MASSACHUSETTS

CONSOLIDATED APPROPRIATIONS ACT PRESCRIPTION DRUG DATA COLLECTION PROVISION BACKGROUND/ FREQUENTLY ASKED QUESTIONS

For Accounts and Brokers
December 2023

2023 Blue Cross Blue Shield of Massachusetts CAA RxDC FAQ

As the Consolidated Appropriations Act of 2021 (CAA, 2021) pharmacy benefits and costs reporting (also known as Prescription Drug Data Collection or RxDC) submission deadline for 2023 data approaches, please make note of the following:

1. BCBSMA has successfully submitted RxDC data for 2020 - 2022 reference years) to CMS by previously required federal deadlines.

2. BCBSMA RxDC data collection/submission approach for the *June 1, 2024 deadline*:

a. *Fully-insured*: BCBSMA will submit all RxDC data for benefits we administer and the appropriate narrative. This includes the P2 (Group Health Plan), D1 (Premium and Life Years), and D2 (Medical Spending by Category) files, as well as the D3-D8 files pertaining to prescription drug benefits.

b. *Self-insured (ASC) – with Rx benefits administered by BCBSMA*: BCBSMA is offering to submit the P2, D1, and D2 files (for benefits we administer), as well as the D3-D8 files, along with appropriate narrative.

c. *Self-insured (ASC) – with Rx benefits administered by another vendor*: BCBSMA is offering to submit the P2, D1, and D2 files (for benefits we administer), along with appropriate Narrative. These accounts must work with their outside vendor to submit their D1, and D3-D8 files for the Pharmacy benefit and corresponding P2 files by the deadline.

d. *Alternative opt-out approach (ASC only)*: The customer may request their data from BCBSMA via the below-mentioned BCBSMA RxDC Plan Sponsor Survey, and opt to submit the data and appropriate Narrative themselves, or engage a third party to submit the data for them. ASC customers wishing to do their own submission should speak with their BCBSA account service team.

   i. *Self-insured (ASC) opt out – with Rx benefits administered by BCBSMA*: BCBSMA will be providing the account its available data for its P2 and D2-D8 files, but **these accounts must sign a non-disclosure agreement (NDA**) in order to access relevant prescription drug data as provided by our PBM. The account is responsible for data collection of its D1 file.

      Access to the NDA is found in the BCBSMA 2024 RxDC Plan Sponsor Survey; accounts that are choosing to self-submit and have prescription drug coverage with BCBSMA must also disclose the name of their third-party vendor who will be accessing the prescription drug data sent by BCBSMA and its PBM (only if applicable). BCBSMA must approve an indicated vendor before data is submitted to the account.

   ii. *Self-insured (ASC) opt out – with Rx benefits administered by another vendor*: BCBSMA will be providing the account its available data for its P2 and D2 files, and no NDA is necessary. The account is responsible for data collection and submission of its D1 and D3-D8 files pertaining to its Rx benefits, as well as associated P2 files.

iii. *Self-insured (ASC) partial opt-out*: BCBSMA is offering to submit the P2 and account's relevant D files (for benefits we administer), along with appropriate Narrative – except for the account's D1 file. Account is responsible for data collection and submission of its D1 file and associated P2 file.

Pertaining to the alternative opt-out approach for ASC accounts, BCBSMA is aiming to send applicable data to customers by May 20, 2024.

Note that BCBSMA is not asking for or including any data related to benefits it does not administer in its RxDC submission. Plan sponsors will need to coordinate its RxDC submissions with its health service vendors for other benefits outside of those administered by BCBSMA. The plan sponsor may be required to submit a P2 filing listing the names and EIN's of all its health service vendors that are submitting RxDC filings on their behalf.

As an additional resource, please review the following table pertaining to BCBSMA RxDC submission options:

