

Consolidated Appropriations Act (CAA) Reporting Pharmacy Benefits & Cost Data (Section 204)

Prescription Drug Data Collection (RxDC) Survey Worksheet

Overview

To support the submission of RxDC data due June 1, 2026, Highmark must collect data not collected or maintained in our systems. To collect the required information, Highmark is requesting that you complete and submit an online survey within the given deadline. The following questions within this document will appear in the survey. We highly recommend you use this worksheet to prepare in advance of receiving the survey link.

The survey will be available beginning **February 13, 2026**, and must be completed by **April 17, 2026**.

Key Takeaways

- The **deadline to complete the survey is April 17, 2026, at 11:59pm EST**. If you fail to complete the survey by this deadline, you will be accountable for submitting it on your group health plan's behalf.
- Responses must be specific to your plan.
- **If you offer multiple group health plans that are administered or insured by Highmark, you must complete a separate survey for each group health plan.**
- **Do not combine Fully Insured amounts with Self-Funded Amounts - two surveys must be submitted, one for each group health plan.**
- The survey takes only 5-10 minutes to complete if this worksheet is prepared beforehand.
- If you do not complete the survey, Highmark will submit the data we maintain prior to the June 1 CMS submission deadline. This submission will not be complete due to data not provided via the survey.
- The [CMS RxDC home page](#) contains links to all the information you need to compile and submit the information. Please see the list of resources below.
 - [RxDC HIOS Access Guide](#)



- [HIOS RxDC User Manual](#)
 - [RxDC Reporting Instructions](#)
 - [RxDC FAQ](#)
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- Please retain your responses for your own records by printing the screen before submitting. The survey does not allow for a copy of the data to be sent to you.

Prescription Drug Data Collection (RxDC) Survey Worksheet

General Information

| Question | Survey Response |
|---|--|
| What is your First Name? <i>Provide first name of individual completing the survey</i> | First Name: |
| What is your Last Name? <i>Provide last name of individual completing the survey</i> | Last Name: |
| What is your Email Address? <i>Email address of individual completing the survey</i> | Email Address: |
| What is your Role with the Company? <i>Individual's role with the company (e.g., HR, Benefit Coordinator, Broker)</i> | Role: |
| Client Manager Name? <i>Provide first name of the Client Manager if known</i> | First Name: |
| Client Manager Name? <i>Provide last name of the Client Manager</i> | Last Name: |
| Client Manger Email Address? <i>Email address of Client Manager</i> | Email Address: |
| What is your Plan Sponsor Name? <i>Enter the name of the Employer for an employee benefit plan offered by a single employer OR the name of the Association or Consortium if the plan is established or maintained jointly by two or more employers.</i> | Plan Sponsor Name: |
| What is your Plan Sponsor EIN? <i>Enter the EIN of the Employer for a group health plan offered by a single employer OR the EIN of the Association or Consortium if the plan is established or maintained jointly by two or more employers.</i> | Plan Sponsor EIN: |
| Highmark Group Number <i>This is the policy number associated with your Highmark policy.</i> | Highmark Group Number: |
| Highmark Client ID <i>The Highmark Client ID can be found on your monthly invoice.</i> | Highmark Client ID: |
| What is the reporting period for which you are providing data? <i>Enter dates that align with the reporting plan year 2025 data or the specific period within 2025 for which RxDC data is being submitted.</i> | Start Date: (MM/DD/YYYY) _____ End Date: (MM/DD/YYYY) _____ |

What is the group funding type?

Select whether your group health plan is Fully Insured or Self-Funded

Fully Insured: A Fully Insured Health Plan is a plan where the employer contracts with a licensed insurer to assume financial responsibility (on a fixed premium basis) for the enrollees' medical claims and for all incurred administrative costs.

Self-Funded: A Self-Funded Group Health Plan is one in which the employer;

- a) assumed the financial risk for providing health care benefits to its employees; and
- b) has an administrative service only agreement with Highmark (rather than a policy of insurance).

In practical terms, self-funded employers pay for each out-of-pocket claim as they are incurred instead of paying a fixed premium to an insurance carrier, which is known as a fully insured plan.

Group Funding Type**:

****If Fully Insured move to Fully Insured section of this worksheet. If Self-Funded, move to Self-Funded section of this worksheet.**

Prescription Drug Data Collection (RxDC) Survey Worksheet

Fully Insured

| Question | Survey Response |
|--|---------------------------------------|
| <p>What is the average monthly premium paid by employers in calendar year 2025?</p> <p><i>Please refer to the Client Tip Sheet on how to calculate the average monthly premium paid</i></p> | <p>Employer paid premiums:</p> |
| <p>What is the average monthly premium paid by members in calendar year 2025?</p> <p><i>Please refer to the Client Tip Sheet on how to calculate the average monthly premium paid</i></p> | <p>Member paid premiums:</p> |

Survey Complete - Review your responses and submit.

