

CareFirst

PRESCRIPTION DRUG AND HEALTHCARE SPENDING (RXDC) REPORTS

INSTRUCTIONAL GUIDE FOR COMPLETING THE CAREFIRST RXDC SURVEY

FULLY-INSURED AND SELF-INSURED GROUP HEALTH PLANS

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INTRODUCTION: WHAT IS RXDC?

Under Section 204 of the Consolidated Appropriations Act of 2021, health insurers and group health plans must report annual data on prescription drugs and healthcare spending to HHS, the Department of Labor and the Department of Treasury. This reporting is known as **RxDC (Prescription Drug Data Collection)**.

CMS collects the reports and provides guidance at: **https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/prescription-drug-data-collection**.

Although the name focuses on prescription drugs, RxDC reporting includes information about premiums, enrollment and overall medical spending. The goal is to improve transparency and inform policy decisions.

Subject	Plan Lists	Data Files
File Names	**P Files (Plan Lists)** ■ P1: Individual and student market ■ P2: Group health plans ■ P3: FEHB plans	**D Files (Data Lists)** ■ D1: Premium and Life-Years ■ D2: Spending by Category ■ D3: Top 50 Most Frequent Brand Drugs ■ D4: Top 50 Most Costly Drugs ■ D5: Top 50 Drugs by Spending Increase ■ D6: Rx Totals ■ D7: Rx Rebates by Therapeutic Class ■ D8: Rx Rebates for the Top 25 Drugs
Purpose	The plan list identifies the plans in a submission and collects plan-level information required by statute, such as plan year effective dates.	The data files report premium and spending information at an aggregate level.
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.
Narrative Response File	A Narrative Response applicable to each plan is required and explains key aspects of plan design and reporting. Different reporting entities may be responsible for different parts of the Response.	

RxDC reporting is due June 1 each year and is submitted through the Health Insurance Oversight System (HIOS). Each "reference year" includes:

- The previous calendar year
- A three-month runout (January–March of the current year).

Claims paid after March 31 are excluded, even if incurred during the previous year.

HOW CAREFIRST SUPPORTS YOUR SUBMISSION

CareFirst BlueCross BlueShield (CareFirst) submits RxDC reporting on behalf of current and former clients for the benefits we administered. Depending on plan type, CareFirst may submit:

- Plan lists and premium data
- Medical spending data
- Pharmacy data (when administered through CareFirst/CVS Caremark)
- Applicable portions of the Narrative Response

When other partners (such as PBMs or Stop Loss carriers) administer benefits, reporting responsibilities may be shared.

GETTING STARTED: WHAT YOU NEED TO KNOW

CareFirst collects certain data each year to complete your RxDC reporting. Before completing the survey, keep the following in mind:

IN GENERAL

- **Complete the survey by the deadline**. Late submissions may be excluded from CareFirst's D1 Premium and Life Years file.
- **You can revise your submission anytime** before the deadline. CareFirst uses the most recent submission.
- **Report total dollar amounts only**.
  - Do not report percentages or averages.
  - Include cents when amounts are not whole dollars.
  - CareFirst aggregates all client totals before calculating averages that will be reported.
  - **Accuracy matters**. Submissions that conflict with enrollment or coverage duration may be excluded.

    Example: If reported premiums for nine months total less than one month of billed premiums, the entry may be invalid.
- If another insurer is submitting the D1 file for the plan—including CareFirst-administered benefits—the client may select Opt Out.
- To retain a record, print or screenshot the review screen before submitting. There is no confirmation email.

AGGREGATION FLEXIBILITY

CareFirst submits reports under **CareFirst, Inc. (EIN 52-2069215)** to maximize reporting flexibility.

This allows aggregation at the:

- Issuer
- Third party administrator (TPA)
- Plan sponsor
- Group health plan

This complies with CMS rules while simplifying reporting for employers with multiple vendors.

PROVIDING DATA TO CAREFIRST

The following sections apply to all funding types unless otherwise noted.

STATES WHERE THE PLAN IS OFFERED (REQUIRED)

Select all states or territories where eligible employees may obtain coverage.

A plan is considered "offered" in a state if an employee living or working in that state is eligible for coverage. Select National if coverage is available in any state and D.C.

TOTAL PREMIUM PAID BY MEMBERS (REQUIRED)

Include all member-paid amounts for CareFirst-administered medical and pharmacy benefits, including:

- COBRA premiums (including 2% administrative fee)
- Surcharges or wellness differentials

COBRA Note: If a COBRA enrollee pays premiums, include them in Member totals. If the employer pays part of COBRA premiums, that portion belongs in Employer totals.

TOTAL PREMIUM PAID BY EMPLOYERS (REQUIRED)

Report all employer-paid amounts for CareFirst-administered coverage during the calendar year.

If the employer pays a portion of COBRA premiums, include that amount here.

200+ FULLY INSURED CLIENTS: PBM NAME & PBM EIN (ONLY REQUIRED IF APPLICABLE)

For Fully Insured plans, report:

- Total premiums paid by members
- Total premiums paid by employers

If pharmacy benefits are included through CareFirst, no additional information is needed.

PHARMACY CARVE-OUT

- If pharmacy coverage is not administered by CareFirst, provide the PBM name and EIN
- If CareFirst provides pharmacy benefits, leave these fields blank

SELF-INSURED SPECIFIC REQUIREMENTS

Self-insured plans may need to report **premium equivalents**, which represent the full cost of providing coverage. Premium equivalents may include:

- Claims paid
- Administrative fees
- Network access fees
- Stop Loss premiums

Exclude:

- Medicare payments
- HAS/HRA contributions
- Member cost sharing (copays and coinsurance)

CareFirst reports only the benefits we administer. Other partners must report their own portion.

LARGE CLIENTS WITH PHARMACY CARVE-OUT

DOES NOT APPLY TO SMALL GROUP OR MIDSIZE MARKETS (2–199)

If pharmacy benefits are not handled through CareFirst/CVS Caremark, CareFirst submits:

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

The PBM submits:

- D3–D8 files
- PBM-related sections of the Narrative Response
- Clients may include all premium data in their CareFirst survey submission if the PBM is not submitting a D1 file. No additional coordination with CareFirst is required.

PLANS WITH PHARMACY OR OTHER CARVE-OUTS

CareFirst reports only the benefits we administer. Other partners must report their own portion.

KEY REMINDERS AND BEST PRACTICES

- Keep reporting factual, consistent and aligned with actual coverage periods.
- Save or print the review page before submitting. No confirmation email is sent.
- When in doubt, report what best reflects the **actual cost of coverage**.
- Contact your CareFirst representative if you have any questions.

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