Pharmacy Benefits and Costs Reporting

Status of Rx Reporting Update 12/1/23

As the pharmacy benefits and costs reporting submission deadline approaches, keep the following reminders in mind when having discussions with brokers, consultants, and customers:

1. UnitedHealthcare submits Pharmacy Benefits & Costs Reporting data to CMS by the deadline June 1 deadline, each year for the prior reference year.
2. UnitedHealthcare submits the RxDC report to CMS for NA, KA, PS and Surest® ASO customers by June 1 each year. There are two options available for self-funded groups:
    - Standard approach (all ASO, Level Funded and fully insured): UnitedHealthcare will submit all data and appropriate narrative for plans administered by UnitedHealthcare and OptumRx carve in (integrated).
        i. Customers that do not provide UHC information that is not in a UHC system by the March 31 deadline will need to submit that data themselves.
    - Alternative approach (ASO only): the customer may request their data from UnitedHealthcare by March 31 and submit the data and appropriate narrative or engage a third party to submit the data for them.

Note: Customers who use an outside PBM (Pharmacy Benefits Management) including OptumRx Direct must coordinate with the PBM to ensure all required data is submitted by the deadline.

3. UMR and certain Surest employers will do an email survey rather than RFI .
4. Fully insured: UnitedHealthcare is responsible for submission of required data for all fully insured groups. However, UnitedHealthcare will be collecting information not in our systems via a Request for Information (RFI). If that information is not provided by March 31, then the fully insured employer must submit the missing information to CMS by June 1.
5. Self-funded (ASO): Employers must provide the information requested by UHC in the RFI on the employer portal. Employers may use the Pharmacy Benefits and Costs Reporting Guide as a resource. The guide is posted uhc.com in the reform section under CAA Pharmacy Benefits and Costs Reporting.
6. UnitedHealthcare does not provide copies of RxDC reports submitted to CMS.
7. All data files submitted is in aggregate as defined by CMS.
8. UnitedHealthcare submits the appropriate narrative for each data file submitted.
9. Each data file submission requires a corresponding P2.
10. UnitedHealthcare produces the P2 using information from the 5500 filing and UHC systems.

- UHC reconciles the Group Health Plan Name based on the Plan Sponsor name in the 5500; where feasible
- Group Health Plan Number requires a unique plan identification number
- UHC uses the EIN from our system as the unique plan identification number
- For companies that use multiple EINs, UHC will use the primary EIN as noted in our UHC systems

11. UHC is unable to incorporate external data or make changes to data if there are discrepancies. If there are data mismatches, UHC will reconcile with CMS directly.
12. For ASO groups that chose to submit the data themselves, UnitedHealthcare provided the required data to customers by mid-May of the reporting year. In 2024, data will be provided by May 15 to 19 and communicated to those customers submitting their own data.

Collecting data via RxDC RFI/survey to report June 1

What does the self-funded customer be required to submit if they do not complete or only partially complete the request for information in the RFI tool or survey? Update 11/30/23

If UnitedHealthcare did not receive an RFI/survey or if we received an incomplete survey, UHC will submit:

- the P2 and D1 with the information we have available,
- a complete D2 for coverage administered by UnitedHealthcare
- a complete D3-D8 for integrated pharmacy

The customer or delegate would be responsible for would be responsible for submitting data to CMS, not provided to us in the UHC survey

If the customer has requested that UHC not submit the D1 or any other combination of D1 through D8 files, an ad hoc is required by 3/31/24. UHC will not submit data for these customers.

For more information refer to the UnitedHealthcare approach to RxDC in the Pharmacy Benefits and Costs Guide.

CMS instructions for submitting data are on the CMS site.

What communications do customers get if they do not complete the RxDC request for information or survey? Update 11/28/23

UnitedHealthcare sends communications through the Connect electronic newsletter to employers, brokers and consultants regarding collection of data needed for UnitedHealthcare to submit data to

CMS for the RxDC reporting requirement. It's important to be signed up for the Connect to get RxDC and other important regulatory information.

