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Department of Health & Human Services
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# Prescription Drug Data Collection (RxDC) Reporting Instructions

## Section 204 Data Submission Instructions for the 2020 and 2021 Reference Years

Updated June 28, 2022

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## Changes from the November 2021 version of the RxDC Instructions

The RxDC reporting instructions have been updated in response to:

- Public comments on the Paperwork Reduction Act package (CMS-10788) related to the interim final rules titled Prescription Drug and Health Care Spending (86 FR 66662), published on November 23rd, 2021
- Help desk inquiries sent to CMS at CMS_FEPS@cms.hhs.gov

The most significant changes to the RxDC reporting instructions include the following:

**Plan Lists**

- Added definitions for the columns in the plan list files
- Clarified the treatment of non-calendar year plans
- Added columns to the plan list files for reporting entities to indicate which plans are included in the data files

**Spending Categories**

- Moved the spending category for drugs covered under a medical benefit (medical benefit drugs) from data file D6 Rx Totals to data file D2 Spending by Category
- Eliminated the spending category in D2 for pharmacy benefit drugs
- Combined the spending categories for wellness services and other medical costs and services
- Required that spending on wellness services be restricted to claims-based costs
- Differentiated spending on medical benefit drugs according to whether the drug was separately billed or included as part of a bundled payment arrangement
- Provided additional detail on classifying claims according to spending category

**Total Spending**

- Specified the circumstances when manufacturer cost-sharing assistance must be subtracted from total spending
- Provided guidance on allocating net payments from any federal or state reinsurance or cost-sharing reduction arrangement or program

**Average Monthly Premium Paid by Members and by Employers**

- Clarified how to calculate the average monthly premium
- Changed the term “employee” to “member” in the instructions for calculating average premium per member per months
- Updated instructions with respect to 2020 and 2021 reference year reporting

**Prescription Drugs**

- Clarified that authorized generics and branded generics are treated as generic drugs for RxDC reporting
- Updated examples to include the RxDC drug codes

# 1 Overview

## 1.1 What is the RxDC report?

In these instructions, the term RxDC report refers to the data submission required under Section 204 of Division BB, Title II (Section 204) of the Consolidated Appropriations Act, 2021 (CAA).[1] The Rx stands for Prescription Drug and the DC stands for Data Collection.

Section 204 requires group health plans (plans) and health insurance issuers (issuers) offering group or individual health insurance coverage to submit information about prescription drugs and health care spending to the Department of Health and Human Services (HHS), the Department of Labor (DOL), and the Department of the Treasury (the Departments). In addition, the Director of the Office of Personnel Management (OPM) requires Federal Employees Health Benefits carriers (carriers) to submit Section 204 data to HHS. The Centers for Medicare & Medicaid Services (CMS) is collecting Section 204 data submissions on behalf of the Departments and OPM.

The implementing regulations for the Section 204 data collection are at 5 CFR part 890, 26 CFR part 54, 29 CFR part 2590, and 45 CFR part 149.

## 1.2 Who must submit the RxDC report?

| Required to Submit | Not Required to Submit |
|---|---|
| • Health insurance issuers offering group coverage<br>• Health insurance issuers offering individual market coverage, including:<br>  ○ Student health plans<br>  ○ Plans sold through the Exchanges<br>  ○ Plans sold outside of the Exchanges<br>  ○ Individual coverage issued through an association<br>• Fully-insured and self-funded group health plans, including:<br>  ○ Non-federal governmental plans, such as plans sponsored by state and local government<br>  ○ Church plans that are subject to the Internal Revenue Code<br>  ○ Federal Employees Health Benefits (FEHB) plans | • Account-based plans, such as health reimbursement arrangements<br>• Excepted benefits[2] including but not limited to:<br>  ○ Short-term limited-duration insurance<br>  ○ Hospital or other fixed indemnity insurance<br>  ○ Disease-specific insurance<br>• Medicare Advantage and Part D plans<br>• Medicaid plans<br>• State children's health insurance program plans<br>• Basic Health Program plans |

These requirements apply regardless of whether a plan is considered a grandfathered or grandmothered health plan.[3]

[1] The CAA is available at https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf. Section 204 Section 204 of Division BB, Title II starts on page H. R. 133—1737.

[2] PHS Act 2722(b) and (c), ERISA Section 732, and Code Section 9831.

[3] Grandmothered plans, sometimes referred to as transitional plans, are non-grandfathered plans in the individual and small group market that were issued prior to January 1, 2014, and for which CMS announced it will not take enforcement action with respect to certain market requirements. See Bulletin: Extended Non-Enforcement of Affordable Care Act-Compliance With Respect to Certain Policies, available at https://www.cms.gov/files/document/extension-limited-non-enforcement-policy-through-calendar-year-2022.pdf.

Plans, issuers, and carriers may have vendors submit the RxDC report on their behalf. See Section 3 for more information about vendor submissions.

### 1.3 When is the deadline?

The last day to submit your data for the 2020 and 2021 reference years is **December 27, 2022**.[4] The deadline for subsequent reference years is June 1st of the calendar year immediately following the reference year. A **reference year** is the calendar year of the data that is in your RxDC report. For example, the RxDC report for the 2020 reference year means the information in the report is based on what happened in 2020.

**What is a Reference Year?**
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### 1.4 Where can I get help?

You can find more information about RxDC reporting on the CMS website at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/Prescription-Drug-Data-Collection. You can also sign up for email announcements and register for training webinars at Registration for Technical Assistance Portal (REGTAP) at https://regtap.cms.gov/rxdc.php.

If you can't find the answer to your question in REGTAP, contact our help desk at 1-855-267-1515 or CMS_FEPS@cms.hhs.gov. Include "RxDC" in the body of the email for faster service. You can typically expect a response within the same day and a full resolution within 1-2 weeks.

**REGTAP**
Sign up for announcements and training webinars at Registration for Technical Assistance Portal (REGTAP): https://regtap.cms.gov/rxdc.php

**Help Desk**
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## 2 Required Files

Plans, issuers, and carriers must submit one or more **plan lists** (P1-P3), **eight data files** (D1-D8), and **a narrative response**.

[4] The statutory deadlines to submit the RxDC report for the 2020 and 2021 reference years are December 27, 2021 and June 1, 2022, respectively. However, the Departments are deferring enforcement for the 2020 and 2021 reference years if you submit your data by December 27, 2022. See FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Part 49, Q12, available at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf and https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf.

## 2.1 Plan Lists and Data Files

| Subject | Plan Lists | Data Files |
|---|---|---|
| **File Names** | P stands for Plan<br>• P1 Individual and student market plan list<br>• P2 Group health plan list<br>• P3 FEHB plan list | D stands for Data<br>• D1 Premium and Life-Years<br>• D2 Spending by Category<br>• D3 Top 50 Most Frequent Brand Drugs<br>• D4 Top 50 Most Costly Drugs<br>• D5 Top 50 Drugs by Spending Increase<br>• D6 Rx Totals<br>• D7 Rx Rebates by Therapeutic Class<br>• D8 Rx Rebates for the Top 25 Drugs |
| **Purpose** | The plan lists identify the plans in a submission. The plan lists also collect plan-level information required by statute, such as the beginning and end dates of the plan year, the number of members, and the states in which the plan or coverage is offered. | The data files collect premium and spending information at an aggregate level. |
| **Requirement** | • P1 is required for plans in the individual or student market<br>• P2 is required for employer-based health plans that are not FEHB plans<br>• P3 is required for FEHB plans | All 8 data files are required. |
| **File Format** | Comma Separated Values (CSV) | Comma Separated Values (CSV) |

The file layouts for the plan lists and data files are in Appendix A of these instructions. The plan list and data file templates are on the CMS website at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/Prescription-Drug-Data-Collection.

## 2.2 Narrative Response

A narrative response is required. Describe the impact of prescription drug rebates on premium and cost sharing in the narrative response. You must also respond regarding the other topics described throughout these instructions. The narrative response file format must be Portable Document Format (.pdf) or Microsoft Word (.doc or .docx). See Section 10 for more information on the narrative response.

### Optional Supplemental Documents

If you want to provide additional information about your submission, the system will allow you to upload supplemental PDF or Word documents. This is optional.

# 3 Submission Process

## 3.1 Where do I submit my data?

Submit your data through the RxDC module in the Health Insurance Oversight System (HIOS). To log in to HIOS, go to the CMS Enterprise Portal at https://portal.cms.gov/portal/.

**Do I need to create a CMS Enterprise Portal or HIOS Account?**
You do **NOT** need to create a CMS Enterprise Portal or HIOS account if:

- You already have a HIOS account, or
- You are not uploading any files (because an issuer, third-party administrator, pharmacy benefit manager, or other reporting entity is uploading files on your behalf).

NOTE: It can take up to two weeks to create your accounts. Don't wait until the last minute!

The instructions to create your CMS Enterprise Portal and HIOS accounts are in the HIOS Portal User Manual. The instructions for using the RxDC module are in the RxDC HIOS User Manual.

## 3.2 Can a vendor submit information on my behalf?

Yes. Plans, issuers, and carriers can contract with issuers, third-party administrators (TPAs), Pharmacy Benefit Managers (PBMs), or other third-party vendors to submit data on their behalf. An entity that submits some or all required information is called a **reporting entity**. In these instructions, "you" generally refers to the reporting entity.

**What is a reporting entity?**
An entity that submits some or all required information is called a **reporting entity**. In these instructions, "you" generally refers to the reporting entity.

## 3.3 Can multiple vendors submit my data?

Yes. A plan, issuer, or carrier can allow multiple reporting entities to submit on its behalf. For example, a self-funded group health plan may contract with a TPA to submit the Spending by Category data file (D2) and separately contract with a PBM to submit the Top 50 Most Costly Drugs file (D4). 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. For example, a TPA and PBM should not both submit D2 for the same group health plan. The HIOS system does not automatically prevent duplicate submissions of the same file. CMS will check whether there are duplicate files after the submission deadline.

Each reporting entity must submit one or more plan list files (P1, P2, and/or P3). That is how CMS will know when multiple entities are reporting for the same plan. If you know which reporting entity will also be reporting on behalf of a plan, enter its company name and Employer Identification Number (EIN) in the appropriate columns in the plan list file. CMS will use this information to streamline the reconciliation process when there are multiple reporting entities.

Note: It's not a problem if multiple reporting entities upload different narrative responses on behalf of the same plan, issuer, or carrier.

To preserve confidentiality, a reporting entity can view only the files that it uploads. It cannot view files uploaded by a different reporting entity even if the information is related to the same plan, issuer, or carrier. For example, if a TPA uploads D2 and a PBM uploads D4 for the same group health plan, the TPA can see only D2 and the PBM can see only D4. The group health plan cannot see either D2 or D4. The plan should contact its reporting entities directly if the plan wants to see the data uploaded on its behalf.

### 3.4 What if a vendor can't fill out an entire file?

Plans, issuers, carriers, and their reporting entities must work together so that each data file submitted in HIOS contains all required information. If one reporting entity is responsible for only some of the fields in a data file, it should fill out those fields and then give the data file to the other reporting entity to complete the remaining information before submitting the data file in HIOS.[5]

### 3.5 What if a plan changes vendors during the reference year?

If a plan, issuer, or carrier changes vendors during the reference year (such as changing a TPA or PBM), there are two reporting options:

- The previous vendor reports the data from earlier in the year and the new vendor reports the data from later in the year; or
- The previous vendor provides the data to the new vendor and the new vendor reports the entire year of data

Either way, the plan sponsor must ensure that all their data is reported and that it is not double-reported.

### 3.6 How do I know if a reporting entity submitted my data?

Currently, CMS does not have a mechanism to notify plans, issuers, or carriers when data has been submitted on their behalf. To confirm submission, plans, issuers, and carriers should contact their reporting entities directly.

## 4 Plan List Definitions

Use the following definitions when you fill out your plan lists.

Note 1: Do not uses slashes ("/") in alphanumeric fields. HIOS won't accept text with slashes because data with slashes requires additional security screening that would slow down processing time. The exception is that you can use slashes in the column headers and in date fields.

Note 2: You may use commas in in alphanumeric fields if the string is enclosed by double-quotation marks as text qualifiers. (Ex: "Mary's Hardware Store, Inc.") The double-quotation marks are necessary so that HIOS can differentiate from commas used as delimiters and commas used in a text string.

[5] If there are extenuating circumstances that prevent vendors from working together, contact the help desk at cms_feps@cms.hhs.gov. CMS will get back to you to discuss the situation.

## 4.1 General Definitions

### Members as of 12/31

**Location:** P1, P2, P3 | **Max decimal places:** 0 | **Must not be blank**
Enter the number of members as of 12/31 of the reference year. You must enter a whole number without decimal places. If a plan year ended before 12/31 of the reference year, enter 0.

**What is a Member?**
For the purposes of these instructions, the term "member" means a person who has health coverage, regardless of whether the coverage is associated with an insurance policy, a group health plan, or an FEHB plan. For example, enrollees, dependents, participants, beneficiaries, and FEHB annuitants are all considered members.

### Plan Year Beginning and End Dates

**Location:** P1, P2, P3 | **Format:** MM/DD/YYYY | **Must not be blank**
Enter the plan year beginning and end dates.

Individual and Student Markets
Generally, you may enter the first and last day of the reference year. For grandfathered and grandmothered individual market plans, you may alternatively enter the date on which the plan was first offered, and the date on which the plan was closed to new enrollment. For student health plans, you may alternatively enter the plan or policy year, or if the year is not designated in the plan or policy document, then the deductible or limit year used under the coverage.

Group Markets
Enter the actual beginning and end dates of the plan year, even if they fall outside of the reference year. For example, if the plan year is July 1, 2019 through June 30, 2020, enter 07/01/2019 for the beginning date and 06/30/2020 for the end date in the 2020 RxDC report. Since the plan year ended before the end of the reference year, enter 0 for the number of members as of 12/31/2020 in the 2020 RxDC report.

Similarly, if the plan year is July 1, 2020 through June 30, 2021, enter 07/01/2020 for the beginning date and 06/30/2021 for the end date in the 2020 RxDC report. Enter the actual number of members as of 12/31/2020 in the 2020 RxDC report.

If a plan renews in the middle of the reference year, use two rows in the plan list file: one row for the plan year that ended on 6/30/2020 and another for the plan year that began on 7/1/2020.

