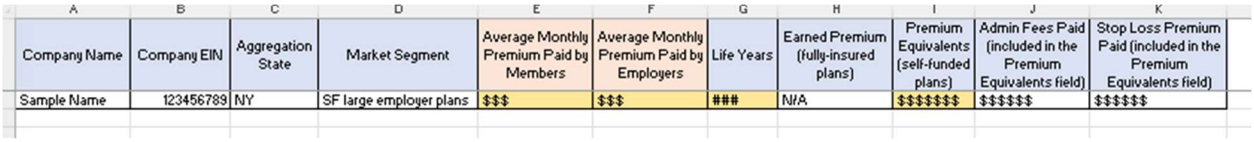
Premium Contribution and RxDC Compliance – What you need to know

Premium information is required for Prescription Drug Data Collection (RxDC) in a few different fields of the D1 – Premium and Life Years file. Below is a snapshot of the D1 file, the fields in yellow are addressed in this article.



A	B	C	D	E	F	G	H	I	J	K
Company Name	Company EIN	Aggregation State	Market Segment	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)
Sample Name	123456789	NY	SF large employer plans	$$$	$$$	###	N/A	$$$$$$$	$$$$$$	$$$$$$

Total Premiums

The D1 file should be completed differently for Insured vs. Self-Funded Plan Sponsors. The below chart will help align the field based on the Market Segment.

Market Segment	Field to Complete	Column H	Column I
SF Large Employer Plans	Premium Equivalents	Blank	Enter Value
SF Small Employer Plans	Premium Equivalents	Blank	Enter Value
Large Group Plans	Earned Premium	Enter Value	Blank
Small Group Plans	Earned Premium	Enter Value	Blank

Large Group and Small Group Plans are likely having their Insurance Carrier complete this file, so be sure to confirm what the Carrier is doing before submitting the file.

Premium Equivalents

Premium Equivalents are total plan costs or total budgets for a Self-Funded health plan. This would include medical claims, pharmacy claims, TPA Admin Fees, PBM Admin Fees, Rebates, Stop Loss Premiums, Stop Loss reimbursements, Broker Fees, PCORI Fees, commissions and fees paid for services rendered on behalf of the health plan, Salaries and Expenses of employees employed on behalf of the health plan, and any other costs or reimbursements to the health plan occurring during the Reference Year. These costs are generally considered by an actuary or analyst when setting premiums for the next year.

Question: Can I just use the Premiums Equivalents that were calculated for me before the reference year? Or Can I use COBRA rates in my calculation?

No, the money accrued/paid in Premium Equivalents during the Calendar year is based on a prospective analysis of what Plan Costs will be during the year. CMS does not want prospective data, instead they

want actual paid claims and expenses during the Reference Year, which can only be gathered at the completion of the Reference Year.

Below is a simple example of how one can calculate a budget once the reference year is complete:

(+) Claims incurred between January and December of the Reference Year and Paid by March 31st of the following year
(+) Admin Fees (Enter this number directly into Column J)
(+) Stop Loss Premiums (Enter this number directly into Column K)
(+) Network Access Fees
(+) PCORI Fees
(+) Broker Commissions
(-) Rebates Received during the Reverence Year
(-) Stop Loss Reimbursements received during the Reference Year
(=) Premium Equivalent (Enter this number directly into Column I)

Question: Do I divide this number at all before inputting it onto the file?

No, CMS is looking for the total number for the Reference Year. A focus of RxDC Reporting is understanding what is driving premium prices to outpace inflation.

Question: Why does CMS want full year numbers in columns I, J, & K?

CMS can use Premium Equivalents then subtract Total Medical Costs submitted on file D2 and Total Pharmacy Costs submitted on file D6 to arrive at non-claims expenses. Then Stop Loss Premiums and TPA Admin Fees, also submitted in a total annual number, can be subtracted to arrive at Non-Admin Expenses. When viewing this breakout through the lens of Trend Management, CMS is now able to specifically measure Claim Trends, Admin Trends, Stop Loss Trends and Non-Admin Expense Trends going forward.

Question: Should I include Vision or Dental claims in the Premium Equivalent calculation above?

