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RxDC Reporting Series

Part 1: RxDC Reporting Overview –
How to complete carrier, TPA or
PBM questionnaires

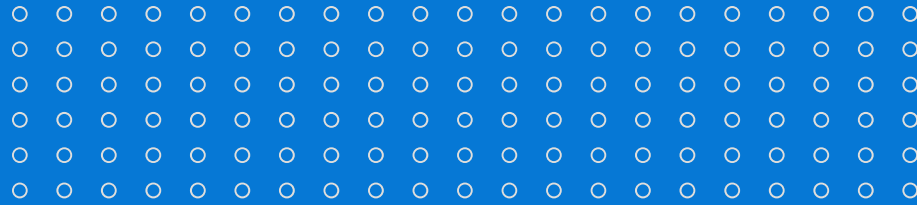


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RxDC Reporting Overview

How to complete carrier, TPA or PBM questionnaires



Agenda

Overview

Completing P2 Reports

Completing D1 Reports

Next Steps

Overview

Prescription Drug Reporting - RxDC Report Section 204

Overview

- The Prescription Drug Data Collection (RxDC) reporting requirement was introduced by the 2021 Consolidated Appropriations Act (CAA). RxDC intends to collect information about prescription drugs, medical spend, and premiums paid by employers and covered participants to grant Congress and HHS greater insight on the cost of healthcare.

Plans subject to reporting

- Grandfathered and non-grandfathered, self-insured, level funded, insured medical plans and MEC plans (even if MEC plans do not cover prescription plans), sponsored by employers of all sizes. Includes plans sponsored by private and public employers and church plans subject to IRC.

Plans exempt from reporting

- Stand-alone and integrated HRAs, HSAs, ICHRAs, dental, vision, excepted benefit plans, health FSAs, retiree-only plans, and plans maintained outside of the U.S. for non-resident aliens are exempt from reporting.

Prescription Drug Reporting - RxDC Report Section 204

What plans report on:

- P2 - Information about the plan, plan year, and plan information
- D1 - Plan enrollment, employer/employee cost-sharing information, TPA fees and stop-loss premiums
- D2 - Medical information
- D3 - Top 50 Most Frequently Dispensed Brand Drugs
- D4 - Top 50 Most Costly Drugs
- D5 - Top 50 Drugs by Spending Increase
- D7 - Rx Rebates by Therapeutic Class
- D8 - Rx Rebates for the Top 25 Drugs

Filing requirements based on plan offering:

- P2 is required for all employer-based group health plans that are not FEHB plans (identifies plan and must be filed with every report submitted to CMS)
- D1 – D8 reports are required for plans with medical and pharmacy benefits
- D1 and D2 are required for plans with only medical benefits (exclude pharmacy coverage)
- D1 and D3 – D8 are required for plans with pharmacy benefits only
- Narrative is required for all plans

Prescription Drug Reporting - RxDC Report Section 204



How are RxDC reports filed:

- Returns must be filed via the HIOS website: <https://portal.cms.gov/portal/>. Paper filings will not be accepted.
- Employers who are required to report on one or more areas must register in HIOS or may consider contracting with a third-party entity to comply with their reporting requirements.

RxDC Reporting Deadline: June 1, 2024. Plans report for the 2023 calendar year, even if the medical plan is not a calendar year plan.

- Note that if an employer sponsors more than one plan (different ERISA plan number or plan ID if the plan does not use Plan number) the plans must be filed as an aggregate submission.
- Different entities can report for different portions of 2023, however information reported must pertain to the 2023 calendar year only.

