COMPLIANCE ALERT

RxDC Reporting Is Due June 1, 2025

March 3, 2025

Quick Facts

- Prescription Drug Data Collection (RxDC) reporting is due annually on June 1.
- Under the RxDC requirements, health plans, including grandfathered plans, and health insurance carriers are required to submit certain information about prescription drug and healthcare spending to the agencies annually.
- The RxDC must be submitted to the Centers for Medicare and Medicaid Services (CMS) through their Health Insurance Oversight System (HIOS) via the **CMS Enterprise Portal**.
- The way that third-party administrators (TPAs), pharmacy benefit managers (PBMs) and other vendors of prescription drug coverage handle the RxDC reporting varies greatly.
- Centers for Medicare and Medicaid Services (CMS) released updated instructions for RxDC submissions in **January 2025** with no changes to prior year reporting requirements or instructions.

Background

In accordance with the Consolidated Appropriations Act, 2021 (CAA), health plans, including grandfathered plans and health insurance carriers are required to submit certain information about prescription drug and healthcare spending to the agencies annually. The Departments intend to use the information provided in the reports to publish findings about prescription drug pricing trends and the impact of prescription drug rebates on patient out-of-pocket costs. The public will be able to download the report from the **RxDC website** or from the websites of the Department of Labor or the Department of the Treasury once the report is available. To date, none are available.

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

The next round of RxDC reporting is due by June 1, 2025. The first round of data reporting for years 2020 and 2021 was due on January 31, 2023 (due to extensions), and year 2022 data reporting was due by June 1, 2023. Subsequent reports are due annually on June 1. 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.

Detailed reporting instructions, including templates for the various data files and other important information, can be found on the **CMS RxDC website**. CMS released **updated instructions** for RxDC submissions in January 2025, noting in the document that there are no changes from the prior year.

Plan and Data Files

The RxDC reporting requirement takes the form of nine different data files, plus a narrative file, that must be submitted to CMS through their HIOS via the **CMS Enterprise Portal**. The files for RxDC reporting for an employer-sponsored group health plan are summarized in the following table:

<table>
<tr><th>Plan File</th><th>Data Files
(8 separate data files)</th><th>Narrative File</th></tr>
<tr><td rowspan="3">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</td><td>D1 – Plan Details
(vendors, number of covered individuals, premiums, etc.)</td><td rowspan="3">Every submission can 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)</td></tr>
<tr><td>D2 – Medical Spending Information</td></tr>
<tr><td>D3 through D8 – Drug Spending Information</td></tr>
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Reporting Responsibilities

Most employer-sponsored health plans rely heavily on their carriers, TPAs and PBMs to provide the data necessary to report to CMS. Some vendors will submit the reporting on behalf of employer client plans. However, others 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 submitting 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 in order 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 TPA/PBMs within the same plan year 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).

As an industry, how carriers, TPAs, PBMs and other vendors of prescription drug coverage handle the RxDC reporting varies.

- 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. They may also request the employer furnish other data required for the D1 file at the same time. For employers that offer a fully insured plan where all prescription drug coverage is handled by the carrier, the carrier will generally handle the RxDC reporting once they receive the necessary D1 information. However, if the employer fails to timely respond, the employer may have to file a P2 and D1 file for the group health plan on its own.
- Some TPAs will file only fields D2-D8 but not D1, in which case the employer is responsible for submitting the P2 and D1 files on its own.
- 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 drugs coverage or other carve-outs such as stop loss 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. EPIC clients can reach out to their EPIC account team for additional information on an EPIC-provided solution for RxDC reporting.

Keep in mind, for carriers, TPAs, PBMs and other vendors who 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 the employer.

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, additional details below provide information to help employers understand the data that is required.

Calculating Average Monthly Premiums

Employers must calculate the premiums paid by members and employers over the course of the reference year, regardless of plan option, coverage tier or rate structure. For self-funded plans, actual plan costs for the reference year (claim costs, stop loss premium, admin fees, etc., minus any stop loss reimbursements and prescription drug rebates). Note that while the CMS instructions call these costs "premium equivalents," the CMS definition is different than the term premium equivalent rates that self-funded plan sponsors are accustomed to. For most self-funded plans, the premium equivalent rates are calculated at the start of the plan year using expected costs. This number is different than the "premium equivalents" based on actual plan costs that CMS requires. The RxDC instructions state that "premium equivalents" may be reported on a cash basis or on a retrospective basis.

Member Premiums

Calculate the average monthly premium (or premium equivalent) paid by members by taking the total annual premium (or premium equivalents) during the reference year and dividing it by 12. You should divide by 12 even if the coverage was not in effect for the entire calendar year.

Employer Premiums

Calculate the average annual premium (or premium equivalent) paid by employers on behalf of members by taking the total annual premium (or premium equivalents) and dividing by 12. You should divide by 12 even if the coverage was not in effect for a member or members for the entire reference year.

Sample Formulas

Average Monthly Premiums Paid by Members = Total annual premiums paid by members / 12
Average Monthly Premiums Paid by Employer = Total annual premiums paid by the employer / 12

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. An exception applies 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.

Employers should do their best to provide an accurate answer; however, any minor errors in the calculation are unlikely to be significant. A carrier or TPA filing a D1 on its groups' behalf is required to aggregate the Average Monthly Premium across its entire book of business by state and market segment. In other words, CMS will 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 likely not have a significant impact on the overall data being reported.

Other D1 Fields

For those employers who have to complete their own D1, or whose carrier or 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/FEIN)	This should be the name and Federal Employment Identification Number (FEIN) of the insurance company that issues the fully insured policy or the TPA that 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 fewer 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	Take the Total Member Months used to calculate Average Monthly Premiums above / 12. Report the result to the eighth decimal place. In the example above with 10,831 member months, the life years reported would be 902.58333333.
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 the medical loss ratio (MLR) or other similar rebates.
Premium Equivalents	This is the total cost of providing self-funded coverage for the year including claims costs, administrative costs, Administrative Services Only (ASO) and other TPA fees, stop-loss premiums minus stop-loss reimbursements, and prescription drug rebates. This should be the same number used in the numerator when calculating Average Monthly Premiums; this field should be left blank for a fully insured plan. Starting with the 2023 reference year premium equivalents may be reported on a cash basis or on a retrospective basis.
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.

Summary

Employers and vendors face many challenges in completing the required RxDC reporting, and CMS understands that the data will not be perfect. Employers must annually 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. While no official good-faith relief has been provided for the upcoming reporting, we anticipate that if an employer makes a good-faith attempt to comply, the regulatory agencies will continue to be lenient with any enforcement action.

EPIC Employee Benefits Compliance Services

For further information on this or any other topic, please contact your EPIC benefits consulting team.