RxDC Reporting – Round 4

February 2025

Another round of prescription drug data collection (RxDC) reporting is just around the corner. Annual reporting is required by June 1 of each year containing data from the previous calendar year (the "reference year"), so reporting for the data from 2024 will be due June 1, 2025. Most employers sponsoring group health plans that provide prescription drug coverage, regardless of size or funding vehicle (fully-insured or self-funded), have some role to play in the RxDC process and should coordinate with their vendors to determine how much of the reporting will be done by the vendor, and what, if anything, the employer needs to do to complete the process. We anticipate that if an employer is making a good faith attempt to comply, the regulatory agencies will continue to be lenient with any enforcement action. We have already started to see letters from vendors requesting information to begin preparing for the reporting over the next couple months, so this article provides a refresher on the RxDC reporting requirements and responsibilities.

Background

In accordance with the Consolidated Appropriations Act, 2021 (CAA), health plans and health insurance carriers are required to submit certain information about prescription drug and health care spending to the agencies annually. The agencies use this information to issue public reports on prescription drug pricing costs and trends. The inaugural report was released in November 2024 and can be found here - https://aspe.hhs.gov/sites/default/files/documents/2380bb90071b49b6a09ee61d0f79d978/nsa-drug-pricing-rtc.pdf.

RxDC reporting collects the following information:
General information regarding the plan or coverage
Enrollment and premium information, including premiums paid by employees versus employers
Total health care spending, broken down by type of cost (hospital care; primary care; specialty care; prescription drugs; and other medical costs), including prescription drug spending by enrollees versus employers and carriers
The 50 most frequently dispensed brand prescription drugs
The 50 costliest prescription drugs by total annual spending
The 50 prescription drugs with the greatest increase in plan expenditures from the previous year
Prescription drug rebates, fees, and other remuneration paid by drug manufacturers to the plan or carrier in each therapeutic class of drugs, as well as for the 25 drugs that yielded the highest amount of rebates
The impact of prescription drug rebates, fees, and other remuneration on premiums and out-of-pocket costs

RxDC reporting requirements apply to group health plans, including grandfathered plans, but not account-based plans such as health reimbursement arrangements (HRAs), retiree-only plans, or excepted benefits (e.g., limited-scope dental or vision, onsite clinics, and many employee assistance programs (EAPs)).

Detailed reporting instructions, including templates for the various data files and other important information, can be found on the CMS RxDC website at https://www.cms.gov/marketplace/about/oversight/other-insurance-protections/prescription-drug-data-collection-rxdc.

Mind Your Ps and Ds

The RxDC reporting requirement takes the form of nine different data files, plus a narrative file, that must be submitted to CMS through their Health Insurance Oversight System (HIOS) via the CMS Enterprise Portal at https://portal.cms.gov/portal/. The files for RxDC reporting are summarized in the following table:

Plan File	Data Files (8 separate data files)	Narrative File
P2 – Group Health Plan List A P2 file could be submitted on its own, but a data file or narrative file cannot be submitted without an accompanying P2 file	D1 – Plan Details (vendors, # of covered individuals, premiums, etc.) D2 – Medical Spending Information D3-D8 – Drug Spending Information	Every submission should include a narrative response file to address topics not captured in the data files (e.g., federal or state reinsurance cost-sharing reduction programs, rebates, drugs missing from the CMS crosswalk)

Reporting Responsibilities

Most employer-sponsored health plans rely heavily on their carriers, TPAs, and PBMs to provide the data necessary to report to CMS. Many vendors will submit the reporting on behalf of employer client plans. However, some vendors may choose to instead provide the data to the employer with the expectation that the employer will submit their own data to CMS. Any organization that submits data to CMS is referred to as a "reporting entity."

It is possible that multiple reporting entities will submit files separately on behalf of a single group health plan to provide CMS with all required data and files. In some cases, separate vendors may include the employer's data in the same file type (e.g., a PBM and a separate specialty drug vendor both must report their drug data for the year in files D3-D8, or separate TPAs/PBMs within the same plan year must each submit files D1-D2). This relieves the employer from having to collect and consolidate the information from separate vendors into a single data file (although that is an option as well). For carriers, TPAs, PBMs, and other vendors who do handle the RxDC reporting on behalf of group health plans, most will submit aggregated data for all of their clients and will not provide plan-specific data to CMS or the employer.

NOTE: For employers that changed vendors during the reference year (e.g., due to a non-calendar year plan), the reporting submission must reflect all plan data from the reference year, so it will be necessary for the employer to confirm with all service vendors involved with the employer's group health plan(s) during the reference year that all required data gets submitted.

Common Industry Approaches

As an industry, how carriers, TPAs, PBMs, and other vendors of prescription drug coverage handle RxDC reporting still varies. Some of the more common approaches are set forth below:

- There is some information in the RxDC reporting that the carrier or TPA may not have, so the carrier or TPA may reach out to employers to ask for information about premium splits (employer and employee contributions) – see "Calculating Average Monthly Premiums" below – as well as other data required for the D1 file. Once this information is provided, the carrier or TPA may handle the entirety of a group health plan's RxDC reporting. However, if the employer fails to timely respond with the requested data, the employer may have to file a P2 and D1 file on their own.
- We have also seen a few carriers and TPAs decide they will file only fields D2-D8, but not the D1, in which case the employer is responsible for submitting the P2 and D1 files.
- For employers using vendors that will not handle the RxDC reporting (only help provide data), or for employers that use multiple unrelated vendors to provide prescription drug coverage (e.g., separate TPAs and PBMs, or carve-out drug coverage), the employer may have to take a more significant role in determining which vendors are reporting which files, and perhaps even consolidating information and submitting more of the files itself.