Financial Arrangement	Pharmacy Coverage	Who submits the RxDC filing?	RxDC submission	Further Actions
Fully Insured	BCBSMA	BCBSMA for benefits it administers	BCBSMA submits P1 or P2 files and D1-D8 for benefits it administers.	No further action needed.
Self-Insured (ASC)	BCBSMA	BCBSMA for benefits it administers	BCBSMA submits D1-D8 and associated P2 files for benefits it administers.	No further action needed.
Self-Insured (ASC) – *Alternative opt-out approach (i)*	BCBSMA	Plan Sponsor	BCBSMA will not submit any files on plan sponsors behalf.	Plan sponsor needs to sign NDA (link embedded in survey) and email to email noted in the NDA. Upon receipt of the NDA and subsequent approval, BCBSMA will provide D2-D8 and applicable P2 files to the plan sponsor's primary contact.
Self-Insured (ASC) *Alternative partial opt-out approach (iii)*	BCBSMA	Plan Sponsor submits D1. Other data files submitted by BCBSMA	BCBSMA will submit D2-D8 and associated P2 files for benefits it administers on behalf of plan sponsor. Plan sponsor will submit D1 and associated P2 files.	BCBSMA will not provide any data files to the plan sponsor.
Self-Insured (ASC)	Non-BCBSMA	BCBSMA for benefits it administers	BCBSMA will submit partial D1, D2 and associated P2 files for benefits it administers on behalf of the plan sponsor. Plan sponsor will be responsible for submission of related D1(for pharmacy and other coverage), D3-D8 and associated P2 files.	BCBSMA will not provide any data to plan sponsor.
Self-Insured (ASC) *Alternative partial opt-out approach (ii)*	Non-BCBSMA	Plan Sponsor	BCBSMA will not include plan sponsor in its RxDC filing	BCBSMA will provide D2 and associated P2 files to plan sponsor's primary contact.
Self-Insured (ASC) *Alternative partial opt-out approach (iii)*	Non-BCBSMA	Plan sponsor submits D1. BCBSMA submits D2.	BCBSMA will submit D2 and associated P2 file on behalf of plan sponsor. Plan sponsor will submit D1, D3-D8 and associated P2 files	BCBSMA will not provide any data to the plan sponsor

3. To support the RxDC initiative this year, BCBSMA will be collecting data that is not in our system from each customer through the **BCBSMA 2023 RxDC Plan Sponsor Survey,** which must be completed no later than *Friday, March 8, 2024*. Even customers that submitted data in the prior year will be required to provide the information because information may change.

4. BCBSMA will not provide copies of RxDC data and/or reports submitted to CMS.

5. All RxDC data submitted by BCBSMA is in aggregate by state and market segments, as defined by CMS.

6. Each RxDC submission requires a corresponding P2, and BCBSMA will submit the appropriate Narrative with its submission.

7. BCBSMA will produce a P2 file using information from the plan sponsor survey (if applicable), and BCBSMA systems.

8. BCBSMA will reconcile to the Group Health Plan Name based on the Plan Sponsor name in the plan sponsor survey; where applicable.

9. BCBSMA will use '501' as the Group Health Plan Number. If an account requires something different, it may provide that information in the BCBSMA 2023 RxDC Plan Sponsor Survey.

10. BCBSMA is unable to incorporate external data or make changes to data if there are discrepancies. If there are data mismatches, BCBSMA will reconcile with CMS directly.

11. Upon submission of BCBSMA's aggregated filing, BCBSMA will confirm successful submission on BCBSMA employer and broker site and related external materials.

12. For ASC groups that choose to submit the data themselves, BCBSMA will provide the required data as detailed above in this document to customers on or before May 20, 2024.

Additional Q&A

What is the deadline for submitting the report?

The last day to submit data for the 2023 reference year is June 1, 2024. The June deadline will be the date for subsequent reference years for the calendar year immediately following the reference year. A reference year is the calendar year of the data that is in the report. For example, the RxDC report for the 2023 reference year means the information in the report is based on what happened in 2023.

For reporting purposes, what is BCBSMA's official company name and Federal EIN?

- Company name: Blue Cross and Blue Shield of Massachusetts, Inc.
- Federal EIN: 041045815

Can different entities report data for a group health plan?

Yes. A group health plan may have separate entities report data such as a TPA for medical coverage and a PBM for pharmacy benefits. The group health plan may need to submit an associated P2 filling that lists all health service vendors submitting RxDC data on its behalf (e.g., wellness, PBM, stop-loss).

Are accounts that are currently inactive with BCBSMA but who were active with BCBSMA in 2023 be included in the BCBSMA RxDC filing process?

Yes, the BCBSMA RxDC filing process seeks to incorporate available data from all accounts active with BCBSMA pertaining to 2023 data. So if a currently inactive account was active with BCBSMA for 2023, such an account will be provided a 2023 BCBSMA RxDC Plan Sponsor Survey and BCBSMA will seek to submit any and all data as available pertaining to benefits that BCBSMA administered, and depending on the account's benefits structure and eligible BCBSMA RxDC reporting preferences.

