2023 RxDC Survey Reference Guide

In February 2024, Centers for Medicare & Medicaid Services (CMS) provided new updates to the RxDC Instructions.

Important:[1]

- Deadline to submit the RxDC survey back to Blue Cross NC is 4/15/2024.
  Please confirm that the email you input into the survey is correct before hitting submit or you will not receive an email confirmation of your RxDC survey submission.
- A submission is not confirmation that the survey was successful.
  - Please look for an email from CAARxDC@bcbsnc.com confirming whether your RxDC survey submission was successful or failed.
  - If you have received a failed submission, please resubmit your RxDC Survey here.
  - If you receive a successful submission but need to make changes to your original submission, please resubmit your RxDC Survey here.
  - We will submit the last submission if a group enters multiple submissions for a funding arrangement.
  - **This mailbox CAARxDC@bcbsnc.com is not monitored. Please do not reply to this email.**
- The RxDC Survey questions may not apply to all plan types; however, all questions require an answer. Please follow instructions within the survey if a question does not apply to your plan.
- The table below provides guidance on each survey question and which plan type must provide data. For example, questions 18 – 22 are questions for self-funded groups only, fully insured or groups that are not applicable would enter 0.

Group Health Plan Name: *All plan types must provide data*	This can be found in your summary plan description, or it can be found on your most recent form 5500 Filing. You can use the Form 5500 Search ,a Group Invoice or Subscriber ID Card to locate this Information.
Group Number: *All plan types must provide data*	The following information can be found on your Group Invoice or Subscriber ID Card. (You could have multiple group numbers. Only one is needed.)
9-digit employer EIN assigned to Plan Sponsor: *All plan types must provide data*	This is your Plan Sponsor's Employer Identification Number.

[1] The information provided throughout this guide is referenced from the 2023 RxDC Instructions (cms.gov)

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Your Health Plan Type: *All plan types must provide data*	Response should be fully insured, self-funded or carve-out Benefit Only.
Fully Insured Group	Fully insured groups purchase health insurance from Blue Cross NC and the employer pays premiums to the insurer some of which are passed on to the employees via payroll deduction. The insurer takes on the financial risk associated with providing coverage and administering the plan.
Self-Funded Group	Self-funded groups are plans for which the employer assumes the financial risk for providing health care benefits to their employees and the insurer is the plan administrator. This would include Balance-Funded Groups.
Carve-Out Benefit Only	A carved-out benefit only plan excludes other benefits because a different entity or entities will provide most of the plan's other benefits.
Do you offer a "Carve-Out Benefit Only" plan? *All plan types must provide data*	"Carve-Out Benefit only" means these benefits are stand-alone, or a separate health benefit. These Carve-out benefits are administered, offered, or insured by Blue Cross NC.
3-digit Plan Number: *All plan types must provide data*	The following information can be found on your most recent form 5500 Filing. You can use the Form 5500 Search to locate this information. If adding more than one plan number separate each with **a comma, and no spaces**.
Name of Pharmacy Benefit Manager (PBM) *Self-Funded Groups must provide data*	This would be the name of the Third-Party Administrator for your pharmacy benefits. Carve out Pharmacy Benefit Managers should submit P2 and D3-D8 data on your Plan's behalf.
9-digit EIN of Carve Out Pharmacy Benefit Manager (PBM) *Self-Funded Groups must provide data*	If not applicable, copy and paste **the 9 zeros (000000000).**

