Prescription Drug and Healthcare Spending (RxDC) Reports

Informational Guide for the CareFirst Annual RxDC Submission

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 offering group health coverage and all self-insured plan sponsors must 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) collects the Section 204 reports 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 reporting is commonly referred to as "RxDC" where "Rx" stands for Prescription Drug and "DC" stands for Data Collection. It is important to note that the RxDC reports require data unrelated to prescription drugs, including premium, enrollment, and other spending related to medical costs.

There are three different types of files included in the reporting – plan lists (or P files), data files (or D files), and a Narrative Response file. The P files are used as a mapping tool for CMS to reconcile the data being reported in the D files. Any entity submitting a D file, must also submit a P file identifying the plans whose data is included in the D file(s). The P2 is the P file applicable to group 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 and collects other data, such as plan year effective dates.	The data files collect 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 • 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 must 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 the reference year.

CareFirst Submission

This section outlines which files CareFirst will submit on behalf of our self-funded clients for the benefits we administered in the applicable reference year.

Self-Insured Clients with No Carve-Outs

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**

Self-Insured Clients with Carve-Outs

Clients with Pharmacy Carve-Out

For clients that did not have pharmacy benefits through CareFirst, we will submit the following files:

- **P2** Group Health Plan List
- **D1** Premium and Life Years
- **D2** Spending by Category
- **Narrative Response** *(for responses not applicable to pharmacy benefits)*

Clients will need to work with the applicable pharmacy benefits manager (PBM) for submission of the data related to the prescription drug coverage, including all of the D3-D8 files and components of the Narrative Response related to that coverage.

Clients may choose to include all relevant premium data in their survey submission to CareFirst if the PBM is not willing to also submit a D1 file on their behalf with the amounts related to the prescription drug coverage. No additional communication is required for this scenario.

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

For group health plans that have other carve-outs for specific services, CareFirst will only report the data for the benefits we administered.

Aggregation Restriction

To provide our clients with maximum flexibility when other entities will be reporting on their behalf, CareFirst is submitting the RxDC reports to CMS in aggregate under the **CareFirst, Inc. (EIN 52-2069215)** entity for all clients. This includes the **D2 Spending by Category** file that regulation identifies as the benchmark for client data aggregation.

Any client data submitted by other entities can therefore be aggregated at the **Issuer, TPA, Plan Sponsor, or Group Health Plan** level and remain compliant with the aggregation restriction.

Getting Started – What You Need to Know

CareFirst is committed to supporting our clients by submitting all RxDC reporting on their behalf. The reports require certain information that CareFirst must collect from each client every year. Below are some key points to keep in mind about this data request.

In General

- CareFirst will submit all RxDC reporting with data aggregated under CareFirst, Inc. and an EIN of 52-2069215.
- **Clients that do not complete the form submission by the due date set by CareFirst will be excluded from CareFirst's D1-Premium and Life Years submission.**
- Forms can be resubmitted as many times as necessary prior to the due date. CareFirst will use the most recent data submission to complete the reporting.

Accessing and Completing the Annual RxDC Submission Form

- Clients can access the form by logging into the secure CareFirst Employer Portal. Clients that have not previously registered may do so by visiting carefirst.com.
- **Financial data should be reported as total dollar amounts for the calendar year.**
  - Do not provide percentages (%).
  - Do not provide averages.
  - Include the decimal if reporting an amount that isn't an even dollar amount.
  - CareFirst will aggregate total dollar amounts for all clients in the applicable market segment before calculating the average(s) that will be reported.
  - Any data provided that is clearly inaccurate will result in the client being excluded from CareFirst's D1-Premium and Life Years submission. For example, if the sum of Premium Equivalents Paid by Member and Premium Equivalents Paid by Employer is 0, the submission will be marked as invalid, and the client will be excluded from CareFirst's D1 submission.
- If another entity is submitting a D1 file on behalf of the client that includes the data associated with the benefits administered by CareFirst during the calendar year, the form should still be accessed and completed by selecting the "opt-out" button.
- Clients that want a record of their submission should print the screen with the completed form before clicking submit and the subsequent pop-up that indicates a successful submission. No other confirmation will be provided.

Market Segment Changes After January 1st of the Calendar Year

If the client renewed their contract with CareFirst for a plan year that was effective after 1/1 of the reference year and that renewal resulted in a market segment change, please review the "Mid-year Market Segment Changes" section of the RxDC CareFirst Portal User Manual(s).

What qualifies as a mid-year market segment change?

- Moving from the Small Group market to the 51+ market, or vice versa
- Moving from the Self-Insured market to the Fully Insured market, or vice versa

What <u>does not</u> qualify as a mid-year market segment change?

- Choosing different plan benefits (ex. BluePreferred instead of BlueChoice)
- Changing member cost-share amounts (ex. Increasing the deductible)
- A change to your CareFirst Group ID
- Moving from CFA to CareFirst Self-Insured, or vice versa
  - In this example, the client would still be considered a Self-Insured Large Employer Plan for the purposes of RxDC reporting **unless** the client's contracting state (situs) also changed

Providing Data to CareFirst

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

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 from the employer. Plans may enter "National" if a person living or working in *any* state and DC would be eligible to obtain coverage under the plan.