**Example:** Non-calendar year plan in the 2020 RxDC report.

| Group Health Plan Name | Group Health Plan Number | Market Segment | Plan Year Beginning Pate | Plan Year End Date | Members as of 12/31 of the reference year |
|---|---|---|---|---|---|
| Jane's Furniture Health and Welfare Plan | 501 | Small group market | 07/01/2019 | 06/30/2020 | 0 |

| Group Health Plan Name | Group Health Plan Number | Market Segment | Plan Year Beginning Pate | Plan Year End Date | Members as of 12/31 of the reference year |
|---|---|---|---|---|---|
| Jane's Furniture Health and Welfare Plan | 501 | Small group market | 07/01/2020 | 06/30/2021 | 27 |

**Note:** In the data files (as opposed to the plan lists), the reporting entity would include only the data related to the 2020 calendar year (e.g. the last six months of the "old" plan and the first six months of the "new" plan).

### Market Segment

**Location:** P1, D1-D8 | **Max length** 100 characters | **Must not be blank**
**Location:** P2 | **Max length** 512 characters | **Must not be blank**

The following table has the names and abbreviations for the market segments. You must use the appropriate abbreviation when you fill out your plan lists and data files. Make sure to use the exact spelling of the abbreviation or you will be unable to upload your data.

| 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 |

- P1: Enter individual market or student market. Do not enter more than one market segment in a cell.
- P2: Enter small group market, large group market, SF small employer plans, or SF large employer plans. If a plan is partially insured and partially self-funded, enter both market segments in the same cell, separated by a semi-colon. Example: Large group market; SF large employer plans. P2 is the only place where you can put more than one market segment in a single cell.
- P3: There isn't a column for market segment because all plans in P3 are FEHB plans.
- D1 – D8: Enter individual market, student market, small group market, large group market, SF small employer plans, SF large employer plans, or FEHB plans. Do not enter more than one market segment in a cell.

See Section 5.1 for more information on market segments.

### Issuer Name

**Location:** P2, P3 | **Max Length** 2048 characters
Enter the issuer name. Do not use slashes.

If there is more than one issuer, enter both in the same cell separated by a semicolon. If the plan is not insured, leave the cell blank.

### Issuer EIN

**Location:** P2, P3 | **Format:** 9 digits
Enter the issuer 9-digit EIN. Do not enter the 5-digit HIOS Issuer ID. If a plan uses more than one issuer, enter both in the same cell separated by a semicolon. If the plan is not insured, leave the cell blank.

### TPA Name

**Location:** P2, P3 | **Max Length** 2048 characters
Enter the TPA name. Do not use slashes. If there is more than one TPA, separate them with a semicolon. If a plan doesn't have a TPA, leave the cell blank.

### TPA EIN

**Location:** P2, P3 | **Format:** 9 digits
Enter the TPA 9-digit EIN. Do not enter the 5-digit HIOS Issuer ID. If there is more than one TPA, separate them with a semicolon. If a plan doesn't have a TPA, leave the cell blank.

### PBM Name

**Location:** P1, P2, P3 | **Max Length** 2048 characters
Enter the PBM name. Do not use slashes. If there is more than one PBM, separate them with a semicolon. If a plan doesn't have a PBM, leave the cell blank.

### PBM EIN

**Location:** P1, P2, P3 | **Format:** 9 digits
Enter the PBM 9-digit EIN. If there is more than one PBM, separate them with a semicolon. If a plan doesn't have a PBM, leave the cell blank.

### Included in D1 – D8

**Location:** P1, P2, P3 | **Valid Values:** 0 or 1 | **Must not be blank**
Enter 1 if a plan's data is included in the respective data file in your submission. Enter a 0 if the plan's data is not included in the respective data file in your submission. For example, if an issuer is submitting D1 and D2 on behalf of a plan, the issuer should enter 1 in "Included in D1" and "Included in D2" and enter 0 for "Included in D3" through "Included in D8." CMS will use this information to reconcile submissions when more than one reporting entity is submitting on behalf of a plan.

## 4.2 HIOS Definitions

### HIOS Plan ID in P1

**Location:** P1 | **Max length:** 25 characters | **Must not be blank in P1**
Enter the 14-character Plan ID from HIOS. Do not enter multiple HIOS Plan IDs in the same cell in P1. Do not leave this cell blank.

Some grandfathered, grandmothered, and student health plans may not have HIOS Plan IDs. If a plan does not have a HIOS Plan ID, create a unique 14-character plan ID as follows:

| Plan Type | Characters 1-5 | Characters 6-7 | Characters 8-14 | Example |
|---|---|---|---|---|
| **Grandfathered Plans** (excluding student plans) | 5-digit HIOS Issuer ID | GF | Generate a unique 7-digit number. | 52986GF0000147 |
| **Grandmothered Plans** (excluding student plans) | 5-digit HIOS Issuer ID | GM | Generate a unique 7-digit number. | 52986GM0000148 |
| **Student Health Plans** | 5-digit HIOS Issuer ID | SH | Generate a unique 7-digit number. | 52986SH0000149 |

### HIOS Plan ID in P2

**Location:** P2 | **Max length:** 2048 characters | **May be blank in P2**
The HIOS Plan ID field in P2 is applicable only to fully-insured small group health plans that already have HIOS Plan IDs. You can enter more than one HIOS Plan ID in a single cell in P2, if applicable. Separate multiple values with a semicolon. You do not need to create HIOS Plan IDs for group health plans that do not already have HIOS Plan IDs. If your group health plan isn't associated with a HIOS Plan ID, leave this cell blank.

### HIOS Plan Name

**Location:** P1 | **Max length** 20 characters | **Must not be blank**
Enter the HIOS Plan Name. If a plan isn't registered in HIOS, enter the plan marketing name.

## 4.3 Group Definitions

### Group Health Plan Name

**Location:** P2 | **Max length** 512 characters | **Must not be blank**
Enter the group health plan name. Do not use slashes.

### Group Health Plan Number

**Location:** P2 | **Max length** 25 characters | **Must not be blank**
Enter a unique plan number. You may use numbers, letters, or punctuation marks (except for slashes).

You may use the Form 5500 plan number as the Group Health Plan Number. If you do, you must also enter the Form 5500 Plan Number in the Form 5500 Plan Number column. That is, the Form 5500 Plan Number would be in the Group Health Plan Number column *and* the Form 5500 Plan Number column.

### Form 5500 Plan Number

**Location:** P2 | **Max length** 25 characters
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.

### Plan Sponsor Name

**Location:** P2 | **Max length** 2048 characters | **Must not be blank**
The term plan sponsor means:

- The employer, for an employee benefit plan that a single employer established or maintains;
- The employee organization in the case of a plan of an employee organization; or

- The association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan, if the plan is established or maintained jointly by one or more employers and one or more employee organizations, or by two or more employers.

Do not enter more than one plan sponsor name in the same cell unless plan sponsorship changed during the reference year. In that case, separate the names with a semicolon.

Note: Sometimes the Plan Sponsor Name is the same as the Group Health Plan Name.

Multiple-Employer Plans
If an association or other entity is not the plan sponsor, enter the name of a participating employer as the sponsor. A plan of a controlled group of corporations should enter the name of one of the sponsoring members. In either case, use the same name in all future RxDC reports unless there is a change in sponsorship.

In HIOS, you may upload a supplemental document listing the names and EINs of the participating employers and/or sponsoring members of the multi-employer plan. This is optional.

### Plan Sponsor EIN
**Location:** P2 | **Max length** 25 characters | **Must not be blank**
Enter the 9-digit employer EIN assigned to the plan sponsor. (Ex: 012345679). A multiple-employer plan or plan of a controlled group of corporations should use the EIN of the entity identified in the Plan Sponsor Name field.

## 4.4 FEHB Definitions

### FEHB Plan Name
**Location:** P3 | **Max Length** 2048 characters | **Must not be blank**

### FEHB Contract Number
**Location:** P3 | **Max Length** 2048 characters | **Must not be blank**
Enter the FEHB Contract ID.

### FEHB Plan Code
**Location:** P3 | **Max Length** 2048 characters | **Must not be blank**
Enter the two-digit FEHB plan code as it appears in the FEHB plan brochure. Separate each two-digit plan code with a semicolon. Ex: 4A; 4B; 4E; 4L.

### FEHB Carrier Name
**Location:** P3 | **Max Length** 2048 characters | **Must not be blank**

### FEHB Carrier EIN
**Location:** P3 | **Max Length** 2048 characters | **Must not be blank**
9-digit EIN. Include leading zeros if your EIN is fewer than 9 digits. Do not use dashes. Ex: 001234567.

### FEHB Affiliate Name

**Location:** P3 | **Max Length** 2048 characters
(If different from the FEHB carrier.) If there is more than one value, separate them with a semicolon.

### FEHB Affiliate EIN

**Location:** P3 | **Max Length** 2048 characters
(If different from the FEHB carrier.)
Enter the 9-digit EIN. Include leading zeros if your EIN is fewer than 9 digits. Do not use dashes. Ex: 001234567. If there is more than one value, separate them with a semicolon.

# 5 Data Aggregation

## 5.1 Market Segment Aggregation

Reporting entities will aggregate data according to market segment. As noted previously, there are 7 market segments: individual market (excluding the student market), the student market, the fully-insured small group market, the fully-insured large group market (excluding the FEHB line of business), self-funded plans offered by small employers, self-funded plans offered by large employers, and the FEHB line of business.

The market segments are mutually exclusive. Do not report the same data in more than one market segment.

For **mixed-funded plans**, which generally self-fund some benefits and fully insure other benefits, report the self-funded business in the self-funded market segment and the fully-insured business in the fully-insured market segment. For example, if a large employer self-funds the pharmacy benefit of a plan and purchases insurance for the medical benefits, the pharmacy benefits would be attributed to the market segment for self-funded large employer plans and the medical component of the same plan would be attributed to the fully-insured large group market.

For "**minimum premium" plans** and similar hybrid arrangements that mimic key aspects of fully-insured arrangements, or that comply with state insurance laws regarding mandated benefits, report the business as fully-insured.[6]

For **level-funded plans**, report the business as self-funded.

*What if a plan sponsor moves from a fully-insured product to self-funded coverage in the middle of the reference year (or vice versa)?*
Report the fully-insured business in the small group or large group market segments and the self-funded business in the self-funded small employer or large employer market segments.

[6] "Minimum premium" plans generally have regular fixed premium or funding payments, often based on past experience, and limit the plan sponsor's liability for claims.

### Employer Size

For group health plans, the market segment depends on the size of the employer. An employer is generally considered small if it has 50 or fewer employees and large if it has more than 50 employees.

**Fully-insured plans**

Use the same market segment that you use for Medical Loss Ratio (MLR) reporting.

**Self-funded plans**

Determine the number of employees by averaging the total number of all employees employed on business days during the calendar year preceding the reference year. Use any reasonable method that takes into account full-time, part-time, and seasonal employees. Examples of reasonable methods include (1) the full-time equivalent method described in 26 CFR 54.4980H-2(c); (2) if a TPA is affiliated with an issuer, the counting method used by the issuer for MLR reporting; and (3) if an applicable state method takes into account non-fulltime employees, the applicable state method.

If the reporting entity for a self-funded plan doesn't have the necessary information to count the number of employees, the entity may use a reasonable estimate of employer size. A reasonable method to estimate employer size for a self-funded plan is to divide the number of employees in the plan by 0.73.[7] For example, if 40 employees are covered by a plan, then the estimated employer size is 55 (40 ÷ 0.73 = 55). If you use an estimate for employer size for a self-funded plan, describe the method you used in your narrative response. If you use an estimation method other than the one described here, explain why you believe it is a reasonable method.

## 5.2 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.

**Coverage in Multiple States**

For self-funded coverage that is not provided through a group trust, association, or MEWA, report the data in the state where the plan sponsor has its principal place of business. For fully-insured plans, report the data in the state where the policy was issued. For individual market business sold through an association, report the data in the state where the certificate of coverage was issued. For FEHB carriers that are not associated with an issuer, TPA, or other third-party vendor and that offer coverage in multiple states, report the data in the state where the policy was issued or where the carrier has its principal place of business.

[7] The divisor is based on estimated take-up rates from the National Compensation Survey, published by the Bureau of labor statistics. A take-up rate is the percentage of workers with access to a plan who participate in the plan. The Departments have used the healthcare take-up rate for employers with fewer than 100 employees. See Table 10 at https://www.bls.gov/ncs/ebs/benefits/2021/employee-benefits-in-the-united-states-march-2021.pdf.

**Employer Business through Group Trust, Association, or MEWA**
For health coverage provided to plans through a group trust or MEWA, report the data in the state where the employer (if the plan is sponsored at the individual employer level) or the association (if the association qualifies as an "employer" under Employee Retirement Income Security Act of 1974 (ERISA) section 3(5) for purposes of sponsoring the plan) has its principal place of business or the state where the association is incorporated, in the case of an association with no principal place of business.

## 5.3 Issuer and TPA Aggregation

### Issuers

Within a state and market segment, issuers and their reporting entities must combine the data for all coverage offered by the same issuer.

If in-network benefits and out-of-network benefits are provided by separate but ***affiliated*** issuers, data may be reported separately for each type by issuer ***or*** combined and reported by the issuer that provides the in-network coverage.

If two ***unaffiliated*** issuers provide coverage as part of a package, the issuers must report the data separately. For example, if one issuer provides inpatient coverage and an unaffiliated issuer provides outpatient coverage, the submission for the first issuer should contain only the information about the inpatient coverage and the submission for the other issuer should contain only information about the outpatient coverage.

### TPAs and self-funded plans

A TPA reporting on behalf of self-funded plans should, within each state and market segment, combine the data for all self-funded plans on whose behalf it is reporting. A self-funded plan is not required to have a TPA report on its behalf. However, we encourage TPAs to submit RxDC reports on behalf of self-funded plans because it will result in fewer submissions and the total amount of data uploaded into HIOS will be much smaller. The combined data is also more useful because a TPA or PBM can determine the Top Drugs based on a larger sample size.

### FEHB carriers

A carrier affiliate or associate such as an issuer, TPA, or other third party such as a vendor or underwriter may be the reporting entity for a FEHB carrier. If a carrier is associated with an issuer, we generally expect that the issuer will report the FEHB line of business in the FEHB market segment of the issuer's submission, rather than the carrier creating a separate submission. Similarly, if a carrier has a contract with a TPA or other third-party vendor, the Departments and OPM expect the TPA or other third-party vendor to report the FEHB line of business data in the FEHB market segment of the TPA's or other third-party vendor's submission.

