2024

Summer Reporting Deadlines

Presented by Benefit Comply

Assurex Global Partners

- C3 Risk & Insurance Services
- CCIG
- Christensen Group Insurance
- Cottingham & Butler
- Cragin & Pike, Inc.
- The Daniel & Henry Co.
- Dean & Draper Insurance Agency
- Henderson Brothers, Inc.
- The Horton Group
- Houchens Insurance Group
- The IMA Financial Group
- INSURICA
- Kapnick Insurance Group
- Lyons Companies
- The Mahoney Group
- MJ Insurance
- Oswald Companies
- Parker, Smith & Feek, Inc.
- The Partners Group
- R&R Insurance
- RCM&D
- Starkweather & Shepley
- Sterling Seacrest Pritchard
- WA Group
- Watkins Insurance Group
- Woodruff Sawyer
- York International

Agenda

- RxDC Reporting
- Form 5500 Reporting
- PCORI Fees

RxDC Reporting

RxDC Reporting

- Rx Reporting
  - Collects data on drug costs with the hope that the data can be used to lower drug costs (federal government will issue an annual report on Rx costs)
  - Reporting required by June 1 annually for all group health plans, but not account-based plans (e.g., HRAs) or excepted benefits (e.g., limited-scope dental or vision)

"Reporting Entities" must set up account in CMS HIOS system

- Multiple entities may report for a single plan (e.g., TPA, PBM, employer)

Submit a plan file, 8 separate data files, and narratives

- Employer must determine who has the necessary data and ensure all files and narratives are completed

Rx Cost Reporting – The Process

- Plan Files and Data Files
  - ~~P1. Individual and student market plan list~~
  - P2. Group health plan list
  - ~~P3. FEHB plan list~~
  - D1. Premium and Life-Years
  - D2. Spending by Category
  - D3. Top 50 Most Frequent Brand Drugs
  - D4. Top 50 Most Costly Drugs
  - D5. Top 50 Drugs by Spending Increase
  - D6. Rx Totals
  - D7. Rx Rebates by Therapeutic Class
  - D8. Rx Rebates for the Top 25 Drugs
- CMS provided templates for each file

D1	Plan Details (vendors, # covered individuals, premiums, etc.)
D2	Medical spending information
D3-D8	Detailed drug spending information
P2	Plan identifying information

CMS encourages carriers, PBMs and TPAs to submit aggregate data rather than report on a plan-by-plan basis

RxDC Reporting

- **Responsibility for Attestation**
  - **Fully-Insured Group Health Plans**
    - Carriers will report on behalf of the plan
    - Employer must provide average monthly premiums (employer/employee contributions)
    - Employer might have to complete P2 and D1 forms
  - **Self-Funded Group Health Plans**
    - TPAs and PBMs likely to report on behalf of the plan, but may only file some of forms
    - Employer must provide average monthly premiums (employer/employee contributions)
    - Employer might have to complete P2, D1 and any other forms not completed by TPA/PBM

Calculating Average Premiums

- **Step 1: Calculate Total Premiums**
  - Add up all participant member contributions paid during 2023
    - Include participant member contributions for all plan options, coverage tiers, and rate structures, including COBRA participants and retirees
  - Add up all employer contributions over the course of 2023

For self-funded plans, use premium equivalents
Same costs used for COBRA premiums, except CMS wants actual costs, not expected costs

- **Step 2: Calculate Average Monthly Premiums**

Avg. Monthly Premiums Paid by Members = Total annual premiums paid by members / 12

Avg. Monthly Premiums Paid by Employer = Total annual premiums paid by employer / 12

How worried should I be about getting this calculation exactly right?

D1 File Submissions

- Must first register with HIOS
  - Approval time can be several weeks and requires personal information for identity verification
- Employers submitting a D1 file must also submit a P2 file
- Instructions and templates available on CMS RxDC website - https://www.cms.gov/marketplace/about/oversight/other-insurance-protections/prescription-drug-data-collection-rxdc

D1 File Submissions

D1 Fields
Company Name & EIN
State
Market Segment
Average Monthly Premiums Paid by Members & Employers
Life Years
Earned Premium (fully-insured)
Premium Equivalents (self-funded)
ASO/TPA Fees Paid
Stop-Loss Premiums Paid