Prescription Drug Reporting - RxDC Report Section 204



Parties Responsible for RxDC Reporting

Plan Type	Responsible Party	What They File
Insured medical plan	<ul style="list-style-type: none"> Insurance carrier 	<ul style="list-style-type: none"> P2, D1-D8 and narrative
	<ul style="list-style-type: none"> Employer 	<ul style="list-style-type: none"> Must complete carrier survey/questionnaire to provide information to file P2 (plan information) and D1 (employer/employee contribution information for 2023). If an employer fails to complete questionnaire on a timely basis, the employer will be responsible for filing missing information with CMS.
Level-funded medical plan and integrated self-insured medical plan (TPA manages PBM services)	<ul style="list-style-type: none"> Employer 	<ul style="list-style-type: none"> Must complete TPA survey/questionnaire to provide information to file P2 (plan information) and D1(employer/employee contribution information for 2023). If an employer fails to complete questionnaire on a timely basis, the employer will be responsible for filing missing information with CMS.
	<ul style="list-style-type: none"> TPA and PBM (if same vendor is used or vendors are integrated) 	<ul style="list-style-type: none"> TPA- P2, D1-D8 and narrative
Self-insured medical plan (unintegrated, RX is carved out)	<ul style="list-style-type: none"> Employer 	<ul style="list-style-type: none"> May be required to file P2, D1-D8 and narrative if TPA and PBM will not assist. If TPA and PBM will assist with filing, the employer must complete questionnaire. Failure to complete questionnaire results in employer assuming reporting responsibilities for missing information.
	<ul style="list-style-type: none"> TPA 	<ul style="list-style-type: none"> P2, D1, D2 and narrative
	<ul style="list-style-type: none"> PBM 	<ul style="list-style-type: none"> P2, D3-D8 and narrative

Prescription Drug Reporting - RxDC Report Section 204

Can multiple parties file RxDC reports for one plan?

- Yes. However, only one entity should file the D1 report for the reporting year. For example, the employer can file P2 and D1, the TPA can file P2 and D2 and the narrative, and the PBM can file D3 through D8 and the narrative as it pertains to pharmacy. Work with your TPA and PBM to encourage them to file P2, D1-D2 on your behalf.

How can I confirm that my insurance carrier, TPA, or PBM completed the RxDC filing on my plan's behalf?

- Unfortunately, the plan will not be able to confirm via CMS that the RxDC reports were filed on their behalf. The employer should confirm with their PBM or TPA that the reports were filed on their behalf and retain a written record that the reports were filed on a timely basis. We recommend including reporting under RxDC in ASO and PBM agreements to ensure that the required reporting is completed.

What happens if the carrier, PBM, or TPA fail to comply with the RxDC reporting requirements?

- If the employer or plan delegated the responsibility of reporting under Section 204 to the carrier, PBM or TPA, and they fail to report as required, the plan will be deemed to be out of compliance with the RxDC reporting requirements. The plan will be required to report.

What happens if the employer went out of business in 2023?

- If the plan is insured, the carrier must still comply with reporting requirements. If the plan is self-insured or level-funded and terminated in 2023, it is left to the discretion of the plan to file.

What happens if there was a change in PBM or TPA during 2023 or the funding medium (e.g., insured to self-insured) changed? Who reports on behalf of the plan?

- Partial submissions are allowed for the months the PBM and TPA were in service for separate parts of the calendar year (e.g., a fully-insured carrier would report only for the months in service, e.g., January-July data, and the subsequent self-insured plan should only report August-December data).

Important:

- If the carrier, TPA, or PBM have informed you that they will be filing RxDC reports on your behalf, confirm what information you must provide to the carrier, TPA and/or PBM.
- If you are required to complete a survey or questionnaire, make sure that you satisfy the carrier, TPA, or PBM's deadline, as failure to meet the deadline you will be required to file with CMS the information that is missing.

Prescription Drug Reporting - RxDC Report Section 204

Where can I obtain the information to file P2, D1, D2, D3-D8 and the Narrative?

- Most of the information to complete P2 will be found in the Form 5500 reports or service contracts
- D1 information: The information is available in an employer's HRIS/payroll system (e.g., percentage of premiums paid by member vs. employer, stop-loss premiums, TPA fees, premium equivalents, etc.)
- D2 information will come primarily from the TPA and, in a minor role, from the PBM for POS discounts and rebates.
- D3- D8 information will come from the PBM
- Narrative information will come from the insurance carrier, TPA, and PBM.

Do I need to create a CMS Enterprise Portal or HIOS Account?