If a carrier chooses to make its own submission, it needs to make sure that the issuer, TPA, or vendor does not report the same data. If a carrier is associated with more than one issuer, TPA, or vendor, the carrier should aggregate data for plans that share the same issuer, TPA, or vendor. If a carrier offers plans that are not associated with an issuer, TPA, or vendor, the carrier should combine the data for those plans.

### PBMs

If a PBM is the reporting entity, the rules for aggregating data by issuer and TPA also apply. For example, if a PBM is reporting data for three issuers, the PBM should aggregate the data separately for each issuer. If a PBM is reporting for 10 self-funded plans that have two different TPAs, the PBM should combine the data for the self-funded plans that share each TPA separately.

### Aggregation Restriction

Pursuant to 26 CFR 54.9825-5T(b)(2)(i), 29 CFR 2590.725-3(b)(2)(i), and 45 CFR 149.730(b)(2)(i), the data submitted in files D1 and D3 – D8 must not be aggregated at a less granular level than the aggregation level used by the reporting entity that submitted the data in file D2 Spending by Category. This means that:

- If the data submitted in D2 IS NOT aggregated by the issuer or TPA (that is, the reporting entity for D2 reports the data separately for each group health plan), the data in D1, D3, D4, D5, D6, D7, and D8 must also be reported separately for each plan.
- If the data submitted in D2 IS aggregated (that is, not reported at the plan level), then the reporting entities for the other data files can *choose* whether they want to report information at the plan level or at the aggregate level. The reporting entities for the other data files don't have to make the same decision for each of the other files. For example, if D2 is at the aggregate level, a reporting entity could choose to submit D1 at the plan level and D4 at the aggregate level.

## 5.4 Examples of Aggregate Reporting

Below are examples of aggregated data files.

Note on Terminology: In HIOS, a 5-digit HIOS Issuer ID is assigned to an issuer in a specific state in which it operates. Therefore, if an insurance company that has a unique 9-digit EIN operates in multiple states, it will have multiple HIOS Issuer IDs. In these instructions, for simplicity, the term "issuer" refers to the insurance company at the EIN level when that is appropriate in context, such as in the examples below.

**Example 1:** Issuer reports for fully-insured plans
Issuer A reports total spending in California in the individual, small group, and large group markets, and in Washington for the individual and student markets.

| Issuer or TPA EIN | State | Market Segment | Total Spending | Total Cost Sharing |
|---|---|---|---|---|
| EIN for Issuer A | CA | Individual market | $177,141,997 | $21,733,552 |
| EIN for Issuer A | CA | Small group market | $8,419,411 | $1,099,238 |
| EIN for Issuer A | CA | Large group market | $23,735,387 | $3,061,628 |
| EIN for Issuer A | WA | Individual market | $168,409 | $22,107 |
| EIN for Issuer A | WA | Student market | $377,582 | $55,690 |

**Example 2:** Issuer reports for multiple issuers in the same holding group
Issuer X, Issuer Y, and Issuer Z are part of the same holding group. Issuer X reports on behalf of itself and also on behalf of Issuer Y and Issuer Z.

| Issuer or TPA EIN | State | Market Segment | Total Spending | Total Cost Sharing |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| EIN for Issuer X | CO | Individual market | $10,437 | $1,404 |
| EIN for Issuer X | CO | Small group market | $333,803,307 | $39,962,932 |
| EIN for Issuer X | CO | Large group market | $107,047,027 | $15,617,091 |
| EIN for Issuer X | ID | Large group market | $219,568 | $26,072 |
| EIN for Issuer X | WY | Large group market | $73,114 | $9,362 |
| EIN for Issuer Y | PA | Small group market | $7,234,076 | $1,002,860 |
| EIN for Issuer Y | PA | Large group market | $231,331,535 | $27,706,578 |
| EIN for Issuer Y | NY | Small group market | $7,234,076 | $1,009,009 |
| EIN for Issuer Y | NJ | Small group market | $23,375,484 | $2,696,362 |
| EIN for Issuer Z | NJ | Small group market | $1,781,722 | $240,568 |

**Example 3:** Issuer reports for fully-insured plans, FEHB plans, and self-funded plans
Issuer B both sells insurance and provides administrative services for self-funded plans. Issuer B reports total spending in Colorado in the individual, small group, and large group markets and for self-funded large employer plans; in Idaho in the individual, small group, and large group markets; and in Wyoming for self-funded large employer plans. Issuer B is also associated with an FEHB carrier and reports for FEHB plans in Colorado.

| Issuer or TPA EIN | State | Market Segment | Total Spending | Total Cost Sharing |
|---|---|---|---|---|
| EIN for Issuer B | CO | Individual market | $58,971,803 | $9,304,571 |
| EIN for Issuer B | CO | Small group market | $338,403 | $35,147 |
| EIN for Issuer B | CO | FEHB plans | $728,966,601 | $88,562,152 |
| EIN for Issuer B | CO | SF large employer plans | $219,568 | $30,149 |
| EIN for Issuer B | ID | Individual market | $150,268 | $23,162 |
| EIN for Issuer B | ID | Small group market | $25,441,865 | $3,912,450 |
| EIN for Issuer B | ID | Large group markets | $1,295,869 | $168,839 |
| EIN for Issuer B | WY | SF large employer plans | $170,953,419 | $26,331,955 |

**Example 4:** TPA reports for self-funded plans
TPA C reports total spending for self-funded small employers and self-funded large employers in multiple states.

| Issuer or TPA EIN | State | Market Segment | Total Spending | Total Cost Sharing |
|---|---|---|---|---|
| EIN for TPA C | KY | SF small employer plans | $162,827,074 | $17,407,842 |
| EIN for TPA C | KY | SF large employer plans | $404,143,910 | $51,431,354 |
| EIN for TPA C | LA | SF small employer plans | $370,421 | $49,929 |
| EIN for TPA C | MI | SF small employer plans | $455,249,960 | $70,231,411 |
| EIN for TPA C | MI | SF large employer plans | $1,077,284,699 | $142,352,400 |
| EIN for TPA C | MN | SF large employer plans | $2,386,062 | $307,850 |

**Example 5:** PBM reports data on behalf of fully-insured plans and self-funded plans
A PBM reports prescription drug rebates for fully-insured plans offered by Issuer D and Issuer E and for self-funded plans administered by TPA F, TPA G, and Issuer D. (See Section 9.2 for information about allocating prescription drug rebates across plans, issuers, carriers, states, and markets.)

| EIN | State | Market Segment | Total Rx Spending under Pharmacy Benefit | Total Rebates, Fees and Other Remuneration |
|---|---|---|---|---|
| EIN for Issuer D | CO | Individual market | $210 | $65 |
| EIN for Issuer D | CO | Small group market | $10,714 | $2,278 |
| EIN for Issuer D | CO | Student market | $2,962,333 | $669,043 |
| EIN for Issuer D's TPA Business | CO | SF small employer plans | $4,483 | $1,372 |
| EIN for Issuer D | WY | Large group market | $1,296 | $456 |
| EIN for Issuer E | PA | Small group market | $205,705 | $45,212 |
| EIN for Issuer E | PA | Large group market | $5,142,346 | $1,445,822 |
| EIN for TPA F | NY | SF small employer plans | $186,672 | $45,212 |
| EIN for TPA F | NJ | SF small employer plans | $1,460,734 | $483,284 |
| EIN for TPA G | CT | SF small employer plans | $4,095,437 | $897,556 |
| EIN for TPA G | CT | SF large employer plans | $776,632 | $296,518 |

**Example 6:** Plan sponsor self-reports for fully-insured plans and self-funded plans
An employer with 10,000 employees is headquartered in Nevada and has employees in Nevada, Utah, and Arizona. In each state, employees can choose among several options. Some of the options are fully-insured through Issuer H and some of the plans are self-funded and administered by TPA I. To help facilitate data analysis and identify duplicate submissions, the first column should be the EIN of the issuer or TPA of the plans, rather than the EIN of the plan sponsor. (If a self-funded plan is self-administered and doesn't use a TPA, then you can use the EIN of the plan sponsor.)

| EIN | State | Market Segment | Total Spending | Total Cost Sharing |
|---|---|---|---|---|
| EIN for Issuer H | NV | Large group market | $ 9,619,527 | $1,119,521 |
| EIN for TPA I | NV | SF large employer plans | $34,540,901 | $5,485,786 |

# 6 Premium and Life-Years

Use the definitions in this section to report premium and life-years in D1 Premium and Life-Years.

## Life-years

**Location:** D1 | **Max decimals:** 8
Life-years are the average number of members throughout the year. As noted above, the term **member** means a person who has health coverage, regardless of whether the coverage is associated with an insurance policy, a group health plan, or an FEHB plan. For example, enrollees, dependents, participants, beneficiaries, and FEHB annuitants are all considered members.

To calculate life-years, you must first calculate member months.

**To calculate member months:**

1. Count the number of members covered on a given day of each month of the reference year
2. Add the number of members from Step 1 to calculate total member months for the reference year

**To calculate life-years:**

1. Divide member months by 12
2. Round the resulting number to the 8th decimal place

**Example:** Calculating member months and life-years

| Date | Members covered by the plan on the given date |
|---|---|
| January 1, 2020 | 882 |
| February 1, 2020 | 872 |
| March 1, 2020 | 884 |
| April 1, 2020 | 921 |
| May 1, 2020 | 924 |
| June 1, 2020 | 923 |
| July 1, 2020 | 925 |
| August 1, 2020 | 916 |
| September 1, 2020 | 907 |
| October 1, 2020 | 906 |
| November 1, 2020 | 902 |
| December 1, 2020 | 869 |
| **Total Member Months** | **10,831** |
| **# of Life-Years** (Total member months / 12) | **902.58333333** |

## Earned premium (fully-insured coverage)

**Location:** D1 | **Max decimals:** 8

Earned premium means all money paid by a member, policyholder, subscriber, and/or plan sponsor as a condition of the member receiving coverage. Earned premium includes any fees or other contributions associated with the health plan. For FEHB plans, earned premium means the member and government shares of premium. Report earned premium on a direct basis, without factoring in reinsurance. Include advance payments of the premium tax credit (APTCs), if applicable. Do not reduce the amount of earned premium to reflect state or federal MLR rebates.

## Premium equivalents (self-funded coverage)

**Location:** D1 | **Max decimals:** 8

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).

## ASO and other TPA fees paid

**Location:** D1 | **Max decimals:** 8

Report the ASO and other fees paid to the TPA. This amount should also be included in Premium Equivalents.

### Stop loss premium paid

**Location:** D1 | **Max decimals:** 8
Report the stop loss premium paid to the insurer. This amount should also be included in Premium Equivalents.

### Average monthly premium paid by members

**Location:** D1 | **Max decimals:** 8
Report the average monthly premium per member per month (PMPM) paid by members.

**Include:**

- Premium paid by members
- APTCs
  Premium equivalents paid by members for self-funded coverage

**Exclude:**

- Premium paid by employers or other plan sponsors on behalf of members.
- Premium equivalents paid by employers or other plan sponsors on behalf of members

**Formula:**

$$Average\ monthly\ premium\ paid\ by\ members = \frac{Total\ premium\ paid\ by\ members}{Total\ member\ months}$$

To calculate average monthly premium paid by members at the aggregate level (EIN, state, market segment), you have two options:

- Calculate the amount for each plan and then take the weighted average across plans in the aggregation level, using member months as the weight; or
- Calculate the amount using total level data from all the plans in the aggregation level.

### Average monthly premium paid by employers

**Location:** D1 | **Max decimals:** 8
Not applicable in the individual or student markets. For group health plans and FEHB plans, report the average monthly premium PMPM paid by employers on behalf of members.

**Include:**

- Premium paid by employers and other plan sponsors on behalf of members (including dependents).[8]
- Premium equivalents for self-funded coverage.
- Premium paid by group trust, association, or MEWA plans if separate employers or other plan sponsors make premium contributions.

[8] For FEHB plans, the amount paid by the employer is the government contribution within the meaning of Title 5 USC Chapter 89.

**Exclude:**

- Premium paid by members

**Formula:**

$$Average\ monthly\ premium\ paid\ by\ employers = \frac{Total\ premium\ paid\ by\ employers}{Total\ member\ months}$$

To calculate the value at the aggregate level (EIN, state, market segment), you have two options:

- Calculate the amount for each plan and then take the weighted average across all plans in the aggregation level, using member months as the weight; or
- Calculate the amount using total level data from all the plans in the aggregation level.

*How do I compute the weighted average?*

To calculate the weighted average monthly premium paid by members:

1. Calculate the average monthly premium paid by members for each plan in the aggregation level (formula box above)
2. For each plan, multiply the amount in Step 1 by the number of member months in the plan
3. Calculate the sum of the amount in Step 2 for all plans in the aggregation level
4. Calculate the sum the number of member months for all plans in the aggregation level
5. Divide the amount in Step 3 by the amount in Step 4

Use the same method to calculate the weighted average monthly premium paid by employers.

*What if I don't know the amount of premium paid by members versus employers?*

Average monthly premium paid by enrollees and average monthly premium paid by employers are data elements required by Section 204 of the CAA and the Prescription Drug and Health Care Spending interim final rules (86 FR 66662). Generally, if you are reporting on behalf of a group health plan or FEHB plan, you must obtain this information from the plan.

**For the 2020 and 2021 reference years only**

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.

# 7 Spending

Report data related specifically to the reference year and paid or received through March 31 of the calendar year immediately following the reference year. For accounting purposes, this is sometimes referred to as "incurred in 12, paid or received in 15." (For non-calendar plan years, include only the portion of experience that was incurred during the reference year and paid or received through March

31 of the following calendar year.) For the 2020 and 2021 reference years, you may choose to use a valuation date that is later than March 31.