Does BCBSMA sign a contractual agreement regarding providing support for submitting the RxDC data as outlined in the CAA?

Our updated account agreement language covers BCBSMA responsibility and therefore there is no requirement to sign other agreements for our clients.

Refer to BCBSMA Account Agreement language, which notes: *Blue Cross and Blue Shield will take reasonable steps to assist the Account in its efforts to meet the Account's obligations under applicable law, including applicable provisions of the Consolidated Appropriations Act of 2021 ("CAA").*

What data will BCBSMA be requesting from accounts through its survey?

BCBSMA is requesting the following information/data from all accounts:

- Confirmation of ASC account's intention to either have BCBSMA submit applicable data on their behalf or to opt-out of this process and have BCBSMA send them their applicable data
- Employer Identification Number (EIN)
- Account's IRS Form 5500 number (if applicable)
- Group Health Plan Name and Number

- *Average percent of the premium* (or premium equivalent for self-insured accounts) paid by the account's subscribers

For ASC plans and other arrangements that do not rely exclusively or primarily on premiums, federal guidance mandates the reporting of the *premium equivalent amounts***.**

If the survey response is not completed and received by *Friday, March 8, 2024*, BCBSMA will submit the available/limited data in our system on or before the June 1, 2024 due date. However, the submission will not be complete. Data elements not provided to BCBSMA will need to be submitted to CMS by the health plan or another reporting entity. The Plan Sponsor accepts any risk arising from the Plan Sponsor's failure to provide any requested information to BCBSMA for reporting.

How do I calculate average monthly premiums/premium equivalent amounts?

Step 1: Calculate Total Member Months

Choose one day of the month, e.g., 1st of the month, 15th of the month, or last day of the month. For each calendar month in the 2023 reference year determine how many members were enrolled in each plan sponsored by the employer on the chosen day that month. "Members" includes not only active employees enrolled in the plan but also dependents, COBRA enrollees, retirees, etc. Add up the 12 monthly member counts – this is Total Member Months for the year.

Step 2: Calculate Total Premiums Paid by Members and Total Premiums Paid By Employer

Add up all the premiums paid by members over the course of the 2023 reference year, regardless of plan option, coverage tier, or rate structure. Then do the same for all premiums paid by the employer over the course of the 2023 reference year.

For ASC plans, use premium equivalents taking into account the same costs used to calculate the COBRA rate but not including the 2% COBRA admin fee. CMS has indicated they expect the premium equivalents reported in the D1 file to be the premium equivalents based on actual plan costs for the reference year. For most self-funded plans, the COBRA premiums are calculated at the start of the plan year using expected costs, which is likely a different number than the premium equivalent based on actual plan costs for the reference year that CMS is looking for.

Step 3: Calculate Average Monthly Premiums

The average monthly premiums paid by members is the total annual premiums paid by members divided by the Total Member Months. Likewise, the average monthly premiums paid by employer is then total annual premiums paid by the employer divided by Total Member Months.

Is there a fee for customers who do the RxDC reporting themselves?

For the 2023 RxDC reporting, BCBSMA will NOT be assessing any fees to collect and report data (pertaining to benefits for which BCBSMA administers) on behalf of fully-insured and ASC accounts (regardless of ASC account's prescription drug carve-in or carve-out status).

However, *for self-funded accounts wishing to submit the filings themselves*, please note the following:

- For self-funded accounts with prescription drug benefits administered by BCBSMA and who are wishing to self-submit, there is a $5,000 flat fee.
- For self-funded accounts with prescription drug benefits carved-out to another PBM and who are wishing to self-submit, there is a $10,000 flat fee.

Who does the RxDC reporting requirement apply to?

The reporting requirement applies to:

- Health insurance issuers offering group coverage (2+ subscribers)
- Health insurance issuers offering individual market coverage, including:
    - Exchanges
    - Student health plans
    - Plans sold exclusively outside of the Exchanges
    - Individual coverage issued through an association
- Fully insured and self-funded group health plans, including:
    - Employer and union sponsored group plans
    - Non-federal governmental plans, such as plans sponsored by state and local government
    - Church plans that are subject to the Internal Revenue Code
    - FEHB plans

Data is submitted separately by market:

- Insured individual, small group, large group
- Self-funded small group, large group
- Student health insurance
- Federal Employees Health Benefits (FEP)

Mixed funded plans report based on type of coverage (e.g., self-funded PBM benefit reports under self-funded market and fully insured medical benefit reports under group insurance).