This communication explains to customers and brokers/consultants that any information not provided via the RFI in the employer/broker portal, would need to be submitted to CMS by them. We only submit data for coverage administered by UnitedHealthcare that we have in our system.

The customer accepts the risk for data elements not provided to UnitedHealthcare. In addition, the customer or another reporting entity will need to submit RxDC data and narrative to CMS by June 1, 2024.

CMS instructions for submitting data are on the CMS site.

What confirmation may I provide to a customer that only partially completed the survey but some information is missing? Update 11/30/23

Inform the customer that UnitedHealthcare is scheduled to submit the data to CMS for the files and narrative for data we have in our system. UnitedHealthcare submits

- P2 and D1 information on file or what the customer provided in the RFI/survey.
- Corresponding files and narrative for D2 and D3 to D8 for carve in pharmacy.

For any data that was not provided to us via the RFI/survey, including if the customer left the D1 RFI/survey information blank or entered a zero, they will need to submit that data to CMS by the June 1 deadline.

UnitedHealthcare is aware that CMS may publish changes to the documented RxDC instructions. If this occurs, UnitedHealthcare, UMR and Surest will evaluate any new instructions and communicate any change to the strategy.

For more information refer to the UnitedHealthcare approach to RxDC in the Pharmacy Benefits and Costs Guide.

CMS instructions for submitting data are on the CMS site.

What is UnitedHealthcare's approach to supporting RxDC reporting for June 1? Update 11/30/23

Under the Consolidated Appropriations Act (CAA), health insurers offering group or individual health coverage and self-funded (ASO) group health plans are required to report data annually regarding prescription drugs and health care spending to the Departments of Health and Human Services, Labor, and Treasury (Tri-Agencies). This information must be submitted to CMS by June 1, 2024, for 2023 data, through a web portal set up by the Centers for Medicare & Medicaid Services (CMS).

The UnitedHealthcare approach for customers:

Standard approach (all ASO, Level Funded and fully insured groups): UnitedHealthcare will submit all data and appropriate narrative for plans administered by UnitedHealthcare and OptumRx carve-in (integrated).

Alternative approach (ASO / Level Funded only): The customer is able to request its data from UnitedHealthcare and submit the data and appropriate narrative or engage a third party to submit the data for them.

Note: Customers that use an outside Pharmacy Benefits Manager (PBM), including OptumRx Direct, must coordinate with the PBM to ensure all required data is submitted by the deadline.

What is UnitedHealthcare standard approach? Update 11/30/23

UnitedHealthcare will submit the P2 (group health plan), D1 (premium and life years), and D2 (spending by category) and the appropriate narratives for all customers with active coverage during the reference year.

For customers with OptumRx integrated PBM, UnitedHealthcare will also submit the D3-D8* files.

For customers that use any other PBM, including OptumRx Direct, the customer will need to work with that PBM to submit the D3-D8 files.

There is no fee for customers that use the standard approach.

Annually, UnitedHealthcare will collect data from each customer to complete the RxDC. To obtain the data, UnitedHealthcare requests all customers to complete an RFI /survey to collect the necessary data elements by the March 31 deadline.

If the RFI response is not completed by the deadline, UnitedHealthcare plans to submit the data in its system on or before the June 1 reporting deadline. However, the submission will not be complete.

UnitedHealthcare will send a reminder message to the customers explaining if they did not complete the RFI in the employer/broker portal, they would be obligated to submit P2 and D1 data as outlined in the communication.

What is expected for customers wanting to use the Alternative approach (ASO customers only)? Update 11/30/23

ASO customers that plan to submit all data must contact their UnitedHealthcare representative prior to March 31 to request their data. A fee may apply.

It is important for the customer selecting this approach that they submit all the data. UnitedHealthcare will provide them with the data we have in our system, but they will need to do the entire reporting themselves for the data the employer requested.

UnitedHealthcare does not include the data for customers reporting their own data in the submission we submit.