You do **NOT** need to create a CMS Enterprise Portal or HIOS account if:

- ★ • You already have a HIOS account, or
- ★ • You are not uploading any files (because an issuer, third-party administrator, pharmacy benefit manager, or other reporting entity is uploading files on your behalf).

NOTE: It can take up to two weeks to create your accounts. Don't wait until the last minute!

Information Medical Carriers, TPAs and PBMs will ask for



- If your TPA, ASO, or PBM sent you a letter informing you that they will not be filing P2, D1, D2 or any other reports (D3-D8 and the narrative), you will have to file the reports directly with CMS or engage another third-party to submit reports for you.
- Please refer to Module 2 to review how to create and register for a HIOS account.
- Please refer to Module 3, after registering in HIOS, on how to submit reports.

Completing RxDC Carrier/TPA or PBM Questionnaires

Information medical carriers, TPAs, and PBMs will ask for



- **Fully insured plans:** The insurance carrier may send a survey or questionnaire to collect information about the plan, such as plan numbers, name of the plan, percentage or premium paid by the employer or members (in aggregate for all plans offered through the carrier), and the total premiums paid for 2023.
 - This information is required to file P2 and D1 reports on your behalf.
 - If you fail to provide the required information to the carrier, it is likely that you will be required to report this information to CMS via the HIOS portal, unless you contract with a third-party vendor to file on your behalf.
- **Level-funded and self-funded plans:** Your TPA or PBM may send a questionnaire requesting plan information, in addition to total percentage of premiums paid by members vs. the employer. In addition, the TPA may request total TPA fees paid, and total stop-loss premiums paid by the plan.
 - This information is required to file P2 and D1 reports on your behalf.
 - If you fail to report the required information to the TPA or PBM, it is likely that you will be required to report this information to CMS via the HIOS portal, unless you contract with a third-party vendor to file on your behalf.

Prescription Drug Reporting - RxDC Completing P2



A P2 report will accompany any files being uploaded into HIOS. P2 identifies the filing entity and reports that will be submitted.

Group Health Plan Name (Required)	Group Health Plan Number (Required)	Carve-Out Description	Form 5500 Plan Number (if known)	States in which the plan is offered	Market Segment (Required)	Plan Year Beginning Date (MM/DD/YYYY)	Plan Year End Date (MM/DD/YYYY)	Members as of 12/31 of the Reference Year
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This section reports on general plan information, where the plan is offered, and plan year.

Plan Sponsor Name	Plan Sponsor EIN	Issuer Name	Issuer EIN	TPA Name	TPA EIN	PBM Name	PBM EIN
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This section reports on the employer sponsoring the plan, their TPA and PBM, if applicable.

Included in D1 Premium and Life Years? (1= Yes; 0 = No)	Included in D2 Spending by Category? (1= Yes; 0 = No)	Included in D3 Top 50 Most Frequent Brand Drugs? (1= Yes; 0 = No)	Included in D4 Top 50 Most Costly Drugs? (1= Yes; 0 = No)	Included in D5 Top 50 Drugs by Spending Increase? (1= Yes; 0 = No)	Included in D6 Rx Totals? (1= Yes; 0 = No)	Included in D7 Rx Rebates by Therapeutic Class? (1= Yes; 0 = No)	Included in D8 Rx Rebates for the Top 25 Drugs? (1= Yes; 0 = No)
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This section identifies the reports that are being filed with the P2 Form (usually filed by carrier/TPA and/or PBM)

You can retrieve the P2 excel template [here](#)

P2 Plan Information: Group Plan Information

Group Health Plan Name (Required)	Group Health Plan Number (Required)	Carve-Out Description	Form 5500 Plan Number (if known)
ABC Health & Welfare Plan	502		502

