# Prescription Drug Data Collection (RxDC) Reporting Instructions

Last Update: 11/30/2022

# What is required?

To understand how SummaCare (SummaCare is the administrator for the plans that are underwritten by Summa Insurance Company, Inc.) and their customer will support the submission of data and applicable narrative, refer to the following information. The CMS instructions define data requirements, including the following letter and number identifiers.

**Requirements**[1]**:** Plans, issuers, and carriers must submit one or more plan lists (P1, P2, P3), eight data files (D1 through D8), and a narrative response.

- Those identifiers beginning with **P** stand for Plan

  **P1**: Individual and Student Market plans

  **P2:** Group Health plan list (most commercial business) required for employer-based health plans that are not FEHB plans

  **P3:** FEHB plan list

  The plan lists identify the Employer group and plans in a submission. The plan lists also collect plan-level information, such as the beginning and end dates of the plan year, number of members, and the states in which the plan or coverage is offered.

**P2 Definitions - What is a Group Health Plan?**

- **Group Health Plan Name** will be the employer group health benefit plan
  - Client Group Health Plan Name should already be completed in the **5500** website
  - SummaCare will reconcile to the **Group Health Plan Name** based on the Plan Sponsor name in the **5500**
  - Where blank, SummaCare will default to the customer's name in our system
- **Group Health Plan Number** will be the unique plan identification number.
  - SummaCare will use the **EIN** from our system as the unique plan identification number
  - We will **reconcile** to the Plan Sponsor **EIN** from the **5500** website
  - For companies that use multiple EINs, SummaCare will use the primary EIN associated with the **5500**

Please note: Any entity that submits a Data file, must also submit a corresponding P2. Therefore, there will be multiple submitters of P2. The Client will submit a Master P2 record which will incorporate the details for all TPAs and PBMs who will be submitting Data on their behalf.

**Best practice: As noted, data from the 5500 website should be used to ensure consistency in the submission of P2 by multiple parties. The Client should use the Group Health Plan Name based on the Plan Sponsor Name and the Group Health Plan Number based on the Plan Sponsor EIN.**

**Narrative**[1] - A narrative response is required to describe the impact of prescription drug rebates on premium and cost sharing. SummaCare will submit the appropriate Narrative for each Data file submitted.

**Market Segment**[1] is also required

The table has the names and abbreviations for the market segments. Submitters must use the appropriate abbreviation when filling out plan lists and data files. The exact spelling of the abbreviation must be used.

| Market Segment | Abbreviation (not case sensitive) |
|---|---|
| Individual market (excluding the student market) | Individual market |
| Student market | Student market |
| Fully-insured small group market | Small group market |
| Fully-insured large group market (excluding the FEHB line of business) | Large group market |
| Self-funded group health plans offered by small employers | SF small employer plans |
| Self-funded group health plans offered by large employers | SF large employer plans |
| FEHB line of business | FEHB plans |

# Creating a Master P2

- The P2 identifies each unique Group Health Plan and is the common thread to link all D files to a particular Group Health Plan.
- Clarification was received from CMS which implies that if the Group Health Plan uses multiple TPAs or PBMs, a P2 should be submitted by the Group Health Plan which incorporates ***all*** TPAs, PBMs and associated EINs. We are referring to this as the Master P2. The Master P2 will be used by CMS to identify the TPAs and PBMs who may also submit **P2** and **D** files on behalf of the Employer group.
- The Master P2 will be used by CMS to identify the full list of TPAs and PBMs who may also submit P2 and Data files on behalf of the Employer group.
- Each TPA or PBM will submit their own corresponding P2 along with the Data files they submit on behalf of the Employer group.

Note: P2 requires the count of Members as of 12/31 of the Reference Year

SummaCare will include all Members in the policy in the submission for the Pharmacy Benefits and Costs data.

### Example 3: Multiple Vendors for Medical Benefits

Suppose Plan C uses TPA A for behavioral health services and TPA B for other medical benefits. Assume Plan C's plan year is a calendar year and both TPAs will submit D1 and D2.