Note: If you request all the data files, you do not need to complete the RFI. However, for partial data requests, the employer will need to complete the RFI (or survey for UMR or certain Surest employers) since UnitedHealthcare will be submitting data for the employer as well.

Can fully insured and Level Funded used the alternate approach to submit data themselves? Updated 11/30/23

Fully insured groups cannot submit the data themselves. UnitedHealthcare will submit on behalf of these customers. However, UnitedHealthcare is request certain data be submitted via the RFI/survey from fully insured and Level Funded customers to support the submission.

If the customer has an EIN that is changing, what should they do? New 11/27/23

UnitedHealthcare submits the data to CMS using the EIN in our system. If the customer has changed the EIN for any reason, they should contact their UnitedHealthcare representative and the EIN can be updated through the normal process. The system will be updated, but not for the 2024 submission.

Rx Reporting Overview of Regulation

Does UnitedHealthcare sign a contractual agreement regarding UnitedHealthcare's support for submitting the CAA Pharmacy Benefits and Costs data? Update 11/30/23

UnitedHealthcare does not have to sign a separate contractual agreement. The ASA language covers UnitedHealthcare responsibility. Therefore, there is no requirement to sign other agreements for our clients.

The Parties agree to comply with all applicable federal, state, and other laws and regulations in its performance under this Agreement.

Refer to the CMS instructions, Section 11.9, Compliance with Laws and Regulations.

Where can customers find more information about Pharmacy Benefits and Costs reporting also referred to as RxDC? New 10/4/22

Go to the CMS website at https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/prescription-drug-data-collection

Customers may sign up for email announcements and register for training webinars at the Registration for Technical Assistance Portal (REGTAP) at https://regtap.cms.gov/rxdc.php.

If a customer is unable to locate an answer to their question in REGTAP, they may contact the help desk at 1-855-267-1515 or go to CMS_FEPS@cms.hhs.gov.

- Remember to include "RxDC" in the body of the email for faster service.
- Generally, a response is provided the same day and a full resolution within 1-2 weeks.

When did the CAA reporting for pharmacy benefits and costs begin? Update 11/30/23

The first report was required by Dec. 27, 2022, and then by June 1 each year thereafter.

What is the deadline for submitting the report? Update 11/30/23

The deadline is every June 1, subsequent to the reference year. The reference year is the calendar year immediately preceding the calendar year in which the RxDC report is due. The RxDC report for the 2023 reference year, which is due in 2024, should contain information based on what happened in calendar year 2023.

Refer to CMS instructions, Section 1.2, for additional detail.

Does the Pharmacy Benefits and Costs Reporting have a Safe Harbor? Update 11/30/23

The Safe Harbor is no longer in effect.

How is the reporting organized? Is there a required standard of reporting? Update 11/30/23

Data is reported by reference year.

- The data that will be reported June 1, 2024, will be for the 2023 reference year.

This information must be aggregated at the state/market level, rather than separately for each plan.

- The guidance provides uniform standards and data definitions, including standards for identifying prescription drugs regardless of the dosage strength, package size, or mode of delivery.
- These uniform standards for submitting data are designed to allow the Tri-agencies and OPM to conduct meaningful data analysis and identify prescription drug trends.

What are the reporting benefits and cost requirements? Update 11/30/23

Section 204 of Division BB, Title II (Section 204) of the Consolidated Appropriations Act, 2021 requires group health plans (plans) and health insurance issuers (issuers) offering group or individual health insurance coverage to submit information about prescription drugs and health care spending to the Department of Health and Human Services (HHS), the Department of Labor (DOL), and the Department of the Treasury (the Tri-Agencies/Departments).

In addition, the Director of the Office of Personnel Management (OPM) requires Federal Employees Health Benefits (FEHB) carriers (carriers) to submit Section 204 data to HHS. The Centers for Medicare & Medicaid Services (CMS) within HHS is collecting Section 204 data submissions on behalf of the Tri-Agencies/Departments and OPM.

CMS instructions for submitting data are on the CMS site.