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	Must be **9 digits** (e.g., 656742879, etc.) or the submission will be rejected.
Do you plan to submit your employer group's D1 Data to HIOS?	Self-Funded groups only may choose to submit their D1 data via the HIOS platform but must indicate this choice within the survey by the deadline. If your self-funded group chooses to submit D1 (and P2 as it is required from all submitters) and indicates as such within the survey by the deadline, Blue Cross NC will not submit D1 on your group's behalf but will submit all other relevant data on your group's behalf.
Enter the Average Monthly Premium Paid by Employees *All plan types must provide data*	In 2023, CMS simplified the calculation of average monthly premium to use total annual premium divided by 12 instead of the average monthly premium on a per-member basis. **A detailed breakdown of the new calculation is on pg. 4-5.**
Enter the Average Monthly Premium Paid by Employer *All plan types must provide data*	In 2023, CMS simplified the calculation of average monthly premium to use total annual premium divided by 12 instead of the average monthly premium on a per-member basis. **A detailed breakdown of the new calculation is on pg. 4-5.**
Does your Average Monthly Premium or Premium Equivalents include members of an Employee Group Waiver Plan (EGWP) *All plan types must provide data*	EGWPs are health plans offered by employers to their retirees.
Did Blue Cross NC administer all aspects of your Self-Funded health plan in 2023 *Self-Funded Groups must provide data*	Please respond Yes, No, or N/A.
Enter the Total Administrative Services Only (ASO) and other Third-Party Administrative fees for carved-out arrangements *Self-Funded Groups must provide data*	Include the total administrative costs, including fees that self-funded plans paid to an ASO, TPA, PBM, or other entity administering a plan. (ex. claims processing fees, etc.) **Do not use the dollar sign or comma.**

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Enter the Stop-Loss Premium if Blue Cross NC is not the carrier *Self-Funded Groups must provide data*	Report the total annual stop-loss premium paid by the plan to its stop-loss insurer. Do not include premium for stop-loss purchased by an issuer. **Do not use the dollar sign or comma.**
Enter the Total claims costs, administrative costs for all carved-out arrangements *Self-Funded Groups must provide data*	This includes medical and pharmacy claims costs (you may use either paid claims or incurred claims.) **Do not use the dollar sign or comma.**
Enter the Network access fees *Self-Funded Groups must provide data*	An example is preferred provider organization (PPO) fees. Groups that have carve out arrangements and are assessed these fees by their carve out vendor(s) need to report this amount via the survey if none enter 0 **Do not use the dollar sign or comma.**
Enter the Payments made under capitation contracts *Self-Funded Groups must provide data*	This means the healthcare provider receives a fixed payment for each patient enrolled in the plan, regardless of the number of services provided or the actual cost of those services. Groups that have carve out arrangements and are assessed these fees by their carve out vendor(s) need to report this amount via the survey if none enter 0 **Do not use the dollar sign or comma.**

Calculating Average Monthly Premiums (table totaling monthly premiums for member and employers)[1]

Month	Total Premiums Paid By Members Monthly	Total Premiums Paid By Employers Monthly
January	6000.00	10000.00
February	6000.00	10000.00
March	6000.00	10000.00
April	6000.00	10000.00
May	6000.00	10000.00
June	6000.00	10000.00
July	6000.00	10000.00
August	6000.00	10000.00
September	6000.00	10000.00
October	6000.00	10000.00
November	6000.00	10000.00
December	6000.00	10000.00
Totals	**72,000.00**	**120,000.00**

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Total Monthly Premium Paid by Members/12 months = $6,000.00 (Average Monthly Premium Paid by Members)

Total Monthly Premium Paid by Employers/12 months = $10,000.00 (Average Monthly Premium Paid by Employers)

- For self-funded plans, this is total plan costs minus premiums paid by members.
- This average is based on Reference Year 2023 instructions
- For surveys containing multiple policies all policies should be included in the calculation.

Should premium paid for coverage of an owner of an S-Corporation or Partnership be counted as amount paid by a member or an amount paid by an employer?

If the owner works for the business and pays their premium out of personal funds, report the premium as an amount paid by a member.

How should I report premium paid for coverage of a sole proprietor or other small business where the coverage only covers the owner and/or the owner's spouse?

If only the owner and/or the owner's spouse are covered by a fully insured policy, you may treat the policy as an individual market policy and you do not have to report whether the amount is paid by a member versus paid by an employer.

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

Section 204 of the CAA, and the Prescription Drug and Health Care Spending interim final rules (86 FR 66662) require premium information to be reported separately according to amounts paid by members and amounts paid by employers. Generally, if you are reporting on behalf of a group health plan or FEHB plan, you must obtain this information from the plan.

If you are unable to obtain all necessary information to calculate average monthly premium paid by members and average monthly premium paid by employers from a plan, you should:

- Exclude the plan when calculating average monthly premium paid by members and average monthly premium paid by employers in columns E and F
- Include the plan when calculating life years, earned premium, premium equivalents, admin fees, and stop-loss premium in columns G – K[1]