**TPA A's P2 file for the 2020 reference year**

| Group Health Plan Name | ... | Plan Year Beginning Date | Plan Year End Date | ... | TPA Name | ... | Included in D1? (1= Yes; 0 = No) | Included in D2? (1= Yes; 0 = No) | ... | Included in D8? (1= Yes; 0 = No) |
|---|---|---|---|---|---|---|---|---|---|---|
| Plan C | ... | 01/01/2020 | 12/31/2020 | ... | TPA A; TPA B | ... | 1 | 1 | ... | 0 |

**TPA B's P2 file for the 2020 reference year**

| Group Health Plan Name | ... | Plan Year Beginning Date | Plan Year End Date | ... | TPA Name | ... | Included in D1? (1= Yes; 0 = No) | Included in D2? (1= Yes; 0 = No) | ... | Included in D8? (1= Yes; 0 = No) |
|---|---|---|---|---|---|---|---|---|---|---|
| Plan C | ... | 01/01/2020 | 12/31/2020 | ... | TPA A; TPA B | | 1 | 1 | ... | 0 |

For TPA A and TPA B to include the information of both TPAs in the TPA fields in their respective P2 files, Plan C needs to provide each TPA with the name and EIN of the other TPA. If Plan C does not provide this information to the TPAs, then Plan C needs to submit a P2 file in HIOS to alert CMS that two different TPAs are submitting the same data file type on its behalf. (**Note**: A reporting entity can submit a plan list in HIOS without submitting a data file, but it is not possible to submit a data file in HIOS without submitting a plan list.)

# Data Definitions

Those identifiers beginning with a D, stands for Data and reference the 8 distinct files of information required in the report. All self-funded D files will be aggregated by TPA/market segment/state (principal place of business). All fully insured D files will be aggregated by Issuer/market segment/state (where the policy was issued).

**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

**D1**: Premium and Life Years Clients will submit this data in a shared arrangement. Note: Safe Harbor applies Premium reporting for 2022.**

**Premium:** For self-funded plans and other arrangements that do not rely exclusively or primarily on premiums, report the premium equivalent amounts representing the total cost of providing and maintaining coverage, including claims costs, administrative costs, Administrative Services Only (ASO) and other TPA fees, and stop-loss premiums. An employer with a self-funded plan may use, as the total cost of providing and maintaining coverage, the same costs that are taken into account for purposes of calculating COBRA premiums (minus the 2% administration charge, if applicable).
Report the ASO and other fees paid to the TPA. This amount should also be included in Premium Equivalents.

**Life-years** are the average number of members in the plan throughout the year.

D1: **Premium Safe Harbor**

For the 2020 and 2021 reference years only, the Safe Harbor states: “If you have obtained the required information, you must report it. However, the Departments recognize there may be significant challenges to obtain information about employer premium contributions, especially when a contractual relationship began before the passage of the CAA. Accordingly, the Departments will not take enforcement action related to the requirement to report average monthly premium paid by employers versus members for the 2020 and 2021 reference years if those data elements are reported in RxDC report for the 2022 reference year and all future reference years.”

# Data Definitions

**D2: Spending by Category**
Claims paid under medical, includes Behavioral claims

| Spending Category | **Abbreviation** (Not case sensitive) |
|---|---|
| Hospital | Hospital |
| Primary care | Primary care |
| Specialty care | Specialty care |
| Other medical costs and services | Other medical costs and services |
| Medical benefit drugs: known amounts (informational) | Known medical benefit drugs |
| Medical benefit drugs: estimated amounts (informational) | Estimated medical benefit drugs |

**Instructions state to NOT report spending on pharmacy benefit drugs anywhere in D2 Spending by Category.**

| Include in Other medical costs and services | Exclude |
|---|---|
| • Radiology and laboratory services that are billed independently by the laboratory (Radiology: 70000–79999; laboratory and pathology: 36415; 36416; 80000–89999)<br>• Non-hospital based skilled nursing and hospice services<br>• Ambulance services not billed by a hospital facility<br>• Home health care<br>• Dental services and supplies<br>• Vision services and supplies<br>• Durable medical equipment<br>• Wellness services billed on a claim. Do not include wellness services that are not covered services under a plan or policy. For the purposes of the RxDC report, wellness services are defined as activities primarily designed to implement, promote, and improve health. | • Claims with a valid revenue code on the UB-04 form.<br>• Wellness services not billed on a claim |