Where must the insurer or health plan submit the pharmacy coverage and cost report? Update 11/28/23

The Centers for Medicare & Medicaid Services (CMS) within HHS is collecting Section 204 data submissions on behalf of the Departments of Health and Human Services, Labor, the Treasury (the Departments) and the Director of the Office of Personnel Management (OPM).

Self-funded customers wishing to do their own submission should speak with their UnitedHealthcare account team.

What do the reports require for reporting of medical services costs and spend? Update 11/30/23

For medical services, the reporting must be broken down by:

- **Type of costs** - including hospital, provider and clinical primary and specialist services, prescription drugs, other medical costs including wellness. For more details around Hospital and Medical spend (excluding spend under a PBM) go to CMS instructions, Section 7.
- **Spending by prescription drugs** by health plan coverage and member. For more details around spend under a PBM go to CMS Instructions, Section 8.4.

CMS instructions for submitting data are on the CMS site.

Add CMS templates

What is considered “wellness” under the Rx Reporting requirement? Update 7/20/22

For the purposes of the RxDC report, wellness services are defined as activities primarily designed to implement, promote, and improve health.

- If a wellness service is billed on a claim, include it in the "Other medical costs and services" spending category in data file D2 Spending by Category.
- If a wellness service is not billed on a claim or is not a covered service under a plan or policy, do not include it anywhere in the RxDC report.

Go to CMS instructions, Section 7.2.

How do the reports require insurers and health plans to report premium costs? Update 11/30/23

The premium must be reported by average monthly premium, by premiums impacted by fees and remuneration, and by any reduction in premiums and out-of-pocket costs as follows:

1. **Average monthly premium:**
    - Paid by employers on behalf of members/enrollees; and
    - Paid by members/enrollees.
2. **Premiums impacted by rebates, fees, and any remuneration** paid by a drug manufacturer to the plan or coverage or administrators or service providers, including:
    - Amounts paid for each therapeutic class of drug, and
    - Amounts paid for each of the 25 drugs that yielded the highest amount of rebates and other remuneration.
3. **Any reduction in premiums and OOP costs** associated with rebates, fees, or other remuneration.

Refer to CMS instructions, Section 6.1, for definitions of "Average monthly premium", Earned Premium", and "Premium equivalents".

What should be included in the average monthly premium paid (AMPP) calculation? New 12/1/23

The following should be included in the associated premium amounts in the Average Monthly Premium Paid (AMPP) member/employer amounts.

1. Pharmacy, Dental , Vision, Behavioral provided by a UHC company and integrated with the Medical Plan
2. Stop Loss policy underwritten by a UHC company

What should NOT BE INCLUDED in the average monthly premium paid (AMPP) calculation? New 11/27/23

The following should be EXCLUDED from the associated premium amounts in the Average Monthly Premium Paid (AMPP) member/employer amounts. This data should be submitted by the non-affiliated reporting entity contracted to provide the services/coverage.

1. Pharmacy, Dental , Vision and Behavioral that is not integrated (carved out or standalone). This includes OptumRx direct (carve out).
2. Stop Loss policy not underwritten by a UHC company.
3. Additional Medical Plans with a company other than UHC.

What should be included as part of the 2023 reference year for the June 1, 2024 submission? New 11/30/23

Average Monthly Premium Paid (AMPP) Member/Employer should represent premium in the reference year, for all months the employer had services/coverage with UnitedHealthcare.

- **Example 1:** employer policy with UnitedHealthcare from 7/1/2022 to 6/30/2023 and Other Medical Carrier from 7/1/2023 to 6/30/2024.
    - Only report the AMPP associated with UHC in the reference year 2023: 1/1/2023 to 6/30/2023.
    - Note: 7/1/2022 to 12/31/2022 as is 1/1/2024 to 6/30/24 is excluded for the 2024 report.
- **Example 2:** employer policy with UnitedHealthcare from 7/1/2022 to 6/30/2023 and renewed with UHC 7/1/2023 to 6/30/2024.
    - Report the AMPP associated with UHC in the reference year 2023: 1/1/2023 to 12/31/2023.