D1 File Assistance

For employers who have to file their own D1 file, or for employers who are asked to provide information to carriers or TPAs filing the D1 on behalf of the employer's plan, below is more information to help employers understand the data that is required.

Calculating Average Monthly Premiums

Whether a plan is fully-insured or self-funded, the employer will generally have to provide information to the carrier or the TPA about average monthly premiums paid by the employer and by plan participants (because the vendors generally will not have this information). There is a 2-step process for calculating the average monthly premiums, described below. (*Note:* Starting with the 2023 reference year reported in June 2024, the process for calculating average monthly premiums changed from a per-member-per-month calculation to a strictly per-month calculation.)

Step 1: Calculate Total Premiums Paid by Members and by the Employer

Fully-Insured Plans

Add up all the premiums paid by plan participants ("members") over the course of the reference year, regardless of plan option, coverage tier, or rate structure. Then do the same for all premiums paid by the employer.

Self-Funded Plans

Add up all the contributions paid by members over the course of the reference year, regardless of plan option, coverage tier, or rate structure. For the employer's portion, first calculate the total cost of providing the self-funded coverage and then subtract the contributions paid by members. NOTE: To calculate the total cost of providing self-funded coverage, first add claims costs, administrative costs, administrative services only (ASO) and other TPA fees, and stop-loss premiums. Then subtract any stop-loss reimbursements and prescription drug rebates. You can use

claims incurred or claims paid when calculating the total cost. It is similar to calculating the COBRA premium except CMS expects the employer to use actual costs for the year, not expected costs (and don't include the 2% admin fee).

Step 2: Calculate Average Monthly Premiums by Members and by the Employer

Avg. Monthly Premiums Paid by Members = Total annual premiums paid by members / 12 Months.

Avg. Monthly Premiums Paid by Employer = Total annual premiums paid by the employer / 12 Months.

****Always divide by 12 months even if the coverage was not in effect for the entire calendar year.*

In most cases, an employer should end up with a single amount for the Average Monthly Premium Paid by Members and Employer, regardless of how many plans, coverage tiers, or rate structures it maintains. The exception would be if the employer (or the carrier or TPA on the employer's behalf) is required to report different plans on different lines in the D1 file. This may occur, for example, if the employer offers different plans from different carriers or TPAs, or if the employer offers a mix of self-funded and fully-insured plans. In that case, the employer will need to calculate a separate Average Monthly Premium for each plan or plans required to be reported on a separate line of the D1 file.

How concerned should an employer be with getting this calculation exactly right? While employers should do their best to provide an accurate answer, any minor errors in the calculation are unlikely to be significant. A carrier or TPA filing a D1 is required to aggregate the Average Monthly Premium across its entire book of business by state and market segment. In other words, CMS will generally not see any one employer's data, but rather a grand weighted average across hundreds or even thousands of employers. Therefore, a small error in one employer's data will not have a significant impact on the overall data being reported.

Other D1 Fields

For those employers who must complete their own D1, or whose carrier/TPA requests additional information, here are some pointers on how to complete the remaining D1 fields:

Field Names	Notes
Company Name (Formerly Issuer or TPA Name/EIN)	This should be the name and EIN of the insurance company who issues the fully-insured policy or the TPA who administers the self-funded plan. Do not enter the employer's name and number unless the plan is both self-funded and self-administered. Do not enter more than one name or number – if there were multiple issuers/TPAs in the same year, they must be entered on separate lines.
Aggregation State	For a fully-insured plan, enter the two-letter postal code for the state where the policy was issued. For a self-funded plan, enter the two-letter postal code for the state of the employer's principal place of business.
Market Segment	The market segments for group plans are: small group market, large group market, self-funded small employer plans, and self-funded large employer plans. Use the same definition of "small" used in your state to identify the small group fully-insured market (typically less than 50 employees), even for a self-funded plan. Do not enter more than one market segment – if the employer offers multiple plans in different segments (e.g., both a self-funded and a fully-insured plan), they should be listed on different lines.

Life years	Calculate Total Member Months / 12. Report the result to the 8th decimal place. To calculate Total Member Months, choose one day of the month and use it consistently. For each month, determine how many members were enrolled in each plan sponsored by the employer on the chosen day that month, and then add up the 12 monthly member counts. "Members" includes enrolled active employees plus all dependents, COBRA enrollees, retirees, etc.
Earned Premium	This is the total amount of premiums paid to the insurance company for a fully-insured plan for the reference year; this field should be blank for a self-funded plan. This should be the same number used in the numerator when calculating Average Monthly Premiums. Do not reduce the premium to reflect MLR or other similar rebates.
Premium Equivalents	This is the total cost of providing self-funded coverage for the year; this field should be left blank for a fully-insured plan. To calculate the total cost of providing self-funded coverage, first add claims costs, administrative costs, ASO and other TPA fees and stop-loss premiums. Then subtract any stop-loss reimbursements and prescription drug rebates. Use the same costs that are used to calculate the COBRA premium except CMS expects the employer to use actual costs for the year, not expected costs (and don't include the 2% admin fee). This should be the same number used in the numerator when calculating Average Monthly Premiums.
ASO/TPA Fees Paid	Report total ASO/TPA fees paid for a self-funded plan for the reference year – this amount should also be included in the premium equivalents amount. This field should be left blank for a fully-insured plan.
Stop-Loss Premiums Paid	Report total stop loss premiums paid for a self-funded plan for the reference year – this amount should also be included in the premium equivalents amount. This field should be left blank for a fully-insured plan.