- **Group Health Plan Name:** Enter the plan’s legal name as it appears in plan documents, wrap SPDs, or Forms 5500.
- **Group Health Plan Number:** If the plan files Forms 5500, enter the plan number on the Form 5500. If not, enter any other unique plan ID number from your accounting system, employer EIN, or contract.
- **Carve-Out Description:** A carve-out benefit is a benefit administered, offered, or insured by an entity that is different from the entity that administers, offers, or insures most of the plan’s other benefits.
 - Enter one of the following (*if applicable*): Pharmacy only; Medical only; Behavioral health only; Fertility only; Specialty drugs only; Hospital only; or Other.
 - Leave this field blank if you are reporting carve-out benefit information and about the plan’s other benefits.
- **Form 5500 Number:** ERISA –subject plans with more than 100 participants covered at the beginning of a plan year file a Form 5500 with the Department of Labor. Enter the Plan Number found in the Form 5500.
 - If you aren’t sure if you have filed a Form 5500, visit <https://www.efast.dol.gov/5500Search/>.
 - If you don’t have a Form 5500 plan number, leave this column blank.

P2 – States and Market Segment



States in which the plan is offered	Market Segment (Required)	Plan Year Beginning Date (MM/DD/YYYY)	Plan Year End Date (MM/DD/YYYY)	Members as of 12/31 of the Reference Year
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- **States in which the plan is offered:** Enter the states and territories in which the plan or coverage is offered (i.e., someone can enroll in the plan if the individual lived in that state) using two-character state postal code. Most PPOs will enter National. If there is more than one state or territory, separate them with a semicolon. (Example: AL; AK; MA.) If a plan is offered in every state and in DC, enter “National”. If a plan is offered nationally and also in one or more territories, enter “National” as well as the two-character postal code for the applicable territories, separated by a semicolon. (Example: National; PR; GU.)
- **Market Segment: Enter one of the following**
 - Small group market: Fully-insured plans offered by employers with 50 or fewer employees (except for states that use under 100 employees as small group).
 - Large group market: Fully-insured plans offered by employers with more than 50 employees (except for states that use over 100 employees for large group).
 - SF small employer plans: Self-funded plans offered by employers with 50 or fewer employees
 - SF large employer plans: Self-funded plans offered by employers with more than 50 employees

P2 Plan Year and Enrollment:

States in which the plan is offered	Market Segment (Required)	Plan Year Beginning Date (MM/DD/YYYY)	Plan Year End Date (MM/DD/YYYY)	Members as of 12/31 of the Reference Year
National	Large Group Market	1/1/2023	12/31/2023	245

- **Plan Year Beginning Date and Plan Year End Date:** Enter the first day of the plan year. For calendar year plans enter 01/01/2023 for beginning and 12/31/2023 for Plan Year End Date. For Non-Calendar Year plans, use two rows as noted below.



Group Health Plan Name	Group Health Plan Number	Market Segment	Plan Year Beginning Date	Plan Year End Date	Members as of 12/31 of the reference year
Jane's Furniture Health and Welfare Plan	501	Small group market	07/01/2022	06/30/2023	0
Jane's Furniture Health and Welfare Plan	501	Small group market	07/01/2023	06/30/2024	27



- **Members as of the 12/31 of the Reference Year:** Enter the number of members as of 12/31 of the reference year. You must enter a whole number without decimal places. If a plan year ended before 12/31 of the reference year, enter 0. A member is defined as employees, retirees, COBRA QBs, and any other individual covered under the plan, including their dependents (“belly-buttons”).

P2 Plan Sponsor, TPA and PBM Vendors

Plan Sponsor Name	Plan Sponsor EIN	Issuer Name	Issuer EIN	TPA Name	TPA EIN	PBM Name	PBM EIN
ABC Company	76-980768	ABC Insurance Company	569087960	BCD TPA	670098790	ABC PBM	670987689

- **Plan Sponsor Name & EIN** - In general, the plan sponsor is the employer, employer organization, association, or trust that sponsors the plan.
- **Issuer Name and EIN** - Fully-insured plans: Enter your insurance company's Name and EIN. Self-insured or level-funded and has stop-loss coverage, enter the stop-loss carrier's name and EIN. If stop-loss coverage is not offered, leave the section blank.
- **TPA Name & EIN**
 - Fully-insured plans: Leave it blank
 - Self-funded plans: Enter the information of your TPA or ASO Administrator and their EIN.
- **PBM Name & EIN** - Enter your PBM's information. If you don't have a PBM, leave it blank.

