COMPLIANCE ALERT

Prescription Drug Data Collection (RxDC) Reporting, Round Two

March 1, 2023

Quick Facts

- The next round of prescription drug data collection (RxDC) reporting is due June 1, 2023.
- Employers may have more involvement than they did during the first round of reporting that was initially due December 27, 2022.
- No additional good faith relief or transition relief has been extended at this time.
- Employers should work with their carriers, third party administrators (TPAs), pharmacy benefits manager (PBMs), and brokers to ensure compliance.

Background

The first round of RxDC reporting just wrapped up, as required by the Consolidated Appropriations Act of 2021 (CAA). Now it's time to prepare for round two. The first submission was initially due December 27, 2022, and was later extended to January 31, 2023. The second round of reporting will be due June 1, 2023. This is an annual reporting requirement which, going forward, will be due June 1 of the year following the calendar year being reported, also known as the reference year.

Many employers, especially those with fully insured plans, did not play much of a role in the first round of reporting because their carrier/TPA/PBM handled the reporting for them. Going forward, employers offering a group health plan, regardless of size and funding vehicle, should prepare to play an expanded role in the RxDC process.

Plan and Data Files

The RxDC reporting requirement takes the form of nine different data files that are submitted to CMS through their Health Insurance and Oversight System (HIOS):

D1	Plan Details (vendors, number of covered individuals, premiums, etc.)
D2	Medical spending information
D3-D8	Drug spending information
P2	Plan identifying information - required by each reporting entity

Most of the data to be included in these files is in the possession of the carrier, TPA or PBM, so they can file the reports without the employer's input or assistance. The notable exception is the D1 file. It contains fields to report Average Monthly Premium Paid by Members, along with Average Monthly Premium Paid by Employers. In some cases, vendors have indicated they will supply the necessary data, but the employer must file the data with the Centers for Medicare and Medicaid Services (CMS) themselves. Plan sponsors should check with their vendors to determine their level of involvement and whether they will file on the employer's behalf.

Most carriers, TPAs, and PBMs do not collect and store an individual group's premium contribution split, which means they must obtain this information from the employer themselves. In the first round of reporting, CMS indicated these data fields were optional, so many carriers, TPAs, and PBMs ignored them.

CMS has now directed these fields will be required going forward, which means employers will have to supply this information. There are two common approaches from carriers and TPAs to collect this data from employers.

1. The carrier/TPA/PBM requires the employer to report the Average Monthly Premium data to them through an online form, email, or paper form. They may also ask the employer to furnish other data required for the D1 at the same time.
2. The carrier/TPA/PBM decides they will simply not file the D1, and the employer will be responsible for submitting that file on its own. If a carrier or TPA takes this approach, the employer will have to register with HIOS and prepare a P2 and D1 file to submit by June 1, 2023.

Calculating Average Monthly Premiums

The method used to calculate the Average Monthly Premium Paid by Members and Employer, as outlined in the RxDC reporting Instructions, is a three-step process.

In most cases, an employer should end up with a single amount for Average Monthly Premium Paid by Members and Employer, regardless of how many plans, coverage tiers, or rate structures it maintains. The exception would be if the employer (or a carrier or TPA on the employer's behalf) is required to report different plans on different lines in the D1 file. This may occur, for example, if the employer offers different plans from different carriers or TPAs, or if the employer offers a mix of plans from different market segments. In that case, the employer will need to calculate a separate Average Monthly Premium for each plan on a separate line of the D1 file.

Employers should do their best to provide an accurate answer, but it is likely that any minor errors in the calculation will not be significant. Relief for the 2020 and 2021 reference years was provided for employers and reporting entities who demonstrated a good faith interpretation of the regulations and instructions. While no good faith relief has been extended for the reference year 2022, it is possible we will see some relief before the filing deadline. Employers should continue to make their best effort to provide accurate information to comply with the requirements and file their reports by June 1, 2023.