## 7.1 Definitions

### Total spending

**Location:** D2, D3, D4, D5, D7, D8 | **Max decimals:** 8

Report allowed claims with dates of service during the reference year. Allowed claims are the total payments made under the plan or policy to health care providers on behalf of members. Report claims on a direct basis (that is, before reinsurance, unless specifically stated otherwise in these instructions).

| Include in Total Spending | Subtract | Exclude |
|---|---|---|
| • Payments by the plan, issuer, or carrier<br>• Cost sharing paid by members<br>• Claims liability, including claims incurred during the reference year but not paid or not reported as of March 31 of the year following the reference year (such as claims reported but still in the process of adjustment or payment) | • Net payments from any federal or state reinsurance or cost-sharing reduction arrangement or program<br>• Prescription drug rebates, fees, and other remuneration (In other words, total spending is net of prescription drug rebates, fees, and other remuneration.)<br>• Manufacturer cost-sharing assistance, to the extent known | • Ineligible claims, such as duplicate claims, recovered claims overpayments, third-party liabilities (e.g., coordination of benefits claims), and any other claims that are denied under the policy's or plan's terms<br>• Payments for services other than medical care (e.g., medical management, quality improvement, and fraud detection and recovery expenses)<br>• Active life reserves (policy reserves, contract reserves, contingency reserves, or any kind of reserves except traditionally defined reserves for claims incurred but not reported) or change in such reserves<br>• Charges or payments from state or federal risk adjustment programs |

### Total cost sharing

**Location:** D2, D3, D4, D5, D7, D8| **Max decimals:** 8

Include cost sharing when you report Total Spending, and also as a separate data element.

| Include in Total Cost Sharing | Subtract | Exclude |
|---|---|---|
| • Deductibles, coinsurance, and copays, including amounts that may have | • Cost sharing paid by a member's secondary insurance, to the extent known | • Cost sharing reductions the issuer paid on behalf of the member under federal or state cost-sharing reduction |

| Include in Total Cost Sharing | Subtract | Exclude |
|---|---|---|
| been paid through a health savings or reimbursement account | • Prescription drug rebates, fees, and other remuneration that are passed to members at the point-of-sale, if not already accounted for as reduced cost sharing amounts paid by members. | programs (include these amounts in total spending but not in total cost sharing)<br>• Premium<br>• Manufacturer cost-sharing assistance |

### Manufacturer cost-sharing assistance

**Location:** D3, D4, D5, D7, D8| **Max decimals:** 8
Report manufacturer cost-sharing assistance amounts paid on behalf of members, such as coupons or copay cards, to the extent information is available.

### Amounts not applied to deductible or out-of-pocket maximum

**Location:** D2 | **Max decimals:** 8
Report billed amounts that were (1) not applied to a member's deductible or out-of-pocket maximum, (2) not paid by the plan, issuer, or carrier, and (3) not included in Total Spending.

Include:

- Disallowed amounts for non-covered services or for prescription drugs not on a plan or coverage's formulary
- Cost-sharing amounts not applied to the deductible or out-of-pocket maximum. For example, if manufacturer cost-sharing assistance is not counted towards a member's deductible or out-of-pocket maximum as part of an accumulator adjustment program.[9]

## 7.2 Spending Categories

**Location:** D2| **Max length**: 256 characters | **Must not be blank**
The following table has the spending category names and abbreviations. You must use the abbreviation when you fill out data file D2. Make sure to use the exact spelling of the abbreviation or you will be unable to upload your data.

| 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 |

[9] A copay accumulator program, sometimes referred to as accumulator adjustment or maximizer program, is a policy under which the value of manufacturer cost-sharing assistance amounts, such as coupons or copay cards, are not applied to a member's deductible and/or out-of-pocket maximum

Mutual Exclusiveness and Double-Reporting

The hospital, primary care, specialty care, and other medical costs and services spending categories are mutually exclusive of each other and *include* known and estimated spending on **medical benefit** drugs billed under those categories. Spending on medical benefit drugs must also be reported in the respective categories for medical benefit drugs. This means that medical benefit drug spending is "double-reported."

Capitation

Total spending includes spending for partial and full capitated services. You must estimate the portion of spending for capitated services that is attributable to each spending category and allocate it accordingly.

Pharmacy Benefit Drugs

Do **NOT** report spending on pharmacy benefit drugs anywhere in D2 Spending by Category. (This is a change from the instructions published on November 23, 2021.)

## Hospital

**Location:** D2| **Max decimals:** 8

Report spending on services provided by hospitals to members and billed by the facility.

| Include in Hospital | Exclude |
|---|---|
| All inpatient and outpatient facility services billed by the facility, including:<br>• Any claim meeting one or more of the following criteria:<br>A. Place of Service codes 21, 31, 32, 33, 34, 51, 56, or 61<br>B. Medicare Severity Diagnosis-Related Group (MS-DRG) code<br>C. All claims with revenue codes 010X – 021X, or a valid revenue code on the UB-04 form and a CPT/HCPCS code. Below are examples of hospital spending:<br>○ Revenue codes 036X, 048X, 049X, 079X and CPT/HCPCS codes 10004-69999<br>○ Revenue codes 045X and CPT/HCPCS codes 99281-99292<br>• Room and board, ancillary charges, services of resident providers, inpatient pharmacy, hospital-based nursing home and hospice care, and any other services billed by hospitals<br>• Services provided in psychiatric and substance abuse hospitals<br>• Facility services for medical, surgical, lab, radiology, therapy, maternity, skilled nursing, and other services that are billed by the facility<br>• Include outpatient care, emergency services, or ambulance services only if billed by the facility<br>• Medications dispensed by an institutional pharmacy and administered on-site as part of a medical service. These include but not are not limited to CPT/HCPCS codes J0000–J9999. | • Any medication covered under the pharmacy benefit<br>• Amounts reported in primary care, specialty care, or other medical costs and services<br>• Provider services if independently billed<br>• Laboratory and radiology services that are billed independently by the laboratory (report these amounts in other medical costs and services) |

## Primary care

**Location:** D2| **Max decimals:** 8

Report spending on clinical health care services provided by a primary care provider in a doctor's office or outpatient care center. For the purposes of the RxDC report, a primary care provider is, generally, a

provider who (1) has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine and (2) is accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

| Include in Primary Care | Exclude |
|---|---|
| • Services billed with the following CPT/HCPCS codes and taxonomy codes:<br>  ○ 99381-99397, 99460-99464<br>  ○ 99202-99215, 99304-99350, G0402, G0438, G0439 and one of the taxonomy codes in the table below<br>• Clinical health care services provided by other clinicians, such as nurse practitioners, clinical nurse specialists, or physician assistants, in a primary care setting<br>• Obstetrics and gynecology clinical health care services if performed by a primary care provider<br>• Administration of medications dispensed by an institutional pharmacy and administered on-site as part of a clinical health care service. | • Amounts reported in hospital, specialty care, or other medical costs and services<br>• Laboratory and radiology services provided in a primary care setting that are billed independently by the laboratory (report these amounts in other medical costs and services) |

**Primary Care Taxonomy Codes**

| Taxonomy Code | Taxonomy Provider Type | Taxonomy Classification | Taxonomy Specialty |
|---|---|---|---|
| 163WC1500X | NURSING SERVICE PROVIDERS | REGISTERED NURSE | COMMUNITY HEALTH |
| 163WG0000X | NURSING SERVICE PROVIDERS | REGISTERED NURSE | GENERAL PRACTICE |
| 207QA0505X | ALLOPATHIC & OSTEOPATHIC PHYSICIANS | FAMILY PRACTICE | ADULT MEDICINE |
| 207RG0300X | ALLOPATHIC & OSTEOPATHIC PHYSICIANS | INTERNAL MEDICINE | GERIATRIC MEDICINE |
| 207QA0000X | ALLOPATHIC & OSTEOPATHIC PHYSICIANS | FAMILY PRACTICE | ADOLESCENT MEDICINE |
| 207QG0300X | ALLOPATHIC & OSTEOPATHIC PHYSICIANS | FAMILY MEDICINE | GERIATRIC MEDICINE |
| 207R00000X | ALLOPATHIC & OSTEOPATHIC PHYSICIANS | INTERNAL MEDICINE | NOT APPLICABLE |
| 207RA0000X | ALLOPATHIC & OSTEOPATHIC PHYSICIANS | INTERNAL MEDICINE | ADOLESCENT MEDICINE |
| 208000000X | ALLOPATHIC & OSTEOPATHIC PHYSICIANS | PEDIATRICS | NOT APPLICABLE |
| 2080A0000X | ALLOPATHIC & OSTEOPATHIC PHYSICIANS | PEDIATRICS | ADOLESCENT MEDICINE |
| 208D00000X | ALLOPATHIC & OSTEOPATHIC PHYSICIANS | GENERAL PRACTICE | NOT APPLICABLE |
| 2083P0901X | ALLOPATHIC & OSTEOPATHIC PHYSICIANS | PREVENTIVE MEDICINE | PUBLIC HEALTH & GENERAL PREVENTIVE MEDICINE |
| 261QC1500X | AMBULATORY HEALTH CARE FACILITIES | CLINIC/CENTER | COMMUNITY HEALTH |
| 261QR1300X | AMBULATORY HEALTH CARE FACILITIES | CLINIC/CENTER | RURAL HEALTH |

| | | | |
|---|---|---|---|
| 261QP2300X | AMBULATORY HEALTH CARE FACILITIES | CLINIC/CENTER | PRIMARY CARE |
| 363A00000X | PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSING | PHYSICIAN ASSISTANT | NOT APPLICABLE |
| 363AM0700X | PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSING | PHYSICIAN ASSISTANT | MEDICAL |
| 363L00000X | PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSING | NURSE PRACTITIONER | NOT APPLICABLE |
| 363LA2200X | PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSING | NURSE PRACTITIONER | ADULT HEALTH |
| 363LC1500X | PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSING | COMMUNITY HEALTH | NOT APPLICABLE |
| 363LF0000X | PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSING | NURSE PRACTITIONER | FAMILY |
| 363LG0600X | PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSING | NURSE PRACTITIONER | GERONTOLOGY |
| 363LP0200X | PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSING | NURSE PRACTITIONER | PEDIATRICS |
| 261QS1000X | AMBULATORY HEALTH CARE FACILITIES | CLINIC/CENTER | STUDENT HEALTH |
| 363LP2300X | PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSING | PRIMARY CARE | NOT APPLICABLE |
| 363LW0102X | PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSING | NURSE PRACTITIONER | WOMEN'S HEALTH |
| 207Q00000X | ALLOPATHIC & OSTEOPATHIC PHYSICIANS | FAMILY MEDICINE | NOT APPLICABLE |
| 364SA2200X | NURSING SERVICE PROVIDERS | CLINICAL NURSE SPECIALIST | ADULT HEALTH |
| 364SC1501X | NURSING SERVICE PROVIDERS | CLINICAL NURSE SPECIALIST | COMMUNITY HEALTH |
| 364SF0001X | NURSING SERVICE PROVIDERS | CLINICAL NURSE SPECIALIST | FAMILY HEALTH |
| 364SP0200X | NURSING SERVICE PROVIDERS | CLINICAL NURSE SPECIALIST | PEDIATRICS |

## Specialty care

**Location:** D2| **Max decimals:** 8

Report spending on clinical health care services provided by specialists. A specialist is, generally, a provider that focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of diseases, symptoms, and conditions.

| Include in Specialty Care | Exclude |
|---|---|
| All professional services not inclusive of primary care, including the following:<br>• Providers that have training in a specific area of health care and are not considered primary care providers as defined above<br>• Chiropractors, podiatrists, optometrists, and physical, occupational, and speech therapists that are not billed as part of hospital or facility services | • Amounts reported in hospital, primary care, or other medical costs and services<br>• Dental services (report in Other medical costs and services)<br>• Laboratory and radiology services associated with |

| Include in Specialty Care | Exclude |
|---|---|
| • Doctor's office or outpatient care center services provided by specialists<br>• Hospital-based specialist services only if the specialist independently bills for those services<br>• Administration of medications dispensed by an institutional pharmacy and administered on-site as part of a clinical health care service. | specialty care in a doctor's office or outpatient care center that are billed independently by the laboratory (report these amounts in other medical costs and services) |

### Other medical costs and services

**Location:** D2| **Max decimals:** 8

Report spending for all other professional and facility clinical health care services and equipment not reported as hospital, primary care, or specialty care.

| Include in Other medical costs and services | Exclude |
|---|---|
| Report spending for all other professional and facility clinical health care services and equipment not reported as hospital, primary care, or specialty care. Examples as follows:<br><br>• 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. | • Amounts reported in hospital, primary care, or specialty care<br>• Claims with a valid revenue code on the UB-04 form.<br>• Wellness services not billed on a claim |

### Medical benefit drugs: known amounts (informational)

**Location:** D2| **Max decimals:** 8 | **Abbreviation:** Known medical benefit drugs

Report 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.

Complete the column for Total Spending (including cost sharing). You are not required to complete the Total Cost Sharing or Amounts Not Applied to Deductible and/or Out-of-Pocket Maximum columns for this informational category.

### Medical benefit drugs: estimated amounts (informational)

**Location:** D2| **Max decimals:** 8 | **Abbreviation:** Estimated medical benefit drugs

Report the 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. You must estimate spending on prescription drugs included in the bundle or other alternative payment arrangement in good faith and to the best of your ability. If you report estimated amounts, explain the circumstances and describe the method you used in the Narrative Response.

Complete the column for Total Spending (including cost sharing). You are not required to complete the Total Cost Sharing or Amounts Not Applied to Deductible and/or Out-of-Pocket Maximum columns for this informational category.

**Example**: Data aggregated by spending category

| EIN | State | Market Segment | Spending Category | Total Spending | Total Cost Sharing | Amounts Not Applied to Deductible and/or Out-of-Pocket Maximum |
|---|---|---|---|---|---|---|
| 123456789 | ND | Individual market | Hospital | $1,240,100 | $183,990 | $10,920 |
| 123456789 | ND | Individual market | Primary Care | $459,300 | $10,200 | $890 |
| 123456789 | ND | Individual market | Specialty Care | $873,300 | $340,000 | $2,680 |
| 123456789 | ND | Individual market | Other medical costs and services | $428,800 | $165,900 | $8,550 |
| 123456789 | ND | Individual market | Known medical benefit drugs | $211,560 | | |
| 123456789 | ND | Individual market | Estimated medical benefit drugs | $145,556 | | |

# 8 Prescription Drug Reporting

## 8.1 Prescription Drug Coverage

### Medical benefit drugs

**Location:** D2

Report information about prescription drugs covered under a medical benefit in D2. You must estimate the portion of bundled or alternative payment arrangements that can be attributed to medical benefit drugs in good faith and to the best of your ability.