Calculating Average Monthly
Premiums/Premium
Equivalents –D1

Prescription Drug Reporting - RxDC Completing D1- Insured Plans



How to complete the medical carrier questionnaire

2023 Annual Premiums Paid to Medical Carrier	Average Monthly Premium Paid by Members	Where is this information found?	Which plans does an employer report for?
<ul style="list-style-type: none"> • Add all medical premiums paid to the carrier during calendar year 2023. • Include premiums paid to medical carrier for all plans offered by the carrier for the 2023 calendar year (e.g. HMO, PPO and EPO). • Must report plans offered during 2023, even if the plan(s) were not offered during all of 2023. 	<p style="text-align: center;">Monthly Average</p> <ul style="list-style-type: none"> • Identify annual premium amounts paid by members covered under the plan(s) during calendar year 2023. • Include all premiums paid by employees, dependents, COBRA QB (include 2% administrative fee), retirees and tobacco and spousal surcharges. • Divide total premiums paid by members by 12. Divide by 12 even if the plan was not in effect for the full-12 months in 2023. 	<ul style="list-style-type: none"> • Insurance carrier or accounting software • Payroll/HRIS system- Contributions paid by members for calendar year 2023. 	<ul style="list-style-type: none"> • Insured medical plans offered by the carrier sending the questionnaire during 2023 that are reported under the same plan number (if an ERISA plan) or treated as a single plan if the employer is exempt from ERISA. • Do not include HRA or HSA contributions made by the employer • If the employer offered more than one carrier, employer must complete the survey for each carrier. • Aggregate the premiums paid for all plans sponsored by the employer through the carrier

Prescription Drug Reporting - RxDC Completing D1- Self-insured or Level Funded Plans



How to complete the TPA questionnaire

How to calculate Premium Equivalents for level-funded and self-insured medical plans	Average Monthly Premium Paid by Employers	Where is this information found?	Which plans does an employer report for?
<p>Annual Total (self-funded plans)</p> <p>Premium equivalents may be reported on a cash basis or on a retrospective basis. <u>May not use COBRA accrual rates.</u></p> <p>Include:</p> <ul style="list-style-type: none"> • Medical and pharmacy claims costs (you may use either paid claims or incurred claims) • Administrative costs, including fees that self-funded plans paid to an ASO, TPA, PBM, or other entity administering a plan • Stop-loss premiums • Network access fees, such as preferred provider organization (PPO) fees • Payments made under capitation contracts with providers for benefits covered under the plan <p>Subtract:</p> <ul style="list-style-type: none"> • Stop-loss reimbursements • Prescription drug rebates that were received and retained by the group health plan during the reference year, regardless of whether the payment is retrospective or prospective 	<p>Monthly Average</p> <ul style="list-style-type: none"> • Identify total premium equivalents for the 2023 calendar year. • Subtract the amount paid by members for 2023 from the total premium equivalents. The resulting amount is the employer contribution. • Divide 2023 premium equivalent amounts paid by employer by 12. Divide by 12 even if the plan was not in effect for the full-12 months 	<ul style="list-style-type: none"> • TPA can provide total claims paid for calendar year 2023 and potentially RX information and stop-loss reimbursements. • If Rx is carved out, PBM can provide claims and prescription drug rebate information. • Total stop-loss premiums paid can be obtained from client's HRIS/accounting system or from the TPA or stop-loss carrier. • Payroll/HRIS system- Contributions paid by members for calendar year 2023. 	<ul style="list-style-type: none"> • Self-insured medical plans and prescription drug plans offered by the employer during 2023 • Do not include HRA or HSA contributions made by the employer • Aggregate all claims and fixed costs for 2023 for all plans offered under the same plan number.