**D2: Spending by Category definitions (continued)**

- **Hospital:** spending on services provided by hospitals to members and billed by the facility.
- **Primary care:** spending on clinical health care services provided by a primary care provider in doctor's office or outpatient care center.
- **Specialty care:** spending on clinical health care services provided by specialists.
- **Other medical costs and services:** spending for all other professional and facility clinical health care services and equipment not reported as hospital, primary care, or specialty care.
- **Medical Benefit Drugs:** known amounts (informational): spending on drugs covered under a medical benefit that are separately billed or otherwise known exactly. The amounts reported here are also included in the hospital, primary care, specialty care, or other medical costs and services categories.
- **Medical benefit drugs:** estimated amounts (informational): estimated portion of bundled or alternative payment arrangements (or other non-fee for service amounts) that can be attributed to drugs covered under a medical benefit. The amounts reported must also be reported in the hospital, primary care, specialty care, or other medical costs and services categories.
- **Cost Sharing:** deductibles, coinsurance, and copays, including amounts that may have been paid through a health savings or reimbursement account.

**D3: Top 50 Most Frequent Brand Drugs**

For each RxDC brand name drug, calculate the total number of paid claims in a state and market by adding the number of paid claims for every NDC associated with the RxDC brand drug name.

- CMS will indicate which drugs are considered brand name drugs.
- Rank the drugs in each state and market segment according to number of paid claims, sorted in descending order.
- Identify the 50 brand name drugs with the highest number of paid claims.
- Create a table with the top 50 drugs and include a row for every state, market segment, and EIN of the issuer or TPA.

**D4: Top 50 Most Costly Drugs**

For each RxDC drug, calculate total spending, net of prescription drug rebates, fees, and other remuneration, in the state and market segment by summing total spending for every NDC associated with the RxDC drug name.

- Rank the drugs in the state and market segment according to total spending, sorted in descending order, and identify the 50 drugs with the greatest total spending.
- Create a table with the top 50 drugs and include a row for every state, market segment, and EIN of the issuer or TPA.
- For each row, report total spending and the other utilization and spending variables in the file layouts.

**D5: Top 50 Drugs by Spending Increase**

For each RxDC drug, calculate total spending, net of prescription drug rebates, fees, and other price concessions, in the state and market segment by summing total spending for the reference year for the NDCs associated with the RxDC drug name.

- For each RxDC drug, calculate the increase in total spending by subtracting total spending in the state and market segment for the year prior to the reference year from total spending in the state and market segment for the reference year.
- If spending on a drug increased from one year to the next, the difference will be a positive number.
- If spending on a drug decreased from one year to the next, the difference will be a negative number.
- Rank the drugs in each state and market segment according to the increase in total, sorted in descending order.

**D6: Rx Totals**

Report information about prescription drugs covered under the pharmacy benefit.

**D7: Rx Rebates by Therapeutic Class**

A therapeutic class is a group of drugs that have a similar mechanism of action or treat the same condition. Therefore, they are assigned the same RxDC therapeutic class name. If an NDC has more than one ingredient and those ingredients belong to different therapeutic classes, the RxDC therapeutic class name is the combination of the therapeutic classes.

**D8: Rx Rebates for the Top 25 Drugs**

For each RxDC drug, calculate total rebates, fees, and other remuneration in the state and market segment by summing total rebates, fees, and other remuneration for every NDC associated with the RxDC drug name.
Rank the drugs in the state and market segment according to total rebates, fees, and other remuneration, sorted in descending order. Identify the 25 drugs with the greatest amount.

****Stop Loss: Premium equivalents (self-funded coverage) D1**

For self-funded plans and other arrangements that do not rely exclusively or primarily on premiums, report the premium equivalent amounts representing the total cost of providing and maintaining coverage, including claims costs, administrative costs, Administrative Services Only (ASO) and other TPA fees, and **stop-loss premiums**.
An employer with a self-funded plan may use, as the total cost of providing and maintaining coverage, the same costs that are taken into account for purposes of calculating COBRA premiums (minus the 2% administration charge, if applicable).