What is being reported regarding prescription drug rebates, fees and other remuneration paid by drug manufacturer? Update 11/28/23

The total fee must be reported. Fees are not required to be reported separately for each drug therapeutic class.

Reporting includes the following in the total fee:

- Renumeration received by and on behalf of entities providing pharmacy benefit management services regardless of the source (e.g., pharmaceutical manufacturer, wholesaler, retail pharmacy or vendor).
- Discounts, chargebacks or rebates.
- Cash discounts, free goods contingent on purchase agreement.
- Up-front payments, coupons, goods in kind.

- Free or reduced-price services, grants, or other price concessions.
- Bona fide service fees paid by a drug manufacturer to the PBM that represent fair market value for itemized services performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the arrangement. The definition includes amounts that may be retained by the plan administrator and not shared with the health plan.

Refer to CMS instructions, Section 9.

What is a reference year? Update 11/30/23

The reference year is the calendar year of the data that is in the Pharmacy Benefits and Costs report. For example, the Pharmacy Benefits and Costs report for 2023 reference year means the information in the report is based on what happened in 2023. This report will be submitted to CMS by June 1, 2024.

Refer to CMS instructions, Section 1.2.

How are the reports submitted for non-calendar year plans? Update 12/1/23

Both calendar plans (Jan. 1 to Dec. 31) and non-calendar plans are required to submit a full year of data related for the reference year.

For calendar years the reports would be Jan 1 through Dec. 31 of the year reported.

However, for non-calendar year plans the reports would be populated with the applicable dates. Therefore, partial years would appear in separate rows per the CMS instructions.

If a plan decides to self-submit then they should go to the CMS instructions, for details on how to report out.

Does cost sharing assistance a drug manufacturer provides to a member have to be included in the reporting? New 3/15/22

To the extent these amounts impact total annual spending by health plans or by participants, beneficiaries, and members/enrollees the amounts must be included in the total health care spending data.

What is total annual spending based on? Update 11/30/23

The total spend is based on incurred claims as defined under the Medical Loss Ratio (MLR) regulation including cost sharing.

- Spending excludes certain MLR reporting adjustments to incurred claims (drug rebates/price concessions, payments recovered through fraud reduction, and payments for risk adjustment programs).
- Spending is net of any drug rebates, fees or other renumeration.
- The calculation is based on incurred claims paid through March 31 of the year immediately following the reference year.

For more details around Hospital and Medical spend (excluding spend under a PBM) refer to CMS instructions, Section 7.

For more details around PBM spend, refer to CMS instructions, Section 8.4.

If a business is acquired during the year by another business, who is responsible for the reporting? New 3/15/22

The acquiring entity.

How does data have to be organized for reporting? New 3/15/22

Data is submitted separately by market -

- Insured individual, small group, large group.
- Self-funded small group, large group
- Student health insurance
- Federal Employees Health Benefits

Mixed funded plans report based on type of coverage (e.g., self-funded PBM benefit reports under self-funded market and fully insured medical benefit reports under group insurance).

The insurer or group health plan reports separately for each state in which the insurer or plan does business. The report includes all plans and policies in the state during the reference year.

- Insured group business is reported for the state where the contract is issued (except for association coverage).
- Self-funded group business is reported for the state where the plan sponsor has its principal place of business.
- Individual insurance market business sold through an association is reported for the state of the certificate of coverage.
- Health coverage provided through a group trust or MEWA is reported for the state where the employer or association has its principal place of business or the state where the association is incorporated (for associations with no principal place of business).

Can different entities report data for a group health plan? Update 11/27/23

Yes. A group health plan may have separate entities report data such as a TPA for medical coverage and a PBM for pharmacy benefits, or the group may report the data to CMS themselves by requesting data from the TPA, PBM or other entity

What count of members (enrollees, beneficiaries) is required? Update 11/28/23

The number of plan participants covered on 12/31 of the reference year.