### Pharmacy benefit drugs

**Location:** D3, D4, D5, D6, D7, D8

Report information about prescription drugs covered under the pharmacy benefit in data files D3, D4, D5, D6, D7, and D8.

## 8.2 Drug Aggregation

### Prescription drug definition

For the purposes of RxDC reporting, a prescription drug is defined as a set of National Drug Codes[10] (NDCs) that are grouped together by name and ingredient. This means that NDCs with the same

[10] The Food & Drug Administration (FDA) assigns a unique National Drug Code to each pharmaceutical product manufactured, prepared, propagated, compounded, or processed for sale in the United States.

ingredient are grouped together even if they have different strengths, dosage forms (ex: capsule, tablet, liquid), routes of delivery (ex: oral, injection), labeler names (manufacturer, re-packager, or distributor), or package types or sizes. For example, if the same active ingredient is available as both a tablet or as a liquid, both forms are considered the same drug for RxDC reporting, unless they have different brand names.

### Drug names and codes

**Location:** D3, D4, D5, D8 | **Must not be blank**
**Drug Name Max Length:** 2048 | **Drug Code Max Length:** 100

The RxDC drug name for brand prescription drugs is the combination of the ingredient name and the brand name.[11] The brand name is enclosed in brackets. Specifically, the format of the RxDC drug name is: ingredient name [brand name]. For generic drugs, the RxDC drug name is just the ingredient name. For the purposes of RxDC reporting, branded generics and authorized generics are treated the same as unbranded generics.[12] Thus, the RxDC drug name for branded generics and authorized generics is just the ingredient name.

If an NDC has more than one ingredient, the RxDC drug name contains all ingredients. The ingredients are separated from each other using a pipe symbol ("|") with a space on both sides of the pipe symbol. For example, the RxDC drug name for a generic drug with two ingredients is: ingredient 1 | ingredient 2. The RxDC drug name for a brand prescription drug with two ingredients is: ingredient 1 | ingredient 2 [brand name]. The ingredients are listed in alphabetic order.

Each RxDC drug name has a unique RxDC drug code. The RxDC names and codes are in the CMS Drug and Therapeutic Class Crosswalk at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/Prescription-Drug-Data-Collection.

**Example:** Crosswalk from NDC to RxDC drug name and code (excerpt for mesalamine)

| 11-Digit NDC | Labeler | Brand Indicator | Strength, Dosage Form, and Package | RxDC Drug Name | RxDC Drug Code |
|---|---|---|---|---|---|
| 00093922489 | Teva Pharmaceuticals | Generic° | 375 mg/1, 120 capsule, extended release in 1 bottle | mesalamine | R00525820101000 |
| 54092010001 | Takeda | Generic° | 1.2 g/1, 120 tablet, delayed release in 1 bottle | mesalamine | R00525820101000 |
| 59762011701 | Greenstone LLC | Generic° | 400 mg/1, 180 capsule, delayed release in 1 bottle | mesalamine | R00525820101000 |
| 59762011803 | Greenstone LLC | Generic | 1000 mg/1, 30 suppositories in 1 box | mesalamine | R00525820101000 |

[11] For the purposes of RxDC reporting, the Departments generally use the brand name and active ingredient name from RxNorm. RxNorm is a standardized drug naming convention for clinical drugs produced by the U.S. National Library of Medicine. See https://www.nlm.nih.gov/research/umls/rxnorm/index.html for more information about RxNorm.

[12] Branded generics are marketed under a brand name but go through the same FDA approval process as unbranded generics. Branded generics and unbranded generics may only be sold after the brand prescription drug loses marketing exclusivity. Authorized generics are created by makers of brand prescription drugs under the same New Drug Approval (NDA) authorization as the original brand prescription drug. Authorized generics may be marketed before the brand prescription drug loses marketing exclusivity.

| | | | | | |
|---|---|---|---|---|---|
| 60687055632 | American Health Packaging | Generic | 400 mg/1, 20 blister pack in 1 box, unit-dose | mesalamine | R00525820101000 |
| 62559042007 | ANI Pharmaceuticals | Generic° | 4 g/60mL, 7 bottles in 1 box | mesalamine | R00525820101000 |
| 69238127403 | Amneal Pharmaceuticals | Generic | 1000 mg/1, 30 suppositories in 1 carton | mesalamine | R00525820101000 |
| 69918056030 | Amring Pharmaceuticals | Generic | 1000 mg/1, 30 suppositories in 1 box | mesalamine | R00525820101000 |
| 70771111002 | Cadila Healthcare | Generic | 800 mg/1, 10 tablet, delayed release in 1 blister pack | mesalamine | R00525820101000 |
| 70771135302 | Cadila Healthcare | Generic^ | 800 mg/1, 10 tablet, delayed release in 1 blister pack | mesalamine | R00525820101000 |
| 43353088479 | Aphena Pharma Solutions | Brand | 375 mg/1, 2160 capsule, extended release in 1 bottle | mesalamine [Apriso] | R00525820101001 |
| 65649010301 | Salix Pharmaceuticals | Brand | 375 mg/1, 1 bottle in 1 carton | mesalamine [Apriso] | R00525820101001 |
| 00023590118 | Allergan, Inc. | Brand | 800 mg/1, 180 tablet, delayed release in 1 bottle | mesalamine [Asacol] | R00525820101002 |
| 58914050101 | Allergan, Inc. | Brand | 1000 mg/1, 3 suppository, 1 box | mesalamine [Canasa] | R00525820101003 |
| 00023585318 | Allergan, Inc. | Brand | 400 mg/1, 180 capsule, delayed release in 1 bottle | mesalamine [Delzicol] | R00525820101004 |
| 50090300200 | A-S Medication Solutions | Brand | 400 mg/1, 180 capsule, delayed release in 1 bottle | mesalamine [Delzicol] | R00525820101004 |
| 54092047601 | Takeda | Brand | 1.2 g/1, 120 tablet, delayed release in 1 bottle | mesalamine [Lialda] | R00525820101005 |
| 54092018981 | Takeda | Brand | 250 mg/1, 240 capsules in 1 bottle | mesalamine [Pentasa] | R00525820101006 |
| 00037002207 | Meda Pharmaceuticals | Brand | 4 g/60mL, 7 bottles, with applicator in 1 carton | mesalamine [Rowasa] | R00525820101007 |
| 00037006603 | Meda Pharmaceuticals | Brand | 4 g/60mL, 28 bottles, dispensing in 1 carton | mesalamine [Rowasa] | R00525820101007 |

° Authorized generic; ^ Branded generic

**Example:** Data aggregated by RxDC drug name

| Issuer or TPA EIN | State | Market segment | RxDC Drug Name | RxDC Drug Code | Number of paid claims |
|---|---|---|---|---|---|
| 123456789 | CA | Individual Market | mesalamine | R00525820101000 | 9,744 |
| 123456789 | CA | Individual Market | mesalamine [Apriso] | R00525820101001 | 3,904 |
| 123456789 | CA | Individual Market | mesalamine [Asacol] | R00525820101002 | 5,642 |
| 123456789 | CA | Individual Market | mesalamine [Canasa] | R00525820101003 | 2,145 |
| 123456789 | CA | Individual Market | mesalamine [Delzicol] | R00525820101004 | 6,015 |
| 123456789 | CA | Individual Market | mesalamine [Lialda] | R00525820101005 | 8,983 |
| 123456789 | CA | Individual Market | mesalamine [Pentasa] | R00525820101006 | 198 |
| 123456789 | CA | Individual Market | mesalamine [Rowasa] | R00525820101007 | 1,703 |

### Therapeutic classes

**Location:** D7 | **Must not be blank**
**Therapeutic Class Max Length:** 2,048 | **Class Code Max Length:** 100 characters

A therapeutic class is a group of drugs that have a similar mechanism of action or treat the same condition. For example, mesalamine, balsalazide, olsalazine, and sulfasalazine are medications used to reduce inflammation in the lining of the intestine. Therefore, they are assigned the same RxDC therapeutic class name, Aminosalicylate.[13] 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. The therapeutic classes are listed alphabetically and separated from each other using a pipe symbol ("|"), with a space on both sides of the pipe symbol. Ex: Therapeutic Class 1 | Therapeutic Class 2.

Each RxDC therapeutic class has a unique RxDC class code. The RxDC names and codes are in the CMS Drug and Therapeutic Class Crosswalk at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/Prescription-Drug-Data-Collection.

**Example:** Data aggregated by therapeutic class

| Issuer or TPA EIN | State | Market Segment | RxDC Therapeutic Class | RxDC Class Code | Number of paid claims |
|---|---|---|---|---|---|
| 123456789 | CA | Individual market | Corticosteroid | E01755760101 | 5,567 |
| 123456789 | CA | Small group market | Corticosteroid | E01755760101 | 7,389 |
| 123456789 | CA | Large group market | Corticosteroid | E01755760101 | 15,011 |
| 123456789 | CA | Individual market | Anti-epileptic Agent | E01757530101 | 5,136 |
| 123456789 | CA | Small group market | Anti-epileptic Agent | E01757530101 | 14,034 |
| 123456789 | CA | Large group market | Anti-epileptic Agent | E01757530101 | 9,333 |

**Where can I download the CMS Drug and Therapeutic Class Crosswalk File?**
The crosswalk file is available on the CMS website at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/Prescription-Drug-Data-Collection.

*What if an NDC is missing from the CMS Drug and Therapeutic Class Crosswalk?*
If the CMS crosswalk is missing an NDC for a prescription drug that was dispensed during the reference year, you should assign the prescription drug a RxDC drug name using the naming method described in Section 8.2. You should also assign a unique RxDC drug code. If the CMS crosswalk is missing the RxDC therapeutic class name for an NDC, you should use the FDA Established Pharmacologic Class (EPC) (or combination of EPCs) that you believe is most accurate. Provide information about the missing NDC or missing therapeutic class in your Narrative Response.

## 8.3 Rx Utilization

Use the following definitions to report prescription drug utilization.

[13] For the purposes of RxDC reporting, we generally group drugs by therapeutic class according to their FDA Established Pharmacologic Class (EPC). See https://www.fda.gov/industry/structured-product-labeling-resources/pharmacologic-class for more information on EPCs.

### Number of paid claims

**Location:** D3, D4, D5, D7, D8 | **Max decimals:** 8
The number of claims paid for prescriptions filled during the reference year.

### Number of members with a paid claim

**Location:** D3, D4, D5, D7, D8 | **Integer**
The number of members with at least one paid claim for a prescription filled during the reference year.

### Total dosage units

**Location:** D3, D4, D5, D7, D8 | **Max decimals:** 8
The total number dosage units dispensed during the reference year. Dosage unit means the smallest form in which a pharmaceutical product is administered or dispensed, such as a pill, tablet, capsule, ampule, or measurement of grams or milliliters.

## 8.4 Rx Spending

Total spending and total cost sharing are net of prescription drug rebates, fees, and other remuneration. The definitions in this section are the same as the definitions in Section 7.

### Rx Total Spending

**Location:** D3, D4, D5, D6, D7, D8 | **Max decimals:** 8
Report allowed claims with dates of service during the reference year. Allowed claims are the total payments made under the plan or policy to health care providers on behalf of members. Report claims on a direct basis (that is, before reinsurance, unless specifically stated otherwise in these instructions).

| Include in Rx Total Spending | Subtract | Exclude |
|---|---|---|
| • Payments by the plan, issuer, or carrier<br>• Cost sharing paid by members<br>• Claims liability, including claims incurred during the reference year but not paid or not reported as of March 31 of the year following the reference year (such as claims reported but still in the process of adjustment or payment) | • Net payments from any federal or state reinsurance or cost-sharing reduction arrangement or program (see options below)<br>• Prescription drug rebates, fees, and other remuneration (In other words, total spending is net of prescription drug rebates, fees, and other remuneration.)<br>• Manufacturer cost-sharing assistance, to the extent known | • Ineligible claims, such as duplicate claims, recovered claims overpayments, third-party liabilities (e.g., coordination of benefits claims), and any other claims that are denied under the policy's or plan's terms<br>• Payments for services other than medical care (e.g., medical management, quality improvement, and fraud detection and recovery expenses)<br>• Active life reserves (policy reserves, contract reserves, contingency reserves, or any kind of reserves except traditionally defined reserves for claims incurred but not |

| Include in Rx Total Spending | Subtract | Exclude |
|---|---|---|
| | | reported) or change in such reserves<br>• Charges or payments from state or federal risk adjustment programs |

*How do I account for net payments from federal or state reinsurance and cost-sharing reduction programs when I report spending on prescription drugs?*

Option 1
Determine the exact amount of net payments from federal or state reinsurance and cost-sharing reduction programs attributable to specific drug claims, and use these amounts when reporting spending at the drug level. If you choose Option 1, note the accounting method you used in the narrative response.

Option 2
Use a reasonable method to allocate net payments from federal or state reinsurance and cost-sharing reduction programs to the drug level. For example, you could allocate the amounts according to the ratio of spending at the drug level divided by total spending on medical and pharmacy claims at the aggregate level, either for all enrollees or for only the reinsurance-covered or CSR-eligible enrollees, as applicable. If you choose Option 2, describe the allocation method you used in the narrative response and explain why you think it is reasonable.

Option 3
You may choose to account for net payments from federal or state reinsurance and cost-sharing reduction programs attributable to drug spending in the narrative response, rather than subtracting the amounts from drug spending reported in data files D3 – D8. If you choose Option 3, the narrative response must include the total amount of net payments from federal or state reinsurance and cost-sharing reduction programs, as applicable, allocated or attributable to prescription drugs, separately for each state and market segment. The reporting entity that submits D3 – D8 can be different than the reporting entity that submits the narrative response.

## Rx Cost Sharing

**Location:** D3, D4, D5, D7, D8 | **Max decimals:** 8
Note: Report cost sharing as a stand-alone data element and include it when you report total spending.

| Include in Rx Cost Sharing | Subtract | Exclude |
|---|---|---|
| • Deductibles, coinsurance, and copays, including amounts that may have been paid through a health savings or reimbursement account | • Cost sharing paid by a member's secondary insurance, to the extent known<br>• Prescription drug rebates, fees, and other remuneration that are passed to members at the point-of-sale, if not already | • Cost sharing reductions the issuer paid on behalf of the member under federal or state cost-sharing reduction programs (include these amounts in total spending but not in total cost sharing) |

| Include in Rx Cost Sharing | Subtract | Exclude |
|---|---|---|
| | accounted for as reduced cost sharing amounts paid by members. | • Premium<br>• Manufacturer cost-sharing assistance |

### Rx Manufacturer cost-sharing assistance

**Location:** D3, D4, D5, D7, D8 | **Max decimals:** 8

Report manufacturer cost-sharing assistance amounts paid on behalf of members, such as coupons or copay cards, to the extent the information is available.

