. for all:

- CareFirst
- CareFirst Administrators (CFA)
- National Claims Administrative Services (NCAS)

This approach allows client data to be aggregated by:

- Issuer
- TPA
- Plan sponsor
- Group health plan

This complies with CMS rules and gives flexibility when multiple partners report data.

# PROVIDING DATA TO CAREFIRST: SELF INSURED

## STATES WHERE THE PLAN IS OFFERED

- Select all states and territories where eligible employees may access coverage.
- Select **National** if coverage is available in all states and D.C.
- If coverage includes territories, select **National** plus the applicable territories.
- If CareFirst will not submit the D1 file (client opted out), the client must ensure state data is included in their own P2 file submission.

## STOP LOSS ISSUER NAME & ISSUER EIN

Enter this only if Stop Loss was provided by a carrier **other than CareFirst**.

- Enter the carrier's full name
- Enter the **9-digit EIN** (no dashes)

Leave blank if the client had no Stop Loss coverage, or Stop Loss was through CareFirst.

## PBM NAME & PBM EIN

Enter this only if pharmacy benefits were administered outside CareFirst.

- Provide PBM name
- Provide the **9-digit EIN** (no dashes)

Leave blank if pharmacy benefits were through CareFirst.

## TOTAL PREMIUM EQUIVALENTS PAID BY MEMBERS

Include:

- Member paid amounts
- COBRA premiums + 2% administrative fee
- Surcharges (tobacco, spouse, wellness, etc.)

Include retiree only plans unless they are qualified EGWP or Medigap. Do **not** include:

- Stand alone dental or vision
- EAPs or other excepted benefits

COBRA rule: Employer paid portions belong under **Employer Premium Equivalents**.

## TOTAL PREMIUM EQUIVALENTS PAID BY EMPLOYERS

Include all employer paid contributions for CareFirst administered coverage, including:

- Employer paid portions of COBRA premiums
- Retiree only plans, unless qualified EGWP or Medigap

Do **not** include:

- Stand alone dental
- Vision
- EAPs

Employers may optionally include pro rated internal administrative costs.

## TOTAL PREMIUM EQUIVALENTS (TOTAL PLAN COST)

Enter the total cost of providing coverage for the year.

Include:

- **Claims paid** (use paid, not incurred amounts)
- **Administrative costs** (including fees paid for benefit design or enrollment assistance)
- **Stop Loss premiums**
- **PPO/Network access fees**

Subtract:

- **Stop-loss reimbursements**
- **Prescription drug rebates received** during the year

Exclude:

- **Medicare payments**
- **Premium equivalents reported by another entity**
- **FSA/HSA/HRA/MSA contributions or administrative costs**
- **EAPs and other excepted benefits**
- **Member copays and coinsurance**
- Trust contributions not tied to claims

Premium equivalents should reflect **actual costs**, not COBRA rates.

## TOTAL ADMIN FEES PAID

Enter the total administrative paid by the client. This may include a pro-rata share of internal administrative costs.

What to Exclude

- FSA administration
- Wellness programs
- Fees paid by CareFirst, CFA or NCAS to external vendors that are not passed through to clients

## TOTAL STOP LOSS PREMIUM PAID

Enter the total Specific and Aggregate Stop Loss premiums paid during the year. This amount should be included in Total Premium Equivalents.

# PROVIDING DATA TO CAREFIRST: FULLY INSURED

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

## STATES WHERE THE PLAN IS OFFERED (REQUIRED)

Same requirements as Self-Insured.

## TOTAL PREMIUM PAID BY MEMBERS (REQUIRED)

Include:

- All member paid premiums
- COBRA premiums + 2% admin fee
- Member surcharges

## TOTAL PREMIUM PAID BY EMPLOYERS (REQUIRED)

Report all employer-paid amounts for medical and pharmacy benefits through CareFirst.

## PBM NAME & EIN (200+ FULLY INSURED, IF APPLICABLE)

- Only required if pharmacy benefits were carved out.
- Provide PBM name and 9 digit EIN.
- Leave blank if pharmacy benefits were through CareFirst.

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