

EMPLOYEE BENEFITS

Prescription Drug Data Collection (RxDC) Reporting

March 2025





















Under the No Surprises Act health care transparency provisions of the Consolidated Appropriations Act of 2020, group health plans and health issuers offering group health coverage (reporting entities) must complete annual reporting on prescription drug and health care enrollment, premiums and spending. This guide is intended to inform group health plans of their obligations under the RxDC reporting requirements.

Applicability of Reporting Requirement

To begin, a group health plan must first analyze whether any of their group health plan are subject to the RxDC reporting requirement. The chart below reflects the most common types of group health plans that are subject to the RxDC reporting requirement or that are excluded from the reporting obligation.



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Health Plan Type	Reporting is Required	Reporting is Not Required
Group Health Plans (major medical coverage)¹:		
<ul style="list-style-type: none"> Grandfathered/grandmothered Non-grandfathered Retiree-only plans Certain expatriate plans² Medical benefit-only plans with no prescription drug coverage 	   (covered lives and total cost reporting required)	 
Prescription Drug Plans:		
<ul style="list-style-type: none"> Integrated with major medical Non-integrated 	 	
Account-Based Health Plans:		
<ul style="list-style-type: none"> HRA/FSA integrated with group health plan Qualified Small Employer HRAs (QSEHRAs) and Individual Coverage HRAs (ICHRAs) Non-integrated HRA/FSA Limited purpose HRA/FSA 		   
Wellness Benefits³:		
<ul style="list-style-type: none"> Integrated with major medical Non-integrated 		
Excepted Benefits:		
<ul style="list-style-type: none"> Limited-scope stand-alone dental and vision plans Hospital fixed indemnity insurance Specified illness (e.g., cancer/critical illness) fixed indemnity insurance Short-term limited duration insurance Accident indemnity insurance On-site medical clinic 		     
Other types of group health plans:		
<ul style="list-style-type: none"> Direct payment/concierge services Large case management Chronic disease care support Telemedicine, Virtual medicine Employee assistance plans 	 (may be subject to reporting requirements if the plan provides benefits for services that constitute "significant medical care")	

¹ Group health plans subject to the reporting requirement include fully insured and self-insured plans, including plans subject to ERISA, non-federal governmental plans, church plans that are subject to the Internal Revenue Code and the Federal Employee Health Benefit (FEHB) plan. Applies to plans, issuers and carriers in all 50 states, the District of Columbia and US territories.

² Group health plans maintained outside of the US primarily for the benefit of persons substantially all of whom are non-resident aliens are not subject to the RxDC reporting requirement.

³ Integrated wellness benefits both (a) provide significant benefits in the nature of medical care, and (b) submit claims for wellness services to the medical plan.



Data Elements

For group health plans, the following information is required at the plan or coverage level:

File	Identifies
Plan List (File P2)	<ul style="list-style-type: none">• The plan/issuer/reporting entity• The beginning and ending dates of the plan year that ended within the reporting reference year• The number of participants and beneficiaries covered on the last day of the reference year• The states in which coverage is offered for each plan or coverage
Life Years and Premiums (File D1)	<ul style="list-style-type: none">• Average monthly premiums paid by members and employer (total premiums divided by 12), including:<ul style="list-style-type: none">» Spousal and tobacco surcharges, and» COBRA participant premium payments (including a 2% COBRA admin fee, if applicable)• Life years = average number of members (employees + dependents) for entire year• Earned premium (fully insured) or premium equivalent (self-insured)⁴ on actual cost or retrospective basis for the entire reference year• Administrative fees and stop loss premiums⁵
Spending by Category (File D2)	<ul style="list-style-type: none">• Hospital• Primary Care• Specialty Care• Other medical costs and services• Medical benefit drugs (known and estimated amounts)
Drug Spending (Files D3-D8)	<ul style="list-style-type: none">• Top 50 Most Frequent Brand Drugs (File D3)• Top 50 Most Costly Drugs (File D4)• Top 50 Drugs by Spending Increase (File D5)• Rx Totals (File D6)• RX Rebates by Therapeutic Class (File D7)• Rx Rebates for Top 25 Drugs (File D8)