# Who is responsible for data submission?

**CAA PHARMACY BENEFIT AND COST REPORTING FOR ASO CUSTOMERS**

We will report our data in **aggregate** as supported by CMS aggregation instructions.
**NOTE: SummaCare will submit P2 and Data files directly to the CMS portal as required.**
**SummaCare is unable to provide individual customer specific reporting**

**Multiple Reporting Entities:**
A plan, issuer, or carrier can allow multiple reporting entities to submit on its behalf.
The submission for a plan, issuer, or carrier is considered complete if CMS receives all required files, regardless of who submits the files. Multiple reporting entities *should not submit the same data file* for a plan, issuer, or carrier.
Each reporting entity must submit one or more plan list files (P2) that is how CMS will know when multiple entities are reporting for the same Group health plan.

A common **Group Health Plan Name** and **Group Health Plan Number** will tie multiple submissions to a single employer group health plan. Please reference Summa Insurance Company rather than SummaCare when submitting a file. This will enable CMS to tie the submissions together.

**Carve Out Arrangements:** Some clients will need to coordinate with other carriers based on carve out arrangements. If MedImpact is not the PBM (customer carves out pharmacy benefits) or stop loss, the customer needs to ensure their carrier(s) submit the appropriate files:

**Carve out Pharmacy carrier will submit:**
- **P2:** TPA Name & TPA EIN
- **D3-D8:**

**Carve out Stop Loss carrier will submit:**
- **P2:** TPA Name & TPA EIN
- **D1:** Stop Loss Premium equivalent

## Terminated Groups

We will follow the standard approach as indicate above for groups that were active in 2020 or 2021. The terminated client will have a shared responsibility to submit their P2, D1 data directly to CMS.

## Narrative Response

SummaCare/MedImpact will submit the appropriate Narrative Response for each data file. The CMS instructions include details as to the information required in the Narrative Response.
Examples include:

- Employer size
- Identify whether actual counts or estimates were used to determine the size of the employer for self-funded plans
- Describe the estimation method if estimates were used
- Net payments from federal or state reinsurance or cost-sharing reduction programs
- Drugs missing from the CMS crosswalk
- Medical benefit drugs
- Prescription drug rebate descriptions, impact and allocation methods

- Describe the impact of prescription drug rebates on the tier assignment of prescription drugs in the formulary, or the removal of generic equivalents from a formulary. If possible, provide a quantitative estimate of the impact

# Form 5500 Plan Number

Form 5500 Number – Mandatory for fully insured and ASO filing

**Location: P2**
If applicable, enter the 3-digit plan number reported on the IRS Form 5500 filed with DOL.
If there is more than one value, separate them with a semicolon.

It is the Group Health Plan's responsibility to file the Form 5500. For reference, here is the link to the U.S. Department of Labor Form 5500 Search Tool: https://www.efast.dol.gov/5500Search/
5500 data is expected to be found in the 5500 site for most employer groups.

# Legal Entity and EIN

Following please find the Legal Entity and EIN combinations for TPA Name and EIN and PBM Name and EIN. This information may be shared, upon request:

| Legal Entity | EIN |
|---|---|
| Summa Insurance Company, Inc. (SummaCare is the administrator for the plans that are underwritten by Summa Insurance Company, Inc.) | 34 -1809108 |
| Apex Benefits Services, LLC (DBA Apex Health Solutions) | 34 -1961463 |
| MedImpact | Available Upon Request |

# State Aggregation

The state aggregation rules for RxDC are like the requirements in the MLR reporting form instructions. In general, a reporting entity should report fully-insured business in the state where the policy was issued.

For self-funded plans, the reporting entity should generally report the data in the state where the plan sponsor has its principal place of business. When a plan covers members in multiple states, or when coverage is sponsored by a group trust, association, or multiple employer welfare arrangement (MEWA), the reporting entity should follow the instructions below.

# CMS Site and Reference links

**The CMS Portal is now open for Clients to submit their data.**

Confirmation of completion of submission of RxDC data to CMS:

- SummaCare will send a communication to our internal teams on 12/21 to confirm that we are on track to complete the required submission to CMS.
- There will be a follow up confirmation on 12/28 to confirm that the submission is complete.
- The account teams may use these communications to provide updates to Clients, Brokers and Consultants.

| CMS Site | Content |
|---|---|
| CMS Reporting Instructions | Contains details regarding reporting instructions and deadlines |
| CMS - Sign In | CMS.gov sign in link |
| HIOS RxDC User Manual (cms.gov) | HIOS RxDC User Manual |
| HIOS Portal User Manual (cms.gov) | HIOS Portal User Manual |