Form 5500 Reporting

Employers Who Have to File Form 5500s

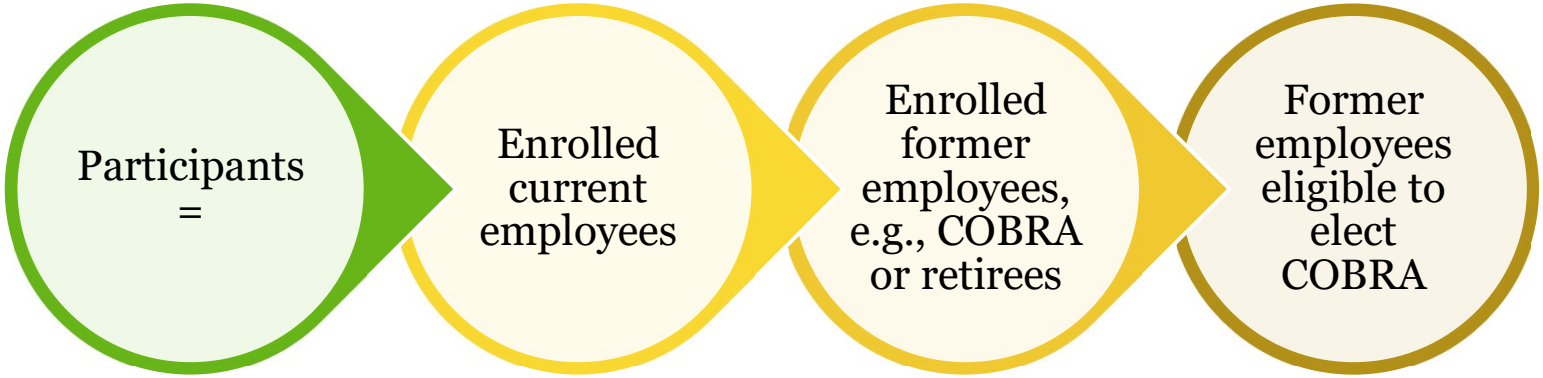
- All employers who offer a health and welfare plan subject to ERISA must file a 5500 for those plans(s) unless they qualify for the small plan exception (<100 participants)
  - Government employers and church employers are not subject to ERISA

Common ERISA Plans
• Medica, Rx, Dental, Vision • HRAs and Health FSAs • Telemedicine Plans • Life Insurance and AD&D • STD / LTD (fully-insured or funded only) • Business Travel Accident Plans • Hospital Indemnity • Critical Illness / Disease Specific Plans • EAPs • Prepaid legal • Onsite medical clinics • Onsite day care center • Executive Reimbursement Plans • Formal severance pay plans

Non-ERISA Plans
• §125 cafeteria/POP plans • Dependent Care FSAs • Qualified Transportation Plans • HSAs • Identity Theft • Pet Insurance • Adoption Assistance • Paid Time Off (vacation, sick, PTO, holiday pay, parental leave, self-funded STD plans paid out of general assets) • Work comp • State mandated paid disability and family leave benefits • Educational assistance and tuition reimbursement plans

Small Plan Exception

- A plan with <100 participants on the *first* day of the plan year does not have to file a 5500 unless the plan is funded



- Dependents enrolled on the plan are **not** counted as participants
- Do **not** rely on Schedule A data
  - Schedule A reports number of participants on the *last* day of the plan year

Small Plan Exception

Unfunded:

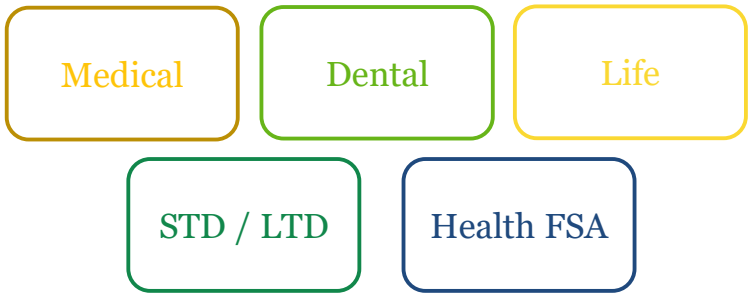
- A plan is unfunded if benefits are paid through an insurance policy or out of the employer's general assets
- Most ERISA plans are unfunded

Funded:

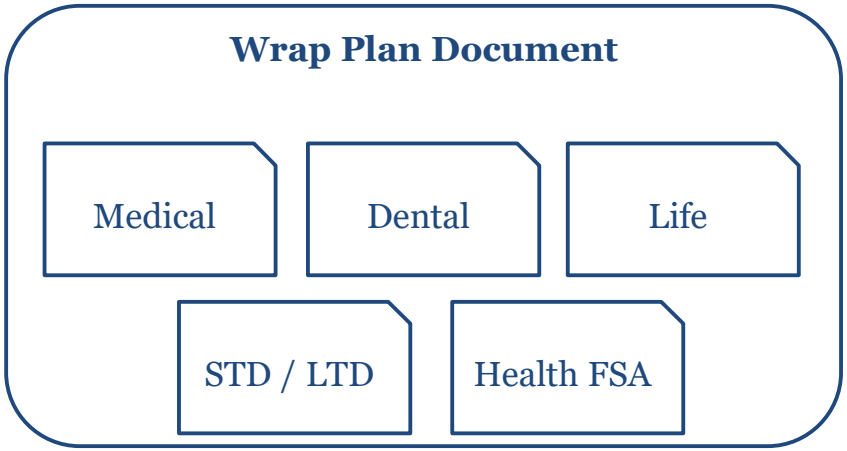
- A "funded" plan is one where benefits are paid from funds that are set aside in a separate account or trust fund for the exclusive benefit of participants (e.g., VEBA)
- All funded plans must file a 5500, regardless of the number of plan participants

Number of Form 5500 Filings

- Each ERISA plan with 100 or more participants must file a separate 5500
  - Default rule is that each benefit with its own policy/contract/plan document is a separate plan, except for benefits of the same type
  - WRAP document can be used to bundle benefits into a single ERISA plan



No WRAP document
5 plans → 5 5500s



WRAP document
1 plan → 1 5500

5500 Due Date

- 5500 for a given plan is due last day of the 7th month after the end of the plan year
  - Plan years cannot exceed 12 months
  - 5500s must be filed for short plan years

Plan Year Ending	5500 Due Date	Extended Due Date
June 30, 2023	January 31, 2024	April 15, 2024
July 31, 2023	February 29, 2024	May 15, 2024
August 31, 2023	March 31, 2024	June 15, 2024
September 30, 2023	April 30, 2024	July 15, 2024
October 31, 2023	May 31, 2024	August 15, 2024
November 30, 2023	June 30, 2024	September 15, 2024
December 31, 2023	**July 31, 2024**	**October 15, 2024**
January 31, 2024	August 31, 2024	November 15, 2024
February 29, 2024	September 30, 2024	December 15, 2024
March 31, 2024	October 31, 2024	January 15, 2025
April 30, 2024	November 30, 2024	February 15, 2025
May 31, 2024	December 31, 2024	March 15, 2025

- If due date is a Saturday, Sunday or federal legal holiday, due date is the next day
- Automatic 2-½ month extension available if Form 5558 is filed by original due date

Electronic Filing

- All 5500s must be filed electronically using either EFAST2 approved third-party software or the government's free online IFILE system; there is no paper filing option
  - Most employers use EFAST2 through a 3rd party vendor
  - Vendor can prepare the forms and schedules for submission, but employer must still electronically sign the form

NOTE: EFAST2 website credentials have changed to Login.gov

Main Body & Schedules

- 5500 consists of Main Body and up to six schedules
  - Schedule A - Insurance Information
  - Schedule C - Service Provider Information
  - Schedule D - DFE/Participating Plan Information
  - Schedule G - Financial Transaction Schedules
  - Schedule H - Financial Information
  - Schedule I - Financial Information - Small Plan

- Most plans will need only a Schedule A for fully-insured plans and no other schedules

Self-Funded Plans

- Most self-funded plans, including health FSAs, will not have any schedules
  - No Schedule A because not fully-insured
  - No Schedules C – I because claims are paid out of the employer's general assets
  - Some TPAs and vendors will automatically generate a Schedule C for self-funded plans, but a Schedule C only needs to be filed with the 5500 if the plan is funded

Main Body

Form 5500 Main Body Parts	Information Required
Part I	Plan year, plan type (e.g., single employer plan), and filing type (e.g., first, final or amended filing)
Part II	• Plan name, number, and effective date • Plan sponsor name, EIN and contact information • Plan administrator's name, EIN and contact information • Counts for various participant groups at the beginning and ending of the plan year • Codes to indicate what type of benefits are offered by the plan • Plan funding details (e.g., insured, trust, general assets of the employer) • Which schedules, if any, are attached
Part III	Indicate whether the plan is a MEWA required to file a Form M-1