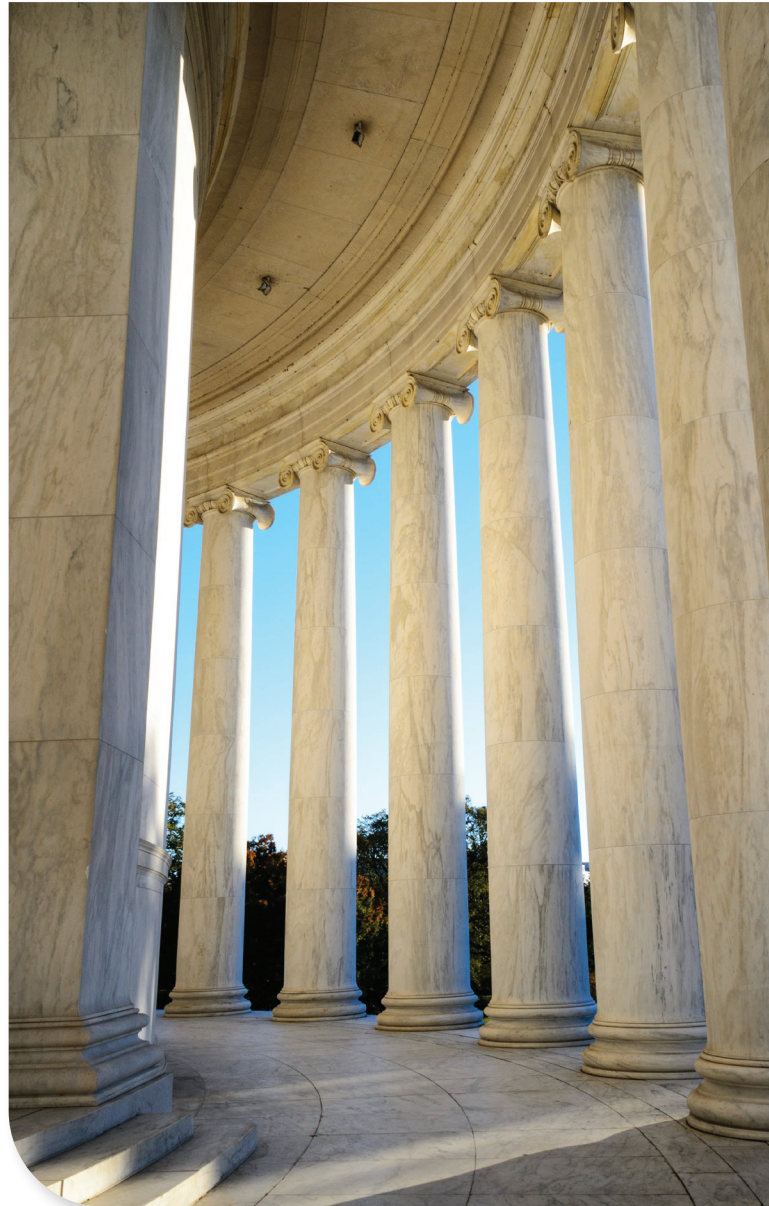
⁴ Paid in total for entire reference year - may be on a cash or incurred (accrual/retrospective) basis

⁵ Paid in total for entire reference year

Plan Sponsors' Reporting Responsibility

Plan sponsors may use a third party (e.g., insurance carrier, TPA, PBM, etc.) to fulfill the RxDC reporting requirement on behalf of the health plan.

- Regulations allow **fully insured** group health plans to shift all responsibility to the carrier if the carrier agrees to complete the RxDC reporting under a written agreement.
- Regulations allow a third party to perform the reporting on behalf of a **self-insured** group health plan pursuant to a written agreement, but the group health plan (and plan sponsor) retains ultimate responsibility.
- The plan sponsor could be a reporting entity for some or all of the data files if a third party/third parties do not agree to submit all data files on behalf of the plan sponsor. For example, in some cases the plan's carrier/TPA/PBM will not agree to submit the D1 data file. In that case, the plan sponsor would need to submit a P2 plan list file and the D1 data file to CMS.
- Even when they agree to handle all of the RxDC reporting on behalf of the plan, carriers/TPAs/PBMs typically will not have all of the required data to complete all of the RxDC reporting (especially premium information).
 - » The plan sponsor may need to provide certain pieces of information to the carrier/TPA/PBM so it may incorporate this information into the RxDC reporting they are submitting on the plan's behalf.
 - » Carriers/TPAs/PBMs generally impose deadlines for providing this requested information. Plan sponsors should pay close attention to these deadlines and furnish the data if they wish for the third party to submit all of the RxDC reporting information to CMS on behalf of the group health plan in a timely manner.
- A plan may have multiple reporting entities that submit information on the plan's behalf. For example, an employer sponsoring a self-funded plan may enter into a written agreement for the TPA to submit the D2 data file and another written agreement with a PBM to submit the D3 through D8 data files. Plan sponsors should ensure that all elements of the reporting are completed.
- The instructions also permit multiple entities to submit the same type of data file if they are unable to coordinate or work together. In such cases, "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." If multiple reporting entities are submitting D2 data files on behalf of a plan, the plan sponsor should confirm with the reporting entities that they are complying with the aggregation restriction, especially when the data in the D2 File is aggregated at the plan sponsor level.



Filing Procedure for Reporting Entities

Step 1: If the user is not yet registered in the [Health Insurance Oversight System \(HIOS\)](#), create a HIOS account. Instructions are provided in the [HIOS Portal User Manual](#) and this manual contains important contact information at CMS in the case the reporting entity has any questions related to the RxDC reporting requirement.

Step 2: Submit data through the RxDC Module in the [Health Insurance Oversight System \(HIOS\)](#). Refer to the [RxDC HIOS Module User Manual](#) for instructions.

Reporting Deadline

RxDC reporting is due to CMS by **June 1** of each year, reflecting data for the preceding calendar year (i.e., the “reference year”).

Resources

CMS RxDC website (which contains a link to reporting instructions)	https://www.cms.gov/marketplace/about/oversight/other-insurance-protections/prescription-drug-data-collection-rxdc
HIOS Portal User Manual	https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/HIOS-Portal-User-Manual.pdf
RxDC HIOS Module User Manual	https://regtap.cms.gov/reg_librarye.php?&i=3862
Text of Consolidated Appropriations Act	https://www.congress.gov/bill/116th-congress/house-bill/133/text
Transparency in Coverage Final Rules	https://www.federalregister.gov/documents/2020/11/12/2020-24591/transparency-in-coverage
RxDC FAQs	https://regtap.cms.gov/reg_librarye.php?i=4183