Prescription Drug Data Collection (RxDC) Survey

Self-Funded

| Question | Survey Response |
|--|--|
| <p>Does Highmark administer or insure pharmacy benefits under your group health plan?</p> <p>Select YES if RX coverage is offered through Highmark.</p> <p>Select NO if RX is carved out of your Highmark group health plan.</p> | <p>Yes / No:</p> |
| <p>Only applicable if NO selected above</p> <p>Please enter the name of your pharmacy benefit manager (PBM).</p> <p>Please note that you will need to work with your PBM to ensure your pharmacy benefit information is reported as required (D3-D8 RxDC Files) This information is being collected for inclusion on the P2 plan file entry for your group health plan</p> | <p>Pharmacy Benefit Manager:</p> |
| <p>Only applicable if NO selected above</p> <p>Please enter the PBM EIN</p> <p>Please note that you will need to work with your PBM to ensure your pharmacy benefit information is reported as required (D3-D8 RxDC Files) This information is being collected for inclusion on the P2 plan file entry for your group health plan</p> | <p>PBM EIN:</p> |
| <p>Enter the total premium equivalents paid in calendar year 2025.</p> <p>Premium equivalents represent the total cost of providing and maintaining coverages for all members, including claims costs, administrative costs (including Administrative Services Only (ASO) and other Highmark administration fees (TPA fees)), stop-loss premiums, network access fees, and capitations payments. Refer to pages 33-35 of the RxDC reporting instructions published by CMS in the event a more detailed description is needed.</p> | <p>Total Premium Equivalents for 2025:</p> |
| <p>Enter the total ASO and other TPA fees paid in calendar year 2025</p> <p>Report all administrative costs, such as ASO or TPA fees. These amounts should also be included in the total premium equivalents amount. For reference, this amount must be reported separately in addition to the total premium equivalents amount.</p> | <p>Total ASO and other TPA Fees for 2025:</p> |
| <p>Enter the total stop-loss premium paid in calendar year 2025.</p> <p>Report all stop-loss premiums paid to your stop-loss insurer. This amount should also be included in the total premium equivalents amount. For reference, this amount must be reported separately in addition to the total premium equivalents amount.</p> | <p>Total Stop-Loss Premiums for 2025:</p> |
| <p>Enter the average monthly premium paid by members in 2025.</p> <p>Please refer to the CMS RxDC reporting instructions for calculation details.</p> | <p>Average monthly Premiums Paid by Members for 2025:</p> |

Prescription Drug Data Collection (RxDC) Survey

Self-Funded

Question

Enter the average monthly premium paid by employers in 2025.

Please refer to the CMS RxDC reporting instructions for calculation details.

Survey Response

Average monthly Premiums Paid by Employers for 2025:

Survey Complete - Review your responses and submit.

Premium and Premium Equivalent Average Month Calculation

For clarity, the examples below are being provided for how to calculate the average monthly premium paid for both members and employers. This corresponds to questions asked for Fully Insured clients in the survey.

Full Calendar Year Example

| Total Premium (or Premium Equivalents) | | | |
|--|-----------------|-------------------|--------------------|
| Month | Paid by Members | Paid by Employers | Total Paid by Plan |
| January | 4390 | 17560 | 21950 |
| February | 3330 | 17320 | 21650 |
| March | 3330 | 17320 | 21650 |
| April | 4700 | 18800 | 23500 |
| May | 4700 | 18800 | 23500 |
| June | 4700 | 18800 | 23500 |
| July | 4400 | 17600 | 22000 |
| August | 4400 | 17600 | 22000 |
| September | 4600 | 18400 | 23000 |
| October | 4600 | 18400 | 23000 |
| November | 4000 | 16000 | 20000 |
| December | 4000 | 16000 | 20000 |
| Total | 51150 | 212600 | 265750 |
| | Total A | Total B | |
| Average Monthly Premium Paid: | 4263 | 177167 | |

In this example, the employer has a medical policy with Highmark for the full calendar year

- Coverage Period: 1/1/2025-12/31/2025
- Calendar Period: 1/1/2025-12/31/2025
- Employer paid portion is 80% of the total plan premium (or premium equivalents) paid.
- Divide by 12 even if coverage was not in effect for the entire 12 months of the reference year.
- Average Monthly Premium Paid by Members = Total A divided by 12
- Please report this value as a whole number (numeric only). Do not include decimals or cents

Calculation: $51150 / 12 = 4263$ ← Amount to populate in survey

- Average Monthly Premium Paid by Employers = Total B divided by 12

Calculation: $212600 / 12 = 177167$ ← Amount to populate in survey

Partial Calendar Year Example

| Total Premium (or Premium Equivalents) | | | |
|--|----------------------------|-------------------|--------------------|
| Month | Paid by Members | Paid by Employers | Total Paid by Plan |
| January | 4390 | 17560 | 21950 |
| February | 3330 | 17320 | 21650 |
| March | 3330 | 17320 | 21650 |
| April | 4700 | 18800 | 23500 |
| May | 4700 | 18800 | 23500 |
| June | 4700 | 18800 | 23500 |
| July | 4400 | 17600 | 22000 |
| August | Moved to non-Highmark Plan | | |
| September | | | |
| October | - | - | - |
| November | - | - | - |
| December | - | - | - |
| Total | 29550 | 126200 | 157750 |
| | Total A | Total B | |
| Average Monthly Premium Paid: | 2463 | 105167 | |

In the example below, the employer has a medical policy for a partial calendar year

- Coverage Period: 1/1/2025-7/31/2025
- Calendar Period: 1/1/2025-7/31/2025
- Employer paid portion is 80% of the total plan premium (or premium equivalents) paid.
- Divide by 12 even if coverage was not in effect for the entire 12 months of the reference year.
- Average Monthly Premium Paid by Members = Total A divided by 12
- Please report this value as a whole number (numeric only). Do not include decimals or cents

Calculation: $29550 / 12 = 2463$ ← Amount to populate in survey

- Average Monthly Premium Paid by Employers = Total B divided by 12

Calculation: $126200 / 12 = 105167$ ← Amount to populate in survey

The following entities, which serve the noted regions and are independent licensees of the Blue Cross Blue Shield Association, may provide benefits and/or benefit administration:

Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, HM Health Insurance Company d/b/a Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, or First Priority Life. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., HM Health Insurance Company d/b/a Highmark Health Insurance Company, or Highmark Choice Company.

Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield or HM Health Insurance Company d/b/a Highmark Health Insurance Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.