Does number of members/enrollees include all members/enrollees even if they were not enrolled entire plan year? Update 11/28/23

Yes. The count is based on the number of plan participants covered on 12/31 of the reference year.

Does the aggregation state equal the situs state or states where the plan is offered? Update 11/30/23

For self-funded plans, the aggregation state is the state where the plan has its principal place of business. For fully insured plans, the aggregation state is the state where the policy was issued.

For more details, refer to CMS Instructions, Section 5.4.

What if a member's plan is situsedin one state but services are rendered in another (snowbirds, students), would they report both states? Update 11/30/23

For self-funded plans, the aggregation state is the state where the plan has its principal place of business. For fully-insured plans, the aggregation state is the state where the policy was issued.

For more details , refer to CMS Instructions, Section 5.4.

Would a mailed or 90-day script be considered one script or three scripts? New 6/4/21

A 90-day script would be one script.

Which wellness services must be included in the RxDC report? Update 11/30/23

For the purposes of the RxDC report, wellness services are defined as activities primarily designed to implement, promote, and improve health. If a wellness service is billed on a claim, include it in the “Other medical costs and services” spending category in data file D2 Spending by Category. If a wellness service is not billed on a claim or is not a covered service under a plan or policy, do not include it anywhere in the RxDC report.

Scope of the RxDC Reporting

To whom does the reporting of pharmacy benefits and costs apply? New 3/15/22

The reporting requirement applies to:

- Health insurance issuers offering group coverage
- Health insurance issuers offering individual market coverage, including:
  - Exchanges
  - Student health plans
  - Plans sold exclusively outside of the Exchanges
  - Individual coverage issued through an association
- Fully insured and self-funded group health plans, including:
  - Employer and union sponsored group plans
  - Non-federal governmental plans, such as plans sponsored by state and local government
  - Church plans that are subject to the Internal Revenue Code
  - FEHB plans

The reporting requirement does NOT apply to account-based plans, such as health reimbursement arrangements, excepted benefits including but not limited to short-term limited-duration plans, hospital or other fixed indemnity insurance, disease-specific insurance, or non-commercial plans such as Medicare Advantage and Prescription Drug plans, Medicaid managed care plans, state children's health insurance program plans and Basic Health Program plans.

What is a retiree only plan? Update 11/1/22

A retiree only plan is a group health plan with no more than one active employee. A retiree only plan would have its own SPD and Form 5500 as outlined by the Department of Labor (DOL).

Does the Pharmacy Benefits and Costs reporting apply to retiree only plans? Update 11/4/22

Retiree plans are in scope if they have more than more than one active employee. Most retiree only plans do not have any active employees and are out of scope. However, UnitedHealthcare will include all customer data in the policy (including retiree) in the Pharmacy Benefits and Costs data submission.

- Member counts may include retiree data submission.
- Premium data is averaged across the entire policy.

- Note: if the retiree only plan rolls up under a master policy that includes both active and retirees, the data will be included for all the plans in the policy.

Does pharmacy benefits and costs include COBRA membership-count? Update 12/1/23

We do not include COBRA in the counts.

Are Health Saving Accounts and HRA are out of scope? New 11/15/22

Information on payments from a health savings account and health reimbursement account would be out of scope for the RxDC report.

Is EAP (Employee Assistance Program) in or out of scope for RxDC reporting? Update 11/30/23

EAP is out of scope for the RxDC report.

Does cost sharing assistance a drug manufacturer provides to a member have to be included in the reporting? New 3/15/22

To the extent these amounts impact total annual spending by health plans or by participants, beneficiaries, and members/enrollees the amounts must be included in the total health care spending data.

Does number of enrollees include all members/enrollees even if they were not enrolled entire plan year? Update 3/15/22

Yes. The count is based on the number of plan participants covered on the last day of the reference year for the reporting.

Are customer networks included in the data submitted? New 11/15/22

We will include all data requested including CSP (for example: Progyny) as long as we pay the claims.