Use this test to determine inclusion: Can a member elect medical benefits without Dental and without Vision? Wherever the answer is No, those claims and fees should be included in the Premium Equivalent number AND they should be reported on the D2 – Medical Spending by Category. If Members can purchase vision and dental separately those costs should be excluded from Premium Equivalents and the D2 file.

Average Monthly Premium Paid by Members

When CMS requests Average Monthly Premium Paid by Members, they are specifically looking at the member's cost for maintaining coverage. This is usually paid directly through a payroll deduction or remitted to the Plan Sponsor some other way.

CMS is not collecting Copay or Deductible information on the D1 File.

The CMS preferred option for providing this information is to collect actual monthly payroll deductions for health insurance during the reference year. The chart below has been reproduced from CMS as a guide for calculating Average Monthly Premium Paid by Members. Keep in mind that certain member contributions may not be collected through payroll deductions, for example COBRA members or members on leave who are maintaining their coverage. These Member Contributions must be added back into the total Member Contribution calculation to arrive at the true number.

This chart can be used to develop Life Months, Life Years, and Average Monthly Premium Paid by Employers. If a Health Plan Started or Ended functioning during the reference year, leave the appropriate months blank.

Month in Reference Year	Member Count (A)	Employee Premium Payment (B)
January		
February		
March		
April		
May		
June		
July		
August		
September		
October		
November		
December		
Total		

Column E: Average Monthly Premium Paid by Members = Total B / 12

Column G: Life Years = Total A / 12

Average Monthly Premium Paid by Employers

Column F: Average Monthly Premium Paid by Employers = (Premium Equivalents – Total B) / 12

Question: Can I calculate Average Monthly Premium Paid by Employers using the chart above?

Yes, the recommended approach is to use incurred costs by month when completing the chart above. This means if the plan experienced high claims in one month, that month should have higher costs compared to less costly months. CMS requires a retrospective or actual incurred cost figure, therefore using Premium Funding Allocations to calculate this number is not advised.

Other Considerations

Question: What do I need the P2 – Plan Data file for?

If you are submitting the D1 – Premium and Life Years file through the HIOS Portal yourself then you will need to build a submit a P2 file first. The HIOS Portal will not allow any files to be submitted without a P2 being submitted first.

Narrative Considerations

Health Insurance is a complex and varied product that cannot be fully represented with data, therefore CMS also requires a Narrative to be submitted by a Reporting Entity. Formatted as a free text file this word or PDF document should address assumptions made in collecting and presenting the data as well as address a few specific questions related to submitted data.

If submitting the D1 file, the Plan Sponsor or Reporting Entity should consider submitting a narrative addressing how rebates are used in developing Premium Equivalents and in turn Member Premiums. CMS assumes that Member Premiums are a function of Premium Equivalents. Therefore, if rebates are taken into consideration when developing Premium Equivalents and Member Premiums, this should be stated in the Narrative Submission. If the Plan does not receive rebates, that should be indicated in the Narrative. If the Plan receives rebates but doesn't use them as a cost reduction to the budget, this should be addressed in the Narrative along with any additional context to help provide a picture.

Question: What if my TPA is submitting the D1 on behalf of my group?

Use the questions below to determine if this is a sufficient solution:

1. Does the TPA have all of the information required to produce the total Premium Equivalent calculation? This information can be gathered directly from a Plan Sponsor via a survey or the TPA may manage all aspect of the health plan and have this information easily available.
2. If the TPA reports their D1 file will only contain Medical Claims data then it likely is not a compliant solution. A few clarifying questions should be asked using the prior list of Budget/Premium Equivalent elements from the first paragraph under Premium Equivalents above.

About Rx Data Collection – Compliance with RxDC is complex and often confusing. Rx Data Collection is an independent Reporting Entity providing full service RxDC compliance solutions. Our services include consulting, coordination, file development, submission and training for all types of plan sponsors. RxDC creates unique transparency opportunities for our clients to better understand what they are paying and where opportunities for cost savings may exist. Moreover, our proprietary submission process assures the plan sponsor is compliant and has the documentation to prove compliance if challenged by CMS. If you are struggling with RxDC compliance, reach out to us at info@rxdatacollection.com, we can help.