D1 Company- Average Monthly Premiums Paid by Members



	Average Monthly Premium Paid by Members	Average Monthly Premium Paid by Employers	Life Years	Earned Premium (fully-insured plans)	Premium Equivalents (self-funded plans)	Admin Fees Paid (included in the Premium Equivalents field)	Stop Loss Premium Paid (included in the Premium Equivalents field)
INSURED PLAN	\$172,000	\$359,000	902.58	\$6,372,000			
SELF-INSURED/LEVEL-FUNDED PLAN	\$85,560	\$295,689	789.86		\$4,574,988	\$250,560	\$185,000

Average Monthly Premium Paid by Members:

- Fully-insured plans: Divide annual premium amounts paid by members (active employees, dependents, retirees and other covered participants including COBRA QB plus 2% administrative fee, spousal surcharges, and tobacco surcharges) by 12. Members include all participants covered under the group health plan in 2023.
 - Divide by 12 even if the plan was not in effect for the full-12 months. For example, in 2023 the medical plan was implemented on 6/1/23, still divide by 12 even if the plan was in effect for only seven months of 2023.
- Self-insured and level-funded plans: Divide premium equivalents (may not use COBRA accrual rates) paid by members by 12. Premium equivalents paid by members include the COBRA administrative fee, spousal surcharges, and tobacco surcharges. Premium equivalents may be reported on a cash basis or on a retrospective basis.
 - Divide by 12 even if the plan was not in effect for the full-12 months.

D1 Company- Average Monthly Premiums Paid by Employers



	Average Monthly Premium Paid by Members	Average Monthly Premium Paid by Employers	Life Years	Earned Premium (fully-insured plans)	Premium Equivalents (self-funded plans)	Admin Fees Paid (included in the Premium Equivalents field)	Stop Loss Premium Paid (included in the Premium Equivalents field)
INSURED PLAN	\$172,000	\$359,000	902.58	\$6,372,000			
SELF-INSURED/LEVEL-FUNDED PLAN	\$85,560	\$295,689	789.86		\$4,574,988	\$250,560	\$185,000

Average Monthly Premium Paid by Employers:

- Fully-insured plans: Divide annual premium amounts paid by employer for 2023 and divide by 12. Divide by 12 even if the plan was not in effect for the full-12 months.
- Self-insured and level-funded plans: Divide premium equivalents (may not use COBRA accrual rates) paid by the employer by 12. Divide by 12 even if the plan was not in effect for the full-12 months. For example, in 2023 the self-insured plan was implemented on 7/1/23, still divide by 12 even if the plan was in effect for only six months in 2023.

D1 Company Name, EIN, Aggregation State & Market Segment



Company Name	Company EIN	Aggregation State	Market Segment
ABC Insurance Company	789456890	CA	Small Group Market

- **Company Name:** For insured plans, enter the name of the medical insurance company. For self-insured or level-funded plans, enter the TPA name.
- **Company EIN:**
 - Enter the EIN of the insurance company that you entered in Column A, if the plan is fully-insured.
 - If the plan is self-insured or level-funded, enter the TPA's EIN.
- **Aggregation State:** For fully-insured plans, the aggregation state is generally the state where the policy was issued. For self-insured and level-funded plans, the aggregation state is the state where the plan has its principal place of business. You may use any reasonable method to determine the principal place of business for purposes of RxDC reporting. You can only enter one state.
- **Market Segment:** Enter one of the following: Small Group Market, Large Group Market, SF Small Employer Plans, or SF Large Employer Plans (refer to P2 for a description of each market segment).