### Rx Amounts not applied to deductible or out-of-pocket maximum

**Location:** D6| **Max decimals:** 8

Report billed amounts that were (1) not applied to a member's deductible or out-of-pocket maximum, (2) not paid by the plan, issuer, or carrier, and (3) not included in Rx Total Spending.

**Include:**

- Disallowed amounts for non-covered services or for prescription drugs not on a plan or coverage's formulary
- Cost-sharing amounts not applied to the deductible or out-of-pocket maximum. For example, if manufacturer cost-sharing assistance is not counted towards a member's deductible or out-of-pocket maximum as part of an accumulator adjustment program, include it here.

## 8.5 Top Drug Lists

Exclude drugs covered under a non-pharmacy benefit when you create the four RxDC top drug tables. If there are ties when you rank the top drugs, use the number of members with a paid claim as the tie breaker. If there is still a tie, choose one of the other utilization or spending measures to break the tie.

### D3 Top 50 Most Frequently Dispensed Brand Name Drugs

Use the following steps to create the Top 50 Most Frequent Brand Name Drugs table.

1. 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.
   - Only count paid claims for prescriptions filled during the reference year
   - If you are reporting on behalf of multiple group health plans, include all of them when calculating the total in the state and market for the issuer or TPA.
   - CMS will indicate which drugs are considered brand name drugs in the CMS Drug and Therapeutic Class Crosswalk File, or provide instructions for you to determine which drugs are considered brand name drugs.
2. Rank the drugs in each state and market segment according to number of paid claims, sorted in descending order. Using this ranking, identify the 50 brand name drugs with the highest number of paid claims. Note: A rank value of 1 means the drug is the most frequently prescribed brand name drug.

3. Create a table with the top 50 drugs and include a row for every state, market segment, and EIN of the issuer or TPA.[14]
   - This means that there will be 50 rows for every state, market segment, and EIN combination.
4. For each row, report the number of paid claims and the other utilization and spending variables in the file layouts.

### D4 Top 50 Most Costly Drugs

Use the following steps to create the Top 50 Most Costly Drugs table.

1. 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.
   - Use the definition of Total Spending in Section 7.1 above.
   - If you are reporting on behalf of multiple group health plans, include all of them when calculating the total in the state and market for the issuer or TPA.
2. 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. Note: A rank value of 1 means that the drug has the greatest value for total spending.)
3. Create a table with the top 50 drugs and include a row for every state, market segment, and EIN of the issuer or TPA.
   - This means that there will be 50 rows for every state, market segment, and EIN combination.
4. For each row, report total spending and the other utilization and spending variables in the file layouts.

### D5 Top 50 Drugs with the Greatest Increase in Spending

Exclude prescription drugs if they were not approved for marketing, or issued an Emergency Use Authorization (EUA), by the Food and Drug Administration for the entire reference year *and* for the entire calendar year immediately preceding the reference year. For example, if a drug was introduced in 2020, exclude the drug from D5 in the 2020 RxDC report and in the 2021 RxDC report. The CMS Drug and Therapeutic Class Crosswalk will be updated to indicate the year in which a drug was first approved for marketing or issued an EUA.

Include all plans and coverage in your calculations, even if the plan or coverage was not in effect for both years. For example, if you are calculating the increase in spending from 2020 to 2021 and a plan was only effective in 2020, you should include the plan in your 2020 total even though it isn't in the 2021 total.

#### *What if my client had a different reporting entity last year?*

There are two reporting options:

- The previous reporting entity includes the client's data in the prior year column of their report (assuming they are still reporting on behalf of other clients); or

[14] When we say the "EIN of the issuer or TPA", this is a shorthand way of referring to the EIN of the relevant issuer, TPA, carrier, or plan according to the Aggregation section above. Similarly, "market" or "market segment" includes the FEHB line of business, where applicable.

- You obtain prior year data from the previous reporting entity and include it in the prior year column of your report.

Note: there will be a disconnect between the current year and prior year columns. (Because the set of clients in the current year columns is different from the set of clients in the prior year column.)

Use the following steps to create D5 Top 50 Drugs with the Greatest Increase in Spending.

1. 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.
    - Use the definition of Total Spending in Section 7.1 above.
    - Only include NDCs if they were approved for marketing or issued an EUA for the entire reference year and for the entire year prior to the reference year.
    - If you are reporting on behalf of multiple group health plans, include all of them when calculating the total in the state and market for the issuer or TPA.
2. For each RxDC drug, calculate total spending, net of prescription drug rebates, fees, and other price concessions, in the state and market segment for the year prior to the reference year by summing total spending for the NDCs associated with the RxDC drug name.
    - Use the definition of Total Spending in Section 7.1 above.
    - Only include NDCs if they were approved for marketing or issued an EUA for the entire reference year and for the entire year prior to the reference year.
    - If you are reporting on behalf of multiple group health plans, include all of them when calculating the total in the state and market for the issuer or TPA.
3. 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 (the amount from Step 2) from total spending in the state and market segment for the reference year (the amount from Step 1).
    - 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.
4. Rank the drugs in each state and market segment according to the increase in total spending (the amount from Step 3), sorted in descending order. Identify the 50 drugs with the greatest increase in total spending. A rank value of 1 means the drug has the greatest increase in total spending.
    - Use the dollar amount increase, not the percent increase.
5. Create a table with the top 50 drugs and include a row for every state, market segment, and EIN of the issuer or TPA.
    - This means that there will be 50 rows for every state, market segment, and EIN combination.
6. For each row, report total spending in the reference year, total spending in the year prior to the reference year, the increase in total spending, and the other utilization and spending variables in the file layouts.

### D8 Top 25 Drugs with the Greatest Amount of Rebates

Use the following steps to create the Top 25 by Rx Rebates table.

1. 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.
    - Use the definition of Total Rebates, Fees, and Other Remuneration in Section 9.1 below.
    - If Rx rebates, fees, and other remuneration cannot be measured at the NDC level, use a reasonable method to allocate rebates, fees, and other remuneration to the NDC level. See Section 9.2 below for more information about allocation methods.
2. 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. A rank value of 1 means the drug has the greatest amount of total rebates, fees, and other remuneration.
3. Create a table with the top 25 drugs and include a row for every state, market segment, and EIN of the issuer or TPA.
    - This means that there will be 25 rows for every state, market segment, and EIN combination.
4. For each row, report prescription drug rebates, fees, and other remuneration, as well as the utilization, spending, and other associated Rx rebate variables in the file layouts.

# 9 Rebates, Fees, and Other Remuneration

## 9.1 Definitions

### Pharmacy benefit manager

Pharmacy benefit manager (PBM) generally means an entity that, either directly or through an intermediary, acts as a price negotiator, manages the prescription drug benefits, or provides other pharmacy benefit management services to the plan, issuer, or carrier. Pharmacy benefit management services include processing and paying of prescription drug claims, performing drug utilization review, processing prior authorization requests, adjudicating appeals or grievances related to the prescription drug benefit, contracting with network pharmacies, designing formularies, and controlling the cost of covered prescription drugs.

### Rebates retained by PBMs

**Location:** D7, D8 | **Max decimals:** 8
**Include:**

- Manufacturer rebates received by PBMs and not passed through to any member or entity
- Amounts received directly from a manufacturer or indirectly from a pharmacy, wholesaler, or other entity
- Include rebate amounts that are expected but have not yet been received if the PBM will retain the expected amounts

### Rebates retained by plans/issuers/carriers

**Location:** D7, D8 | **Max decimals:** 8
**Include:**

- Manufacturer rebates received by plans, issuers, or carriers and not passed through to any member or entity
- Amounts received directly from a manufacturer or indirectly from a PBM, pharmacy, wholesaler, or other entity

- Rebate amounts that are expected but have not yet been received if the plan, issuer, or carrier will retain the expected amounts
- Rebate guarantee amounts. A rebate guarantee amount is a payment received from a PBM to account for the difference between the rebate amount guaranteed by a PBM, as likely delineated in the contract between the two parties, and the actual rebate amount received from a drug manufacturer

### Rebates passed to members at POS

**Location:** D7, D8 | **Max decimals:** 8

**Include:**

- Manufacturer rebates passed through (rather than retained by PBMs or plans/issuers/carriers) to members at the point of sale (POS)

**Exclude:**

- Manufacturer cost-sharing assistance

### Net transfer of other remuneration from manufacturers to plans/issuers/ carriers/PBMs

**Location:** D7, D8 | **Max decimals:** 8

Report *net* amounts. For example, if transfers from manufacturer to a PBM exceed transfers from the PBM to manufacturer, report a positive number. If transfers from a PBM to the manufacturer exceed transfers from the manufacturer to the PBM, report a negative number.

**Include:**

- Price concessions, fees, and other remuneration provided to a plan, issuer, carrier, or PBM, directly or indirectly. For example, include the following amounts:
    - Bona fide service fees
    - Discounts
    - Chargebacks
    - Cash discounts
    - Free goods contingent on a purchase agreement
    - Up-front payments
    - Coupons
    - Goods in kind
    - Free or reduced-price services
    - Grants
    - Other price concessions or similar benefits
- Fees and other remuneration that are expected but not yet transferred

**Exclude:**

- Any remuneration, coupons, or price concessions for which the full value is passed on to the member

### Net transfer of other remuneration from pharmacies to issuers/plans/carriers/PBMs

**Location:** D7, D8 | **Max decimals:** 8

Report the amounts described above (in the data element for the net transfer of other remuneration from manufacturers to issuers, plans, carriers, and PBMs) except that the amount reported here should be the net transfer from pharmacies, wholesalers, and other entities, rather than from manufacturers.

Report *net* amounts. For example, if transfers from pharmacies to a PBM exceed transfers from the PBM to pharmacies, report a positive number; if transfers from a PBM to pharmacies exceed transfers from pharmacies to the PBM, report a negative number.

### Total rebates, fees, and other remuneration

**Location:** D7, D8 | **Max decimals:** 8
Sum of the previous five data elements.

### Restated prior year rebates, fees, and other remuneration

**Location:** D7, D8 | **Max decimals:** 8
Restate total rebates and other remuneration from the prior reference year as of 3/31 of the calendar year following the current reference year (that is, incurred in 12 months, paid or received in 27 months). So, for example, in the 2021 RxDC report, there would be one column for total rebates for 2021 (as of 3/31/2022) and another column for restated rebates for 2020 (restated as of 3/31/2022). This field is required starting with the RxDC report for the 2021 reference year.

#### *What if my client had a different reporting entity last year?*

As noted in Section 8.5, there are two reporting options:

- The previous reporting entity includes the client's data in the prior year column of their reference year report (assuming they are still reporting on behalf of other clients); or
- You obtain prior year data from the previous reporting entity and include it in prior year column of your report.

Note: There will be a disconnect between the current year and prior year columns. (Because the set of clients in the current year columns is different from the set of clients in the prior year column.)

### Bona fide service fees

**Location:** D6 | **Max decimals:** 8
Bona fide service fees are fees that a manufacturer pays to a PBM that:

- Represent fair market value for a bona fide, itemized service performed on behalf of the manufacturer. These are services that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement; and
- Are not passed on in whole or in part to a client or customer of an entity, whether or not the entity takes title to the drug.

### PBM spread amounts

**Location:** D6 | **Max decimals:** 8
The PBM spread is the difference between the amount the plan, issuer, or carrier paid to the PBM and the amount the PBM paid to manufacturers, wholesalers, pharmacies, or other vendors. For example, if plans paid $250 to the PBM, and the PBM paid $200 to manufacturers, wholesalers, pharmacies, or other vendors, the PBM spread amount would be $50.

**Include:**

- amounts for all drugs furnished through the PBM.
- amounts paid to retail, mail-order, and other pharmacies.

If a plan, issuer, or carrier uses pass-through pricing to pay PBMs, use zero for the PBM spread amount. If a plan, issuer, or carrier uses lock-in pricing to pay PBMs, report the difference between the lock-in price and the price ultimately received by the pharmacy.

## 9.2 Allocation Methods

Use a reasonable method to allocate rebates, fees, and other remuneration if they cannot be tied to a specific prescription drug for a specific EIN, state, and market segment.

Here are examples of reasonable and unreasonable methods to allocate prescription drug rebates.

| Method | Description | Reasonable? | Explanation |
|---|---|---|---|
| Based on dosage units | Allocate rebates received for multiple drugs based on total dosage units for each drug as a percent of total drug spending for all the prescription drugs for which the rebate was received. | Yes | Appropriately accounts for differences in a specific drug's utilization across plans and issuers. |
| Based on total drug spending | Allocate rebates received for multiple drugs based on total drug spending for each drug as a percent of total drug spending for all the prescription drugs for which the rebate was received. | Yes | Approximates differences in utilization and spending on rebate eligible drugs. |
| Based on billed rebate amounts | Rebates received for a specific drug are allocated to a plan, issuer, or carrier and 11-digit NDC based on the rebate amounts billed to the pharmaceutical manufacturer for the specific plan, issuer, or carrier and drug as a percent of the total rebate amount billed to the pharmaceutical manufacturer for all the PBM's plans or issuers. | Yes | Appropriately accounts for differences in a specific drug's utilization across plans or issuers. |
| Based on plan's brand drug spending | Rebate amounts received for multiple drugs are allocated to a plan, issuer, or carrier based on the total drug spend for drugs under the plan, issuer, or carrier as a percent of the total drug spend for brand drugs under all of the PBM's plans or issuers, and further to a prescription drug based on the NDC-specific total drug spend under the plan, issuer, or carrier as a percent of the total drug spend for brand drugs under the plan, issuer, or carrier. | Yes, but only if the PBM receives rebates only for brand drugs. | Accounts for differences in utilization and spending on rebate-eligible drugs across plans or issuers. |
| Based on enrollment | Rebates received for multiple drugs are allocated to a plan, issuer, or carrier for | No | Does not sufficiently approximate |

| Method | Description | Reasonable? | Explanation |
|---|---|---|---|
| | prescription drug based on the number of members enrolled in the plan, issuer, or carrier as a percent of the total number of members enrolled in all the PBM's plans, issuers or carriers. | | differences in utilization and spending on rebate eligible drugs across plans or issuers. |
| Based on the number of paid claims | Rebates received for multiple drugs are allocated to a plan, issuer, or carrier for prescription drugs based on the number of claims under the plan, issuer, or carrier as a percent of the total number of claims received under all the PBM's plans, issuers or carriers. Thus, allocation is based on the total number of claims for all the drugs rather than the number of claims received for each drug. | No | Does not sufficiently approximate differences in utilization and spending on rebate eligible drugs across plans or issuers. |

Describe the method you used in the narrative response. If you used an allocation method other than one of the methods described as reasonable in the table above, include enough detail for CMS to evaluate whether the method is reasonable.