UnitedHealthcare Approach to Rx Reporting

What do RxDC reports require for reporting of pharmacy costs? Update 11/30/23

Plans and issuers in the group and individual markets are required to submit certain information on prescription drug and other health care spending to the departments annually, including:

- General information identifying the insurer or plan
- Enrollment and premium information, including average monthly premiums paid by employees and the employer
- Total health care spending, broken down by type of cost (hospital care; primary care; specialty care; prescription drugs; and other medical costs, including wellness services) by members/enrollees and employer or issuer
- Prescription drug spending by members/enrollees versus employers and issuer
- The 50 most frequently dispensed brand prescription drugs
- The 50 costliest prescription drugs by total annual spending
- The 50 prescription drugs with the greatest increase in plan or coverage expenditures from the previous year
- Prescription drug rebates, fees, and other remuneration paid by drug manufacturers to the plan or issuer in each therapeutic class of drugs, as well as for each of the 25 drugs that yielded the highest amount of rebates
- The impact of prescription drug rebates, fees, and other remuneration paid by prescription drug manufacturers on premiums and out-of-pocket costs.

How does the report get submitted and who submits the report? Update 11/30/23

The report must be submitted to The Centers for Medicare & Medicaid Services (CMS) on behalf of the Departments of Health and Human Services, Labor, the Treasury (the Tri-Agencies or Departments) and the Director of the Office of Personnel Management (OPM).

UnitedHealthcare's standard approach is to submit the data for UnitedHealthcare fully insured, level funded and self-funded employers including UMR, Surest, FEHBP and Railroad.

Carve out business must be reported by the PBM or carrier that has the business.

Refer to the **UHC Approach to CAA Pharmacy Benefits and Costs Reporting Guide** for more detail.

To support this initiative, UnitedHealthcare will be collecting data that is not in our system from each customer annually to complete the RxDC reporting. Data will be collected through an RFI tool on the employer/broker portal. For 2024, Surest employers that are not integrated in a UnitedHealthcare system and UMR will use a survey in place of the RFI.

Even customers that submitted data in the prior year will be required to provide the information because information may change.

Self-funded customers wishing to do their own submission should speak with their UnitedHealthcare account team.

What are ASO UnitedHealthcare legal entities EINs? Update 11/28/23

Legal Entity	EIN
UMR, Inc.	39-1995276
United HealthCare Services, Inc.	41-1289245
OptumRx, Inc.	33-0441200
HealthSCOPE Benefits, Inc	71-0847266

How will UnitedHealthcare handle how the premium splits between the employer and employee are reported, since that information is not in UnitedHealthcare's system? Update 11/30/23

This is based on the RFI/survey data received from the employer.

Employers who do not complete and attest to an RFI/survey will be required to submit the data requested in the RFI directly to CMS.

In what format will UnitedHealthcare provide the data to CMS? Update 12/1/23

Excel.

If a customer provided data to us to do the complete submission for the prior reference years, do they need to provide information again this year? Update 11/27/23

Yes. Data may change from year to year so we will collect it each year.

How will UnitedHealthcare request the data they do not have in their system? New 11/30/23

UnitedHealthcare changed the approach for employers or brokers/consultants to submit information that will support UHC submission of pharmacy benefits and costs reporting data by the June 1, 2024 deadline.

- To do this, UHC will request employers to complete a Request for Information (RFI)/Survey by a March 31, 2024 deadline. The RFI /survey will be available on Feb. 1, 2024.
- The RFI tool is embedded in the employer portal and can be accessed after the employer or their delegate signs in with their secure passcode.
- For 2024, UMR and certain Surest employers not yet integrated into the UnitedHealthcare USP platform, will be requested to submit a survey.

In order to complete the RFI, employers or their delegates will need access to the employer portal.

Customers, brokers and consultants will need access to our Connect newsletters to stay informed of the process.

For customers with direct or carve out OptumRx, will UnitedHealthcare or Optum submit the report? Update 12/1/23

Work with the OptumRx account team to determine who will be submitting the pharmacy data to CMS.