Schedule A

- Each fully-insured plan must have a Schedule A attached to the 5500
  - Most insurance companies will automatically issue a Schedule A for any plans or component benefit plans with 100 or more participants
  - Employer's responsibility to request Schedule A if not automatically furnished
    - If a carrier will not furnish a Schedule A, employer must complete a Schedule A to the best of their ability and indicate that the carrier failed to provide the required information
  - Carriers will typically issue Schedule A based on policy renewal date
    - If this is different than the plan year, use the Schedule A for the policy year that ends within the plan year

DFVC

- Delinquent Filer Voluntary Compliance (DFVC) Program
  - Employers who are late filing 5500s can use the DFVC to file missing 5500s
  - Employers who use DFVC pay reduced late filing penalties
    - $10/day, but no more than $2000 per plan per year or $4000 per plan total
    - Compare to standard penalty of $2,400 ***per day*** if DOL discovers missing 5500s on its own
  - Technically not supposed to retroactively wrap plans before completing DFVC
    - E.g., If employer had 4 plans with more than 100 participants with no WRAP document and missed 5500 filing for 3 years, employer should file 4 separate late DFVC filing for a total penalty of $16,000

Form 5500 Search

- Can search both health and welfare and retirement plan 5500s on DOL website
- Search by:
  - Plan Name
  - Plan Sponsor
  - EIN
  - Other filters available

https://www.efast.dol.gov/5500Search/

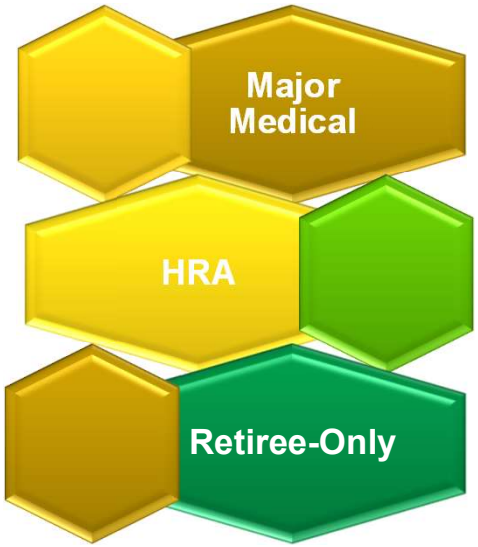
PCORI Fees

PCORI

- PCORI Fee
  - Requires group health plans to pay $1-3 per covered life
  - Effective for group health plan years ending in 2012 – 2029
  - Helps fund the institute https://www.pcori.org/

PCORI

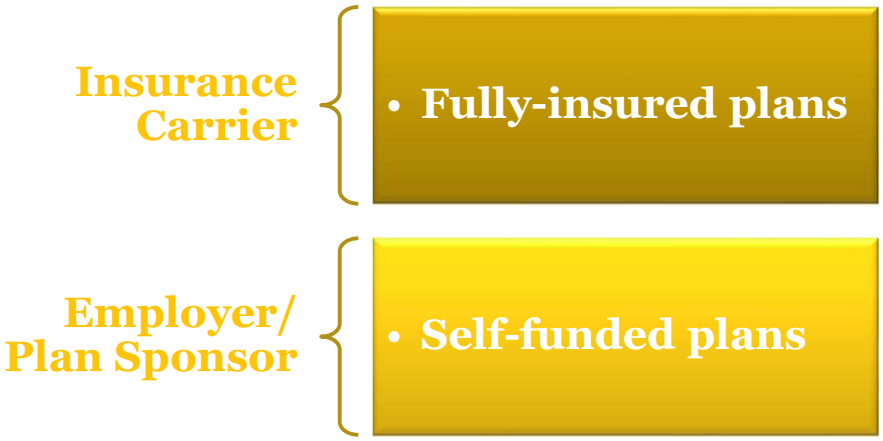
- Plans Subject to Fee
  - Group health plans, but not excepted benefits