Also describe the methods you used to allocate fees or other remuneration in the narrative response. Some allocation methods, such as allocation based on the number of paid claims, are considered unreasonable for allocating rebates but might, based on the support that you provide in the narrative response, be considered reasonable for allocating fees.

# 10 Narrative Response

Address the following topics in your narrative response. Save your narrative as a Word document or pdf before uploading it into HIOS.

## Employer size for self-funded plans

Did you use actual counts or estimates to determine the size of the employer for self-funded plans? Describe your estimation method if you used estimates.

## Net payments from federal or state reinsurance or cost-sharing reduction programs

If applicable, describe how you accounted for net payments from federal or state reinsurance and cost-sharing reduction programs. (See Section 8.4.)

## Drugs missing from the CMS crosswalk

If the CMS crosswalk is missing an NDC for a drug that was prescribed during the reference year and covered under the pharmacy benefit, provide the RxDC drug name and therapeutic class that you used.

## Medical benefit drugs

Describe how you estimated the portion of bundled or alternative payment arrangements that can be attributed to drugs covered under a medical benefit (as reported in D2). Describe allocation methods, if applicable.

### Prescription drug rebate descriptions

Describe the types of rebates, fees, and other remuneration that you included or excluded in the Rx Totals, Rx Rebates by Therapeutic Class, and Rx Rebates for the Top 25 Drugs. Explain any negative values for rebates, fees, or other remuneration.

### Allocation methods for prescription drug rebates

Describe the methods you used to allocate prescription drug rebates, fees, and other remuneration. If you used an allocation method other than one of the methods described as reasonable in the Section 9.2 above, your description must include enough detail for CMS to evaluate whether the method is reasonable.

### Impact of prescription drug rebates

Describe the impact of rebates, fees, and other remuneration on premium and out-of-pocket costs in your narrative response. Provide as much detail as possible. Describe how and why the impact may vary based on the market segment or for particular types of plans, such as high deductible health plans. 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.

# 11 Appendix A: File Layouts for the RxDC Report

## 11.1 Plan Lists

### P1 Individual and Student Market Plan List

Note: Each row in P1 should have a unique combination of HIOS Plan ID and Plan Beginning Date

| P1 Column Name | Field Type | Instructions |
|---|---|---|
| HIOS Plan Name | String | **Do not enter more than one value.** |
| HIOS Plan ID | String | 14-digit HIOS Plan ID. Ex: 12345NY1234567. **Do not enter more than one value.**<br>Note: Some grandfathered plans and student health plans currently don't have HIOS IDs. If a plan doesn't have a HIOS Plan ID, follow the instructions in Section 4.2. |
| Plan Year Beginning Date | Date | MM/DD/YYYY<br>**Do not enter more than one value**. |
| Plan Year End Date | Date | MM/DD/YYYY<br>**Do not enter more than one value.** |
| Market Segment | String | Valid Values:<br>Individual market<br>Student market<br>**Do not enter more than one value.** |
| Members as of 12/31 | Integer | The number of enrollees on the last day of the reference year. If a plan ended before the last day of the reference year, enter 0. |
| PBM Name | String | If there is more than one value, separate them with a semicolon. |
| PBM EIN | String | 9-digit EIN. Include leading zeros if your EIN is fewer than 9 digits. Do not use dashes. Ex: 001234567. If there is more than one value, separate them with a semicolon. |
| Included in D1 Premium and Life Years?<br>(1= Yes; 0 = No) | Integer | Valid Values:<br>0<br>1 |
| Included in D2 Spending by Category?<br>(1= Yes; 0 = No) | Integer | Valid Values:<br>0<br>1 |

| P1 Column Name | Field Type | Instructions |
|---|---|---|
| Included in D3 Top 50 Most Frequent Brand Drugs?<br>(1= Yes; 0 = No) | Integer | Valid Values:<br>0<br>1 |
| Included in D4 Top 50 Most Costly Drugs?<br>(1= Yes; 0 = No) | Integer | Valid Values:<br>0<br>1 |
| Included in D5 Top 50 Drugs by Spending Increase?<br>(1= Yes; 0 = No) | Integer | Valid Values:<br>0<br>1 |
| Included in D6 Rx Totals?<br>(1= Yes; 0 = No) | Integer | Valid Values:<br>0<br>1 |
| Included in D7 Rx Rebates by Therapeutic Class?<br>(1= Yes; 0 = No) | Integer | Valid Values:<br>0<br>1 |
| Included in D8 Rx Rebates for the Top 25 Drugs?<br>(1= Yes; 0 = No) | Integer | Valid Values:<br>0<br>1 |

## P2 Group Health Plan List

Each row should have a unique combination of Group Health Plan Number, Plan Effective Date, and Plan Sponsor EIN.

| P2 Column Name | Field Type | Instructions |
|---|---|---|
| Group Health Plan Name | String | Do not include FEHB plans. |
| Group Health Plan Number | String | Enter a **unique** plan identification number. You can use the identification number in your own database or any other numbering sequence as long as there is a unique plan ID number for every plan. You may use the Form 5500 Plan Number. |
| HIOS Plan ID | String | Fully-insured small group plans only. Enter the 14-digit HIOS Plan ID(s). Do not use dashes. Ex: 12345NY1234567. You may enter more than one value in the same cell. If there is more than one value, separate them with a semicolon. |
| Form 5500 Plan Number | String | If applicable, enter the 3-digit plan number reported on the IRS Form 5500 filed with the Department of Labor. If there is more than one value, separate them with a semicolon. |

| P2 Column Name | Field Type | Instructions |
|---|---|---|
| States in which the plan offered | String | Enter the state(s) in which the plan or coverage is offered using 2-character state postal code.[15] If there is more than one state, separate them with a semicolon. For example: AL; AK; MA. If a plan is offered in every state and in DC, enter "National". If a plan is offered nationally and also in the territories, enter "National" as well as the 2-character postal code for the territories, separated by a semicolon. For example: National; PR; GU. |
| Market Segment | String | Valid Values:<br>Small group market<br>Large group market<br>SF small employer plans<br>SF large employer plans<br>For mixed-funded plans, enter both markets and separate them with a semicolon. |
| Plan Beginning Date | Date | MM/DD/YYYY<br>If a plan has a non-calendar plan year and renews during the calendar year, use two rows in the plan list file. (One row for the plan year that ended in the reference year and another for the plan year that began during the reference year.) |
| Plan End Date | Date | MM/DD/YYYY<br>If a plan has a non-calendar plan year and renews during the calendar year, use two rows in the plan list file. (One row for the plan year that ended in the reference year and another for the plan year that began during the reference year.) |
| Members as of 12/31 | Integer | The number of members with coverage, including dependents, on the last day of the reference year. If a plan ended before the last day of the reference year, enter 0. |
| Plan Sponsor Name | String | Enter the plan sponsor or client name. If there is more than one value, separate them with a semicolon. |
| Plan Sponsor EIN | String | Enter the 9-digit EIN. Include leading zeros if your EIN is fewer than 9 digits. Do not use dashes. Ex: 001234567. If there is more than one value, separate them with a semicolon. |
| Issuer Name | String | If there is more than one value, separate them with a semicolon. |

[15] In these instructions, the term "State" includes the District of Columbia and the U.S. territories. For Federal Employee Health Benefit (FEHB) plans, you must report data for the territories. For other plans, reporting on territories is optional.

| P2 Column Name | Field Type | Instructions |
|---|---|---|
| Issuer EIN | String | Enter the 9-digit EIN. Include leading zeros if your EIN is fewer than 9 digits. Do not use dashes. Ex: 001234567. Ex: 001234567. If there is more than one value, separate them with a semicolon. |
| TPA Name | String | If there is more than one value, separate them with a semicolon. |
| TPA EIN | String | Enter the 9-digit EIN. Include leading zeros if your EIN is fewer than 9 digits. Do not use dashes. Ex: 001234567. If there is more than one value, separate them with a semicolon. |
| PBM Name | String | If there is more than one value, separate them with a semicolon. |
| PBM EIN | String | Enter the 9-digit EIN. Include leading zeros if your EIN is fewer than 9 digits. Do not use dashes. Ex: 001234567. If there is more than one value, separate them with a semicolon. |
| Included in D1 Premium and Life Years?<br>(1= Yes; 0 = No) | Integer | Valid Values:<br>0<br>1 |
| Included in D2 Spending by Category?<br>(1= Yes; 0 = No) | Integer | Valid Values:<br>0<br>1 |
| Included in D3 Top 50 Most Frequent Brand Drugs?<br>(1= Yes; 0 = No) | Integer | Valid Values:<br>0<br>1 |
| Included in D4 Top 50 Most Costly Drugs?<br>(1= Yes; 0 = No) | Integer | Valid Values:<br>0<br>1 |
| Included in D5 Top 50 Drugs by Spending Increase?<br>(1= Yes; 0 = No) | Integer | Valid Values:<br>0<br>1 |
| Included in D6 Rx Totals?<br>(1= Yes; 0 = No) | Integer | Valid Values:<br>0<br>1 |
| Included in D7 Rx Rebates by Therapeutic Class?<br>(1= Yes; 0 = No) | Integer | Valid Values:<br>0<br>1 |

| P2 Column Name | Field Type | Instructions |
|---|---|---|
| Included in D8 Rx Rebates for the Top 25 Drugs?<br>(1= Yes; 0 = No) | Integer | Valid Values:<br>0<br>1 |

## P3 FEHB Plan List

Each row should have a unique combination of FEHB contract number, FEHB plan code, and plan beginning date

| P3 Column Name | Field Type | Instructions |
|---|---|---|
| FEHB Plan Name | String | |
| FEHB Contract Number | String | Enter the FEHB Contract ID. |
| FEHB Plan Code | String | Enter the two-digit FEHB plan code as it appears in the FEHB plan brochure. Separate each two-digit plan code with a semicolon. Ex: 4A; 4B; 4E; 4L. |
| States in which the plan is offered | String | Enter the states and territories in which the plan is offered using the 2-character postal code. If there is more than one state or territory, separate them with a semicolon. For example: AL; AK; MA. If a plan is offered in every state and in DC, enter “National”. If a plan is offered nationally and also in the territories, enter “National” as well as the 2-character postal code for the territories, separated by a semicolon. For example: National; PR; GU. |
| Plan Beginning Date | Date | MM/DD/YYYY<br>**Do not enter more than one value.** |
| Plan End Date | Date | MM/DD/YYYY<br>**Do not enter more than one value.** |
| Members as of 12/31 | Integer | The number of FEHB covered individuals, including dependents, on the last day of the reference year. If the plan ended before the last day of the reference year, enter 0. |
| FEHB Carrier Name | String | |
| FEHB Carrier EIN | String | 9-digit EIN. Include leading zeros if your EIN is fewer than 9 digits. Do not use dashes. Ex: 001234567. |
| Affiliate Name | String | (If different from the FEHB carrier.)<br>If there is more than one value, separate them with a semicolon. |
| Affiliate EIN | String | (If different from the FEHB carrier.) |

| P3 Column Name | Field Type | Instructions |
|---|---|---|
| | | Enter the 9-digit EIN. Include leading zeros if your EIN is fewer than 9 digits. Do not use dashes. Ex: 001234567. If there is more than one value, separate them with a semicolon. |
| TPA or Other Third-party Name | String | (If different from the FEHB carrier.)<br>If there is more than one value, separate them with a semicolon. |
| TPA or Other Third-party EIN | String | (If different from the FEHB carrier.)<br>Enter the 9-digit EIN. Include leading zeros if your EIN is fewer than 9 digits. Do not use dashes. Ex: 001234567. If there is more than one value, separate them with a semicolon. |
| PBM Name | String | (If different from the FEHB carrier.)<br>If there is more than one value, separate them with a semicolon. |
| PBM EIN | String | (If different from the FEHB carrier.)<br>Enter the 9-digit EIN. Include leading zeros if your EIN is fewer than 9 digits. Do not use dashes. Ex: 001234567. If there is more than one value, separate them with a semicolon. |
| Included in D1 Premium and Life Years?<br>(1= Yes; 0 = No) | Integer | Valid Values:<br>0<br>1 |
| Included in D2 Spending by Category?<br>(1= Yes; 0 = No) | Integer | Valid Values:<br>0<br>1 |
| Included in D3 Top 50 Most Frequent Brand Drugs?<br>(1= Yes; 0 = No) | Integer | Valid Values:<br>0<br>1 |
| Included in D4 Top 50 Most Costly Drugs?<br>(1= Yes; 0 = No) | Integer | Valid Values:<br>0<br>1 |
| Included in D5 Top 50 Drugs by Spending Increase?<br>(1= Yes; 0 = No) | Integer | Valid Values:<br>0<br>1 |
| Included in D6 Rx Totals?<br>(1= Yes; 0 = No) | Integer | Valid Values:<br>0<br>1 |

| P3 Column Name | Field Type | Instructions |
|---|---|---|
| Included in D7 Rx Rebates by Therapeutic Class?<br>(1= Yes; 0 = No) | Integer | Valid Values:<br>0<br>1 |
| Included in D8 Rx Rebates for the Top 25 Drugs?<br>(1= Yes; 0 = No) | Integer | Valid Values:<br>0<br>1 |

## 11.2 Data Files

### D1 Premium and Life Years

Each row in D1 must have a unique combination of EIN, state, and market segment.

