Pharmacy Benefits and Costs Reporting – Prescription Drug Data Collection (RxDC) FAQ

HINT: If you click on 'View' and then on "Navigation Pane" you may jump to different sections in the FAQ without scrolling through each page.

New 12/31/24

The deadline for submission of RxDC to CMS is 6/1/2025 for reference year 2024 data.

UnitedHealthcare designed a UHC request for information (RFI) tool to gather the information needed for the RxDC submission to CMS. UnitedHealthcare, Level Funded and Surest will submit the required information via the e UHC RFI tool, which is on the portal. UMR customers will receive and complete the UMR request for information (UMR RFI) which will be emailed by the UMR account them to the UMR customer.

About the UHC RFI tool:

- ***RFI tool will be available February 3, 2025, and will close March 31, 2025.***
- ***Data is required for both fully insured (FI) and self-funded (ASO) customers. Process includes termed customers who were active anytime during the 2024 reference year.***
- ***The UHC RFI tool is integrated with employer and broker portals.***
- ***Either the customer or the broker may submit information into the portal via the RFI tool.***
- ***The RFI tool in the portal allows the customer/broker/consultant to input, save, reopen, add, and change the information.***
- ***The customer or broker may check their status real time and download their completed responses. Please note, broker must be noted as the agent of record in order to gain access to their customer's data in the tool.***
- ***Customers who offer both Surest and UHC may be required to complete two separate RFIs, one on each employer portal – Employer Eservices and uhcEservices.***

Data Submission:

- ***Data and narratives are submitted for data UnitedHealthcare has in our systems for prior reference year.***
- ***P2 — Group Health Plan List***
- ***D1 — Premium and Life Years***
- ***D2 — Spending by Category (where appropriate)***
- ***D3 — D8 — Pharmacy data required for OptumRx integrated PBM***
- ***There is no fee for this service.***

Customers must acknowledge that the information provided in the RFI is accurate to the best of their knowledge.

Note: If a customer will submit all data, and request the data files from UnitedHealthcare, the customer will not need to complete the RFI. However, for partial data requests, the customers must complete the UHC RFI (or UMR RFI) since UnitedHealthcare will be submitting data for the customer.

Outside PBMs, including OptumRx direct:

- *For customers who use other PBM including OptumRx direct (carve out), the customer must work with that PBM or carrier to submit the data by the required June 1 deadline.*

Most Common Questions for the UHC RFI Tool

What information is available to support the RxDC process? Update 12/31/24

Use the following information:

- Brainshark Tutorial – external – **will be available 1/25/25**
- UnitedHealthcare's CAA Pharmacy Benefits and Costs FAQ – external
- UnitedHealthcare Pharmacy Benefits and Costs Guide - external
- RxDC RFI Worksheet - external

How do I report a technical RFI issue? Update 12/31/24

Contact your UnitedHealthcare or UMR account team.

What access must the customer or broker have to complete the UHC RFI? New 4/11/24

Anyone at the employer group with **eligibility access** to eServices portal can complete the RFI.

The broker must be listed as the agent or broker of record.

Why can't a broker see their customers profile in the RFI tool when they sign into EmployerEservices portal? Update 12/31/24

The brokers must have the group in their profile to see in the UHC RFI tool.

Not seeing a customers may be because the broker is not listed as the broker of record or some other reasons. A brokers must contact the eservices customer line if they are having issues.

Why could a customer see duplicate RFIs on the RFI tool? Update 12/31/24

If there are duplicates check the funding type first.

1. If they are the same funding type have the customer just complete one RFI. You may ignore the second one.
2. When there are two funding types, you must complete each one.

What if the customer logs in and sees an incorrect name with the policy number? New 3/19/24

Report this to the UHC account team.

What if the customer logs in and sees the correct name and policy number but incorrect EIN? Update 12/31/24

If the EIN is incorrect, the customer may complete the RFI. But it should be reported to the UHC account team.

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 12/31/24

Yes. Data may change from year to year so we will collect it each year. The customer is now able to bring forward prior year data using a button, which is a new feature this year.

The customer/broker would then update, if necessary.

What can a group do if they have termed? New 3/19/24

A termed group can still access the portal. They may need to reset their password.

Where can a broker check if customer completed the RFI? Update 12/31/24

The brokers should talk to their UHC account representative who can provide them with a status report on the employer groups they are listed as BOR.

If the group or broker made an error inputting information in the RFI, how can it be fixed? Update 12/31/24

- Log back into the RFI, click on complete status, and update the RFI, then just submit again.