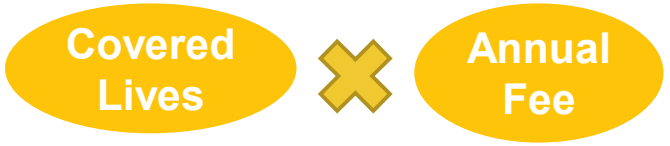
- IRS Chart
  - https://www.irs.gov/newsroom/application-of-the-patient-centered-outcomes-research-trust-fund-fee-to-common-types-of-health-coverage-or-arrangements

PCORI

- Reporting & Fee Responsibility



- Fee Calculation



- Covered Lives
  - Primary subscribers, spouses and dependents
  - Counting methods: actual count method, snapshot method, Form 5500 method
- 2023 Fee – Adjusted Annually
  - $3.00 for plan years ending Jan – Sept
  - $3.22 for plan years ending Oct – Dec
- Fee Due Jul 31, 2024

PCORI

- Counting Methods

Actual Count Method

- Calculate lives covered each day of the plan year divided by number of days in the plan year

Snapshot Method

- Add the lives covered on a consistent date each month or quarter and divide total by number of dates on which count was made (e.g., divide by 12 if count is done each month, or by 4 if count is done each quarter)
- Two methods for counting family members:
  - Count actual lives covered on designated date; or
  - Count participants with single coverage on designated date + participants with coverage other than single on designated date multiplied by 2.35

Form 5500 Method

- Use participant counts reported on Form 5500 for the plan year. Add participant counts at the beginning and end of the plan year
  - If plan offers only single coverage, final result is divided by 2

PCORI

- Special Counting Rules
  - Multiple Self-Funded Plans
    - Same plan sponsor and same plan year = a single plan
  - HRAs and FSAs (only if not excepted benefits)
    - Count only participants/employees (not required to count dependents or beneficiaries)

HRA integrated with Self-Funded Medical	Stand-Alone HRA	HRA integrated with Fully-Insured Medical
• No fee for the HRA if HRA and medical have the same plan sponsor and plan year	• Employer must pay the PCORI fee for the HRA • Count only primary subscribers, not dependents	• Employer must pay the PCORI fee for the HRA • Count only primary subscribers, not dependents

PCORI

- Due Date
  - July 31 in the year after the end of the plan year
    - Fees must be reported and paid by July 31, 2024 for plan years ending during 2023
    - **Remember to report and pay for short plan years**

- Reporting Method
  - Form 720 - https://www.irs.gov/pub/irs-pdf/f720.pdf
  - Must file for 2nd quarter ending June 30th
  - Use Lines 133(c) and (d) to report for self-funded group health plans

PCORI

- Form 720 - https://www.irs.gov/pub/irs-pdf/f720.pdf

Form **720**
(Rev. March 2024)
Department of the Treasury
Internal Revenue Service

Quarterly Federal Excise Tax Return

See the Instructions for Form 720.
Go to *www.irs.gov/Form720* for instructions and the latest information.

OMB No. 1545-0023

Check here if:
☐ Final return
☐ Address change

Name

Quarter ending
June 30, 2024

Number, street, and room or suite no.
(If you have a P.O. box, see the instructions.)

Employer identification number

City or town, state or province, country, and ZIP or foreign postal code

FOR IRS USE ONLY	
T	
FF	
FD	
FP	
I	
T	

Part II

IRS No.	**Patient-Centered Outcomes Research Fee** (see instructions)	(a) Avg. number of lives covered (see inst.)	(b) Rate for avg. covered life	(c) Fee (see instructions)	Tax	IRS No.
	Specified health insurance policies					
	(a) With a policy year ending before October 1, 2022		$2.79			
	(b) With a policy year ending on or after October 1, 2022, and before October 1, 2023		$3.00			
133	Applicable self-insured health plans					133
	(c) With a plan year ending before October 1, 2022		$2.79			
	(d) With a plan year ending on or after October 1, 2022, and before October 1, 2023		$3.00			

PCORI

- Penalty for Failure to Report & Pay
  - No Specific Penalty for PCORI Fee Non-Compliance
  - For Excise Taxes, see Code §6651
    - 5% of excise tax due for each month or part of a month the return is late, with a cap of 25% of the unpaid tax (also a potential penalty of .5% of tax for each month with a cap of 25%)
    - Minimum penalty for failure to file within 60 days of due date is the lesser of $100 or amount of tax owed

2024

Summer Reporting Deadlines

Presented by Benefit Comply