For the Pharmacy Benefit and Cost Reporting provision, will UnitedHealthcare accept responsibility for doing this reporting for its self-funded as well as fully insured customers? Update 12/1/23

Yes. The standard approach is for UnitedHealthcare to submit the data for customer business with UnitedHealthcare only, including integrated pharmacy. UnitedHealthcare will collect the data through an RFI tool on the employer/broker portal.

Note: For 2024 UMR and certain Surest employers that have not migrated to a UnitedHealthcare system will receive a survey to complete. The survey will go out the week of January 31 and be required to be completed by the March deadline identified on the survey.

Optum Direct (carve out) or other PBMs must do their own submission or provide the customers with the data so the customer submits it.

Where does UnitedHealthcare access the group health plan name that goes in the P2 date? Update 5/28/23

UnitedHealthcare asks for this information in the RFI or survey.

If a customer wishes to streamline the P2 health plan number to accommodate their vendors, can UnitedHealthcare accept a custom group health plan number from the customer and use in in our P2 submission rather than use the EIN? Update 11/28/23

No. UnitedHealthcare is unable to accept any customization of data. If there is any discrepancy, UnitedHealthcare will work with CMS to clarify on behalf of our customers.

UnitedHealthcare anticipates clarification from CMS with each subsequent submission of future data submissions and will revisit and refine our approach as needed.

What should a customer do if they have questions on how to calculate D1? Update 5/22/23

Refer to the CMS site for the Pharmacy Benefits and Costs reporting instructions.

Is the plan or insurance company responsible for reporting? Update 11/30/23

The insurer is responsible for reporting based on the legal entity (e.g., UnitedHealthcare of Illinois).

Self-funded health plans would be responsible for reporting for their plans. UnitedHealthcare will support self-funded plans and include the aggregated data when UnitedHealthcare submits the reports.

When there is data that is not captured by UnitedHealthcare, the fully insured and self-funded employers will have to submit that data on their own.

Self-funded employers may choose to do the reporting themselves and should discuss this with their UnitedHealthcare representative. We anticipate a limited number of customers may choose to do this.

If a customer has carve-out pharmacy even with OptumRx should the ASO customer speak with that vendor? New 8/11/22

Yes.

How does UnitedHealthcare plan to collect data? Update 11/30/23

Most employers will be required to complete several questions in an RFI tool on the customer/broker portal. Customers who do not complete and attest to an RFI will be required to submit the data requested in the RFI directly to CMS.

- UnitedHealthcare collects the data using a request for information (RFI) tool in the employer/broker portal.
- The RFI tool is open on Feb. 1, 2024 and must be updated by March 31, 2024.

A survey will be used to collect the necessary data for Surest employers (who have not integrated into UHC system) and for UMR

- The survey will be sent to the employers the week of Jan. 29, 2024 and it must be updated by March 31, 2024.

When UnitedHealthcare submits D2 is the D2 file aggregated? Update 11/28/23

Yes.

Did UnitedHealthcare's contract language change? Update 12/1/23

- OptumRx Direct (carve out) issued a contract amendment.
- UnitedHealthcare ASA agreements have been adapted to cover the CAA provisions.
- Fully insured has no plans to make changes to COCs at this time, there is existing language in the COC that covers regulations.

What are the CMS reporting instructions for how data must be reporting? Update 5/18/23

CMS Reporting Instructions are online for our customers to use if they are doing reporting.

UnitedHealthcare is following these instructions for when we are doing reporting or shared reporting with our customers.

How does UnitedHealthcare define plan-year? Update 11/28/23

The plan year is the date the plan started and the plan ended for example 1/1 through 12/31 or 7/1 through 6/30.

Is cancelled/terminated customer's data included in the reports? Update 11/28/23

The report will include data from the time the customer was active with UnitedHealthcare with in the reference year.

Resources for Reporting

- Pharmacy benefits and costs ASO guide
- CMS Instructions
- Prescription Drug Data Collection (RxDC) Training Materials (cms.gov)