Step One: Calculate the 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 reference year, determine how many members were enrolled in each plan sponsored by the employer on the chosen day that month. "Members" includes all plan participants, not just active employees enrolled in the plan. Add up the 12 monthly member counts – this is Total Member Months for the year. For example:

Date	Members Covered on the Given Date
January 1, 2022	882
February 1, 2022	872
March 1, 2022	884
April 1, 2022	921
May 1, 2022	924
June 1, 2022	923
July 1, 2022	925
August 1, 2022	916
September 1, 2022	907
October 1, 2022	906
November 1, 2022	902
December 1, 2022	869
Total Member Months	**10,831**

If the employer does not regularly track this information, they may need to consult census reports from their carrier/TPA to determine the number of members enrolled each month.

Step Two: Calculate the Total Premiums Paid by Members and Total Premiums Paid by the Employer

Add up all the premiums paid by members over the course of the 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 reference year.

For self-funded plans, calculate premium equivalents similar to the costs used for Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, excluding the 2% COBRA administrative fee. CMS has indicated they expect the premium equivalents reported in the D1 file to be those 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 anticipated costs, which are likely to be a different number than the premium equivalent based on actual plan costs for the reference year that CMS specifies. It is likely that the next set of instructions released by CMS will provide more clarity on this portion of the calculation.

Step Three: 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 the Employer is then the total annual premiums paid by the employer divided by Total Member Months.

Other D1 Fields

Issuer or TPA Name and EIN

This should be the name and employer identification number (EIN) of the issuer (fully insured carrier, TPA, or plan sponsor.) If there were multiple issuers/TPAs in the same year, they must be entered on separate lines.

State

For a fully insured plan, enter the two-letter postal code for the state where the policy was issued. For a self-funded plan, enter the two-letter postal code for the state of the employer's principal place of business. Note that this definition is different from the "state" field in the P2 file.

Market Segment

The market segments for group plans are:

- Small group market
- Large group market
- Self-funded small employer plans
- Self-funded large employer plans

Use the same definition of "small" used in your state to identify the small group fully insured market (typically less than 50 employees), even for a self-funded plan. Do not enter more than one market segment. If the employer offers multiple plans in different segments, e.g., both a self-funded and a fully insured plan, they should be listed on different lines.

Life Years

Take the Total Member Months used to calculate Average Monthly Premiums, above, and divided by 12. Report the resulting number to the 8th decimal place. In the example above with 10,831 member months, the life years reported would be 902.58333333.

Earned Premium

This is the total amount of premiums paid to the insurance company for a fully insured plan for the reference year. This should be the same number used in the denominator when calculating Average Monthly Premiums. Do not reduce the premium to reflect the medical loss ratio (MLR) or other similar rebates. This field should be left blank for a self-funded plan.

Premium Equivalents

This is the total cost of providing self-funded coverage for the year including claims costs, administrative costs, Administrative Services Only (ASO), and other TPA fees and stop-loss premiums. These are the same costs that are used to calculate the COBRA rates, except CMS wants employers to use actual costs for the year, not expected costs. This should be the same number used in the denominator when calculating Average Monthly Premiums. This field should be left blank for a fully insured plan.

ASO/TPA Fees Paid

Report total ASO/TPA fees paid for a self-funded plan for the reference year – this should also be included in the premium equivalents amount. This field should be left blank for a fully insured plan.

Stop Loss Premiums Paid

Report total stop loss premiums paid for a self-funded plan for the reference year – this should also be included in the premium equivalents amount. This field should be left blank for a fully insured plan.

Summary

The reporting responsibility lies with the group health plan sponsor, but their carriers, TPAs, and PBMs will have most of the information necessary to submit the required data on behalf of employer-sponsored plans. Because there are some data elements that these vendors do not keep on file,

some coordination with plan sponsors will be required. Employers should be aware of what information the reporting entities will submit on their behalf, whether they need multiple reporting entities to complete the submission, and should confirm with vendors that the data was submitted in advance of the due date.

EPIC is monitoring any developments with this new requirement to determine how we can best assist our clients and will release additional resources as more information becomes available.

EPIC Employee Benefits Compliance Services

For further information on this or any other topic, please contact your EPIC benefits consulting team.

EPIC offers this material for general information only. EPIC does not intend this material to be, nor may any person receiving this information construe or rely on this material as, tax or legal advice. The matters addressed in this document and any related discussions or correspondence should be reviewed and discussed with legal counsel prior to acting or relying on these materials.