The insurer or group health plan reports separately for each state in which the insurer or plan does business. The report includes all plans and policies in the state during the reference year.

- Insured group business is reported for the state where the contract is issued (except for association coverage).
- Self-funded group business is reported for the state where the plan sponsor has its principal place of business.

The reporting requirement does NOT apply to COBRA membership-count, account-based plans, such as health reimbursement arrangements, health savings accounts, excepted benefits including but not limited to short-term limited-duration plans, hospital or other fixed indemnity insurance, disease-specific insurance, or non-commercial plans such as Medicare Advantage and Prescription Drug plans, Medicaid managed care plans, state children's health insurance program plans and Basic Health Program plans.

What is BCBSMA's approach for Student accounts?

BCBSMA is not including student accounts (FI/ASC) in our survey approach as these accounts are regulated under individual market rules. The survey is built for employer groups (FI/ASC) only. While we are not surveying any of our student accounts, we are including the data we have for them in-house in our filing to CMS on their behalf.

For further context, we assume 100% of premium is funded by subscriber (per individual market rules); we also do not require any of their TIN/tax ID information, so BCBSMA has the data it needs from student accounts to submit their data to CMS as part of our filing process.
However, ASC student accounts may decide to opt-out of having BCBSMA submit their data to CMS, if they should choose to do so. If an ASC student account decides to opt out of our filing process, the account should contact their Account Service Consultant, and BCBCMA will proceed in the process of providing the account all necessary and available data pertaining to benefits administered by BCBSMA so that the account can ultimately self-submit its data to CMS.

What do these RxDC reports require for reporting of pharmacy costs?

Plans and issuers in the group and individual markets are required to submit certain information on prescription drug and other health care spending to the departments annually, including:

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

What do the RxDC reports require for reporting of medical services costs and spend?

For medical services the reporting must be broken down by:

- Type of costs - including hospital, provider and clinical primary and specialist services, prescription drugs, other medical costs including wellness.
- Spending by prescription drugs by health plan coverage and member.

How do the reports require insurers and health plans to report premium costs?

The premium must be reported by average monthly premium, by premiums impacted by fees and remuneration, and by any reduction in premiums and out-of-pocket costs as follows:

1. Average monthly premium:
   a. Paid by employers on behalf of enrollees; and
   b. Paid by enrollees.

2. Premiums impacted by rebates, fees, and any remuneration paid by a drug manufacturer to the plan or coverage or administrators or service providers, including:
   a. Amounts paid for each therapeutic class of drug, and
   b. Amounts paid for each of the 25 drugs that yielded the highest rebates and other remuneration.

3. Any reduction in premiums and out-of-pocket costs associated with rebates, fees, or other remuneration.

What is being reported regarding prescription drug rebates, fees and other remuneration paid by drug manufacturer?

The total fee must be reported. Fees are not required to be reported separately for each drug therapeutic class. Reporting includes the following in the total fee:

- Renumeration received by and on behalf of entities providing pharmacy benefit management services regardless of the source (e.g., pharmaceutical manufacturer, wholesaler, retail pharmacy or vendor).
- Discounts, chargebacks or rebates.
- Cash discounts, free goods contingent on purchase agreement.
- Up-front payments, coupons, goods in kind.
- Free or reduced-price services, grants, or other price concessions.
- Bona fide service fees paid by a drug manufacturer to the PBM that represent fair market value for itemized services performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the arrangement. The definition includes amounts that may be retained by the plan administrator and not shared with the health plan.

Where can I find more information about RxDC reporting?

Helpful resources:

- Blue Cross Employer Portal Regulatory Updates Page
- RxDC data elements/reporting instructions
- CMS RxDC website

For additional questions to Blue Cross as to our approach in RxDC reporting, send us an email at CAAPharmRpt@bcbsma.com.

Customers may also sign up for email announcements and register for training webinars at the Registration for Technical Assistance Portal (REGTAP)

If a customer is unable to locate an answer to their question in REGTAP, they may contact the help desk at 1-855-267-1515 or go to CMS_FEPS@cms.hhs.gov.

- Remember to include “RxDC” in the body of the email for faster service.
- Generally, a response is provided the same day and a full resolution within 1-2 weeks.