| D1 Column Name | Field Type | Instructions |
|---|---|---|
| Issuer or TPA Name | String | Enter the name of the issuer, TPA, FEHB carrier, or plan sponsor, as applicable. **Do not enter more than one value.** |
| Issuer or TPA EIN | String | Enter the 9-digit EIN. Include leading zeros if your EIN has fewer than 9 digits. Do not use dashes. Ex: 001234567. **Do not enter more than one value.** |
| State | String | Enter the 2-character state or territory postal code. Ex: NY. **Do not enter more than one value.** |
| Market Segment | String | Valid Values:<br>Individual market<br>Student market<br>Small group market<br>Large group market<br>SF small employer plans<br>SF large employer plans<br>FEHB plans<br>**Do not enter more than one value.** |
| Average Monthly Premium Paid by Members | Numeric | |
| Average Monthly Premium Paid by Employers | Numeric | |
| Life Years | Numeric | |
| Earned Premium | Numeric | For fully-insured plans. |
| Premium Equivalents | Numeric | For self-funded plans. |

| D1 Column Name | Field Type | Instructions |
|---|---|---|
| ASO/TPA Fees Paid (included in the Premium Equivalents field) | Numeric | For self-funded plans. |
| Stop Loss Premium Paid (included in the Premium Equivalents field) | Numeric | For self-funded plans. |

## D2 Spending by Category

Each row in D2 must have a unique combination of EIN, state, market segment, and spending category.

| D2 Column Name | Field Type | Instructions |
|---|---|---|
| Issuer or TPA Name | String | Enter the name of the issuer, TPA, FEHB carrier, or plan sponsor, as applicable. **Do not enter more than one value.** |
| Issuer or TPA EIN | String | Enter the 9-digit EIN. Include leading zeros if your EIN has fewer than 9 digits. Do not use dashes. Ex: 001234567. **Do not enter more than one value.** |
| State | String | Enter the 2-character state postal code. Ex: NY. **Do not enter more than one value.** |
| Market Segment | String | Valid Values:<br>Individual market<br>Student market<br>Small group market<br>Large group market<br>SF small employer plans<br>SF large employer plans<br>FEHB plans<br>**Do not enter more than one value.** |
| Spending Category | String | Valid Values:<br>Hospital<br>Primary Care<br>Specialty Care<br>Other medical costs and services<br>Known medical benefit drugs<br>Estimated medical benefit drugs<br>**Do not enter more than one value.** |

| D2 Column Name | Field Type | Instructions |
|---|---|---|
| Total Spending | Numeric | |
| Total Cost Sharing | Numeric | |
| Amounts Not Applied to Deductible and/or Out-of-Pocket Maximum | Numeric | |

### D3 Top 50 Most Frequent Brand Drugs

Each row in D3 must have a unique combination of EIN, state, market segment, and drug code.

| D3 Column Name | Field Type | Instructions |
|---|---|---|
| Issuer or TPA Name | String | Enter the name of the issuer, TPA, FEHB carrier, or plan sponsor, as applicable. **Do not enter more than one value.** |
| Issuer or TPA EIN | String | Enter the 9-digit EIN. Include leading zeros if your EIN has fewer than 9 digits. Do not use dashes. Ex: 001234567. **Do not enter more than one value.** |
| State | String | Enter the 2-character state postal code. Ex: NY. **Do not enter more than one value.** |
| Market Segment | String | Valid Values:<br>Individual market<br>Student market<br>Small group market<br>Large group market<br>SF small employer plans<br>SF large employer plans<br>FEHB plans<br>**Do not enter more than one value.** |
| Drug Name | String | Enter the drug name from the CMS crosswalk file. **Do not enter more than one value.** |
| Drug Code | String | Enter the drug code from the CMS crosswalk file. Do not use NDC. **Do not enter more than one value.** |
| Frequency Rank | Integer | Valid Values: 1-50. **Do not enter more than one value.** |
| Number of Paid Claims | Integer | |
| Number of Members with a Paid Claim | Integer | |
| Number of Dosage Units | Numeric | |

| D3 Column Name | Field Type | Instructions |
|---|---|---|
| Total Spending | Numeric | |
| Total Cost Sharing | Numeric | |
| Manufacturer Cost-Sharing Assistance | Numeric | |

## D4 Top 50 Most Costly Drugs

Each row in D4 must have a unique combination of EIN, state, market segment, and drug code.

| D4 Column Name | Field Type | Instructions |
|---|---|---|
| Issuer or TPA Name | String | Enter the name of the issuer, TPA, FEHB carrier, or plan sponsor, as applicable. **Do not enter more than one value.** |
| Issuer or TPA EIN | String | Enter the 9-digit EIN. Include leading zeros if your EIN has fewer than 9 digits. Do not use dashes. Ex: 001234567. **Do not enter more than one value.** |
| State | String | Enter the 2-character state postal code. Ex: NY. **Do not enter more than one value.** |
| Market Segment | String | Valid Values:<br>Individual market<br>Student market<br>Small group market<br>Large group market<br>SF small employer plans<br>SF large employer plans<br>FEHB plans<br>**Do not enter more than one value.** |
| Drug Name | String | Enter the drug name from the CMS crosswalk file. **Do not enter more than one value.** |
| Drug Code | String | Enter the drug code from the CMS crosswalk file. Do not use NDC. **Do not enter more than one value.** |
| Cost Rank | Integer | Valid Values: 1-50. **Do not enter more than one value.** |
| Number of Paid Claims | Integer | |
| Number of Members with a Paid Claim | Integer | |
| Number of Dosage Units | Numeric | |
| Total Spending | Numeric | |

| D4 Column Name | Field Type | Instructions |
|---|---|---|
| Total Cost Sharing | Numeric | |
| Manufacturer Cost-Sharing Assistance | Numeric | |

## D5 Top 50 Drugs by Spending Increase

Each row in D5 must have a unique combination of EIN, state, market segment, and drug code.

| D5 Column Name | Field Type | Instructions |
|---|---|---|
| Issuer or TPA Name | String | Enter the name of the issuer, TPA, FEHB carrier, or plan sponsor, as applicable. **Do not enter more than one value.** |
| Issuer or TPA EIN | String | Enter the 9-digit EIN. Include leading zeros if your EIN has fewer than 9 digits. Do not use dashes. Ex: 001234567. **Do not enter more than one value.** |
| State | String | Enter the 2-character state postal code. Ex: NY. **Do not enter more than one value.** |
| Market Segment | String | Valid Values:<br>Individual market<br>Student market<br>Small group market<br>Large group market<br>SF small employer plans<br>SF large employer plans<br>FEHB plans<br>**Do not enter more than one value.** |
| Drug Name | String | Enter the drug name from the CMS crosswalk file. **Do not enter more than one value.** |
| Drug Code | String | Enter the drug code from the CMS crosswalk file. Do not use NDC. **Do not enter more than one value.** |
| Spending Increase Rank | Integer | Valid Values: 1-50. **Do not enter more than one value.** |
| Number of Paid Claims | Integer | |
| Number of Members with a Paid Claim | Integer | |
| Number of Dosage Units | Numeric | |
| Total Spending | Numeric | |
| Total Cost Sharing | Numeric | |

| D5 Column Name | Field Type | Instructions |
|---|---|---|
| Manufacturer Cost-Sharing Assistance | Numeric | |
| Prior Year Number of Paid Claims | Integer | |
| Prior Year Number of Members with a Paid Claim | Integer | |
| Prior Year Number of Dosage Units | Numeric | |
| Prior Year Total Spending | Numeric | |
| Prior Year Total Cost Sharing | Numeric | |
| Prior Year Manufacturer Cost-Sharing Assistance | Numeric | |
| Dollar Increase in Total Spending | Numeric | |

## D6 Rx Totals

Each row in D6 must have a unique combination of EIN, state, and market segment.

| D6 Column Name | Field Type | Instructions |
|---|---|---|
| Issuer or TPA Name | String | Enter the name of the issuer, TPA, FEHB carrier, or plan sponsor, as applicable. **Do not enter more than one value.** |
| Issuer or TPA EIN | String | Enter the 9-digit EIN. Include leading zeros if your EIN has fewer than 9 digits. Do not use dashes. Ex: 001234567. **Do not enter more than one value.** |
| State | String | Enter the 2-character state postal code. Ex: NY. **Do not enter more than one value.** |
| Market Segment | String | Valid Values:<br>Individual market<br>Student market<br>Small group market<br>Large group market<br>SF small employer plans<br>SF large employer plans<br>FEHB plans<br>**Do not enter more than one value.** |
| Total Rx Spending under Pharmacy Benefit | Numeric | |
| Rx Amounts Not Applied to Deductible and/or Out-of-Pocket Maximum | Numeric | |

| D6 Column Name | Field Type | Instructions |
|---|---|---|
| Bona Fide Service Fees | Numeric | |
| PBM Spread Amounts | Numeric | |
| Total Rebates/Fees/Other Remuneration | Numeric | |
| Restated Prior Year Rebates/Fees/Other Remuneration | Numeric | |

## D7 Rx Rebates by Therapeutic Class

Each row in D7 must have a unique combination of EIN, state, market segment, and therapeutic class code.

| D7 Column Name | Field Type | Instructions |
|---|---|---|
| Issuer or TPA Name | String | Enter the name of the issuer, TPA, FEHB carrier, or plan sponsor, as applicable. **Do not enter more than one value.** |
| Issuer or TPA EIN | String | Enter the 9-digit EIN. Include leading zeros if your EIN has fewer than 9 digits. Do not use dashes. Ex: 001234567. **Do not enter more than one value.** |
| State | String | Enter the 2-character state postal code. Ex: NY. **Do not enter more than one value.** |
| Market Segment | String | Valid Values:<br>Individual market<br>Student market<br>Small group market<br>Large group market<br>SF small employer plans<br>SF large employer plans<br>FEHB plans<br>**Do not enter more than one value.** |
| Therapeutic Class Name | String | Enter the therapeutic class name from the CMS crosswalk file. **Do not enter more than one value.** |
| Therapeutic Class Code | String | Enter the therapeutic class code from the CMS crosswalk file. **Do not enter more than one value.** |
| Number of Paid Claims | Integer | |
| Number of Members with a Paid Claim | Integer | |

| D7 Column Name | Field Type | Instructions |
|---|---|---|
| Number of Dosage Units | Numeric | |
| Total Spending | Numeric | |
| Total Cost Sharing | Numeric | |
| Manufacturer Cost-Sharing Assistance | Numeric | |
| Rebates Retained by PBM | Numeric | |
| Rebates Retained by Plan/Issuer/Carrier | Numeric | |
| Rebates Passed to Member at POS | Numeric | |
| Net Transfer of Fees and Other Remuneration from Manufacturer to Plan/Issuer/Carrier | Numeric | |
| Net Transfer of Fees and Other Remuneration from Pharmacy to Plan/Issuer/Carrier | Numeric | |
| Total Rebates/Fees/Other Remuneration | Numeric | |
| Restated Prior Year Rebates/Fees/Other Remuneration | Numeric | |

## D8 Rx Rebates for the Top 25 Drugs

Each row in D8 must have a unique combination of EIN, state, market segment, and drug code.

| D8 Column Name | Field Type | Instructions |
|---|---|---|
| Issuer or TPA Name | String | Enter the name of the issuer, TPA, FEHB carrier, or plan sponsor, as applicable. **Do not enter more than one value.** |
| Issuer or TPA EIN | String | Enter the 9-digit EIN. Include leading zeros if your EIN has fewer than 9 digits. Do not use dashes. Ex: 001234567. **Do not enter more than one value.** |
| State | String | 2-character state postal code. Ex: NY. **Do not enter more than one value.** |
| Market Segment | String | Valid Values:<br>Individual market<br>Student market<br>Small group market<br>Large group market |

| D8 Column Name | Field Type | Instructions |
|---|---|---|
| | | SF small employer plans<br>SF large employer plans<br>FEHB plans<br>**Do not enter more than one value.** |
| Drug Name | String | Enter the drug name from CMS crosswalk file. **Do not enter more than one value.** |
| Drug Code | String | Enter the drug code from the CMS crosswalk. Do not use NDC. **Do not enter more than one value.** |
| Rebate Rank | Integer | Valid Values: 1-25. **Do not enter more than one value.** |
| Number of Paid Claims | Integer | |
| Number of Members with a Paid Claim | Integer | |
| Number of Dosage Units | Numeric | |
| Total Spending | Numeric | |
| Total Cost Sharing | Numeric | |
| Manufacturer Cost-Sharing Assistance | Numeric | |
| Rebates Retained by PBM | Numeric | |
| Rebates Retained by Plan/Issuer/Carrier | Numeric | |
| Rebates Passed to Member at POS | Numeric | |
| Net Transfer of Fees and Other Remuneration from Manufacturer to Plan/Issuer/Carrier | Numeric | |
| Net Transfer of Fees/Other Remuneration from Pharmacy to Plan/Issuer/Carrier | Numeric | |
| Total Rebates/Fees/Other Remuneration | Numeric | |
| Restated Prior Year Rebates/Fees/Other Remuneration | Numeric | |

## 11.3 File Requirements

**What file format should I use?**
You must use Comma Separated Value (CSV) format for your plan lists and data files. You can generate your own CSV files or you can create them using the RxDC templates provided by CMS.

**Where are the RxDC templates?**
The RxDC templates are on the CMS website at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/Prescription-Drug-Data-Collection.

Follow these instructions when preparing your submission:

- Your files must be in CSV format (If you use the Excel templates provided by CMS, save your files in CSV format before uploading them into HIOS.)
- The order of the columns in your file must exactly match the order of the columns in the file layouts.
- The first row of your file should contain the column names. Your data should start on the second row.
- You can use letters, numbers, and the following special characters in non-numeric fields: - (){}[] & ~ ! ; @ # $ % + =|.
- Do not use commas or dollar signs in numeric fields. Only numbers and decimals are allowed.
- Do not uses slashes ("/") in alphanumeric fields. HIOS won't accept text with slashes because data with slashes requires additional security screening that would slow down processing time. The exception is that you can use slashes in the column headers and in date fields.
- You can use commas in a text field if there are quotation marks on both sides of the text. Ex: "Company ABC, Inc."
    - Excel will automatically insert the quotation marks for you when you save a file in CSV format. For example, you can enter Company ABC, Inc in the template without quotation marks and Excel will convert it to "Company ABD, Inc" when you save it as a CSV file. Without the quotation marks, HIOS won't know whether a comma is part of a text string or is a delimiter between columns.
- Do not use more than 8 decimal places in numeric fields. Ex: 0.6666666666 should be rounded to 0.66666667.