Clients that Opt-Out: 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, the client will need to ensure this data is included on the P2 file that is submitted with their D1 data.

Stop Loss Issuer Name & Issuer EIN

If the client had stop loss coverage that was **not** CareFirst Stop Loss, enter the name of the stop loss carrier and their 9-digit Employer Identification Number (EIN) without dashes (Ex: 012345678).

Leave these fields blank if the client did not have stop loss coverage, or if their coverage was through CareFirst.

PBM Name & PBM EIN

If the client had pharmacy coverage that was **not** through CareFirst (known as "pharmacy carve-out"), enter the Pharmacy Benefits Manager (PBM) name and their 9-digit Employer Identification Number (EIN) without dashes (Ex: 012345678).

Leave these fields blank if your prescription drug benefits were included through CareFirst.

TOTAL Premium Equivalents Paid by Members

Enter the total premium dollars paid by all members for coverage administered in the calendar 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).

This includes retiree-only plans that are not a qualified EGWP or Medigap (or Medicare Supplement) plan, as CareFirst is not able to exclude data for retiree-only plans.

Do not include information for stand-alone dental or vision plans, or other excepted benefits such as Employee Assistance Programs (EAPs).

Note: Premiums and COBRA administrative fees paid by COBRA enrollees should be included in the Total Premium Equivalent 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 Equivalent Dollars Paid by Employers (*discussed below*), as applicable.

TOTAL Premium Equivalents Paid by Employers

Enter the total cumulative dollars paid the employer for the coverage administered in the calendar year, excluding the amount paid by members from above. As noted above, include any portion of COBRA premiums paid by the employer (for example, with an 80/20 split), if applicable.

This includes retiree-only plans that are not a qualified EGWP or Medigap plan as CareFirst is not able to exclude data for retiree-only plans.

Do not include information for stand-alone dental or vision plans, or other excepted benefits such as Employee Assistance Programs (EAPs).

Note: If a group health plan's staff, rather than a TPA, performs some of these functions, the plan may, but is not required to, include a pro-rata portion of these costs in premium equivalents.

TOTAL Premium Equivalents (Total Plan Cost for Self-Funded Coverage)

Enter the total cumulative premium equivalent amounts representing the total cost of providing and maintaining the coverage for all members.

There are various funding arrangements for self-funded plans, and the calculation of premium equivalents is not always straightforward. You should report amounts that best represent the total cost of providing and maintaining coverage for the reference year. Therefore, actual costs on a retrospective basis should be used instead of funding levels whenever possible.

What to Include

- **Claims costs** – To remain consistent with the initial RxDC reporting submission, these should be calculated using paid amounts, not incurred amounts
- **Administrative costs**, including fees paid for benefit design or enrollment assistance for plan participants
- **Stop-loss premiums**
- **Network access fees**, such as preferred provider organization (PPO) fees

What to Subtract

- **Stop-loss reimbursements** – either based on all amounts received during the reference year or based only on amounts attributable to the claims within the reference year that gave rise to reimbursements if the same approach is used consistently across years.
- **Prescription drug rebates received** by the group health plan during the reference year, regardless of whether the payment is retrospective or prospective

What to Exclude

- **Amounts paid by Medicare**

- **Premium equivalents that will be reported by a different reporting entity** (for example, if a different reporting entity will report premium equivalents for a pharmacy carve-out or stop-loss purchased from an outside vendor)
- **Amounts related to health spending accounts**: Flexible Spending Arrangements (FSAs), Health Savings Accounts (HSAs), Medical Savings Accounts (MSAs), and Health Reimbursement Arrangements (HRAs) (such as contributions, reimbursements, or administrative costs)
- **Amounts related to excepted benefits**, including Employee Assistance Programs (EAPs)
- Contributions to a trust that are not contributions for claims incurred but not yet reported
- **Copays and coinsurance paid by members**

To calculate the total annual premium equivalents, an employer with a self-funded plan may use the same types of costs that are considered for purposes of calculating COBRA premiums (minus the 2% administration charge, if applicable). Report total annual costs, not the COBRA rate. Report the total dollar amount actually paid for the calendar year, rather than the amounts used to set the COBRA rate.

TOTAL Admin Fees Paid

Enter the total annual administrative fees that the client paid. This amount should be a portion of what was included in TOTAL Premium Equivalents.

If a client's staff performs some of the administrative functions, the plan may, but is not required to, include a pro-rata portion of these costs in the TOTAL Premium Equivalents.

What to Exclude

- Fees for FSA administration, wellness programs, or financial or clinical analytics
- Fees paid by CareFirst, CFA, or NCAS to an external party that are not passed through to the self-insured employer group

TOTAL Stop Loss Premium Paid

Enter the total stop-loss premium paid by the client to the stop-loss carrier(s) for the calendar year. Include amounts for both Specific and Aggregate Stop Loss coverage, as applicable. This amount should be a portion of what was included in TOTAL Premium Equivalents.

Self-Insured Group Health Plans (3/25)