Prescription Drug Reporting - RxDC Completing D1- At-a-Glance



Average Monthly Premium Paid by <u>Members</u> Column E	Average Monthly Premium Paid by <u>Employers</u> Column F	Life Years Column G	Earned Premium Column H	NEW Premium Equivalents Column I (self-insured and level-funded plans)	Admin Fees Paid (included in Premium Equivalents field) Column J	Stop Loss Premium Paid (included in Premium Equivalents field) Column K
<p>Monthly Average</p> <ul style="list-style-type: none"> • Divide premium amounts (premium equivalents for self-insured plans) paid by members by 12. • Divide by 12 even if the plan was not in effect for the full-12 months 	<p>Monthly Average</p> <ul style="list-style-type: none"> • Divide annual premium amounts (premium equivalents for self-insured plans) paid by employer by 12. • Divide by 12 even if the plan was not in effect for the full-12 months 	<p>Annual Average</p> <p>To calculate member months:</p> <ul style="list-style-type: none"> • Count the number of members covered on a given day of each month of the reference year, and • Add the number of members from Step 1 to calculate total member months for the reference year. <p>To calculate life-years: Divide member months by 12, and round the resulting number to the 8th decimal place.</p>	<p>Annual Total (fully-insured plans)</p> <p>Earned premium means all premiums paid by a policyholder, and/or plan sponsor to a medical insurance carrier for the reporting year.</p>	<p>Annual Total (self-funded plans ONLY)</p> <p>Premium equivalents may be reported on a cash basis or on a retrospective basis. <u>May not use COBRA accrual rates.</u></p> <p>Include:</p> <ul style="list-style-type: none"> • Medical and pharmacy claims costs (you may use either paid claims or incurred claims) • Administrative costs, including fees that self-funded plans paid to an ASO, TPA, PBM, or other entity administering a plan • Stop-loss premiums • Network access fees, such as preferred provider organization (PPO) fees • Payments made under capitation contracts with providers for benefits covered under the plan <p>Subtract:</p> <ul style="list-style-type: none"> • Stop-loss reimbursements • Prescription drug rebates that were received and retained by the group health plan during the reference year, regardless of whether the payment is retrospective or prospective. 	<p>Annual Total (self-funded plans ONLY)</p> <p>Report total annual administrative fees (such as claims processing fees) that self-funded plans paid to an ASO, TPA, PBM, or other entity administering a self-funded plan</p>	<p>Annual Total (self-funded plans ONLY)</p> <p>Total annual stop-loss premium paid by the plan to the stop-loss insurer.</p>

D1 Calculating Life Years

Life Years	Earned Premium (fully-insured plans)	Premium Equivalents (self-funded plans)	Admin Fees Paid (included in the Premium Equivalents field)	Stop Loss Premium Paid (included in the Premium Equivalents field)
902.58	\$6,372,000			
789.86		\$4,574,988	\$250,560	\$185,000

- **Life Years** is the average number of members throughout the year.
 - Count the number of members covered on a given day of each month of the reference year, and add them to get total annual member months
 - Divide by 12

Date	Members covered by the plan on the given date
January 1, 2023	882
February 1, 2023	872
March 1, 2023	884
April 1, 2023	921
May 1, 2023	924
June 1, 2023	923
July 1, 2023	925
August 1, 2023	916
September 1, 2023	907
October 1, 2023	906
November 1, 2023	902
December 1, 2023	869
Total Member Months	10,831
# of Life-Years (Total member months / 12)	902.58333333

D1 Premium Equivalents (Columns J–K)

Admin Fees Paid (included in the Premium Equivalents field)	Stop Loss Premium Paid (included in the Premium Equivalents field)
\$250,560	\$185,000

Administrative Fees Paid

- Report total annual administrative fees (such as claims processing fees) that self-funded plans paid to an ASO, TPA, or other entity administering a self-funded plan. This amount should also be included in Premium Equivalents.

Stop-loss premium paid

- Report the total annual stop-loss premium paid by the plan to the stop-loss insurer. This amount should also be included in Premium Equivalents. Leave this section blank if the self-funded plan does not have stop-loss insurance coverage.

Next Steps

Next Steps



1

Confirm which report(s) your insurance carrier, TPA and/or PBM will file on your behalf and if you must complete a survey/questionnaire and the deadline to submit the survey/questionnaire.

2

If you confirm you are required to report on one or more of the RxDC reports, refer to Module 2 - How to Register on HIOS

3

Gather the necessary information to complete and file RxDC reports from your vendors.

4

Once the registration process is complete and you have the reports to file, view Module 3 – How to Submit Reports in HIOS



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Thank you.