Should the premium include dental, pharmacy and vision if it is integrated with medical? New 3/15/24

Yes.

If any standalone specialty products are not integrated with the medical, they should not be included in the RFI response.

Status of Rx Reporting Account Team Update – Update 12/31/24

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 will update the collection of data to do the submission for clients based on the current CMS Instructions.
2. UnitedHealthcare submits Pharmacy Benefits & Costs Reporting data to CMS by the deadline June 1 deadline, each year for the prior reference year.
3. 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 will be requested to complete an RFI on the employer/broker portal beginning Feb. 3, 2025. Deadline for completion is March 31, 2025.
        ii. UMR customers will receive a UMR RFI beginning on Feb. 3, which must be completed by the March 31 deadline. It will be an email from the customer's UMR account representative.
        iii. Customers that do not provide UHC information that is not contained in a UHC system by the deadline will need to submit that data themselves.
    - **Alternative approach (ASO only)**: the customer may request their data from UnitedHealthcare by March 31. The customer will then be required to 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.

4. UMR customers will complete a UMR RFI, which will be mailed to them.
5. **Fully insured:** UnitedHealthcare is responsible for submission of required data for all fully insured groups. UnitedHealthcare will be collecting information not in our systems via a UHC Request for Information (RFI) on the portal. If that information is not provided by March 31, the fully insured customer must submit the missing information to CMS by June 1. UnitedHealthcare submits all the data in our system.
6. **Self-funded (ASO):** Customers must provide the information requested by UHC in the RFI on the employer/broker portal. Customers may use the RxDC Prescription Drug Costs Reporting (RxDC) Guide as a resource. The guide is posted on uhc.com in the reform section under CAA Pharmacy Benefits and Costs Reporting.
7. UnitedHealthcare does not provide copies of RxDC reports submitted to CMS.
8. All data files submitted is in aggregate as defined by CMS.

9. UnitedHealthcare submits the appropriate narrative for each data file submitted.
10. Each data file submission requires a corresponding P2.
11. 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.
12. 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.
13. For ASO groups that choose to submit the data themselves, UnitedHealthcare provides the required data to customers by mid-May of the reporting year. In 2025, data will be provided beginning May 15 through 19 directly to those customers submitting their own data.

Important: Signing up for access to the CMS submission portal and following the extensive instructions and process CMS provides is more complicated than just answering the few questions we ask in the RFI. In fact, the questions in the RFI are also requirements for the customer that chooses to submit themselves. Remind the customer or brokers that in most cases it is easier to do the UHC RFI.

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.

Rx Reporting Overview of Regulation

What are the reporting benefits and cost requirements? Update 12/31/24

Section 204 of Division BB, Title II (Section 204) of the Consolidated Appropriations Act, 2021 requires group health plans and health insurance 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.

How is the reporting organized? Is there a required standard of reporting? Update 12/31/24

Data is reported by reference year.

- The data that will be reported June 1, 2025, will be for the 2024 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 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 the deadline for submitting the report? Update 12/31/24

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.

Example: The RxDC report for the 2024 reference year, which is due in 2025, should contain information based on what happened in calendar year 2024.

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

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 -

- Fully insured small group, large group.
- Self-funded small group, large group
- 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 as follows:

- 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.
- 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.

Does the aggregation state equal the situs state or states where the plan is offered? Update11/30/23

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 pharmacy script be considered one script or three scripts? New 6/4/21

A 90-day script would be one script.

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**
- **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**
- 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

Out of Scope

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.

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 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 12/31/24

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 RxDC Reporting June 1

Will UnitedHealthcare take in and submit other vendor data? Update 12/31/24

No, UnitedHealthcare will only submit data for plans administered by UnitedHealthcare.

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 1.1, Compliance with Laws, and Regulations.

In what format will UnitedHealthcare provide the data to CMS? Update 12/31/24

In the required csv format

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 12/31/24

No. UnitedHealthcare is unable to accept any customization of data.

What is the self-funded customer required to submit if they do not complete or only partially complete the request for information in the RFI tool? Update 12/31/24

If UnitedHealthcare did not receive an RFI 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 submitting data to CMS for data not provided in the RFI.

If the customer wishes to request that UHC not submit the D1 or any other combination of D1 through D8 files, they must inform their account team by 3/31/25.

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.

How will UHC aggregate and submit the D2? Update 12/31/24

If this is a fully insured plan - it's aggregated at the issuer level - "Group by same Issuer."

- If this is a self-funded plan it's aggregated at TPA level - "Group by same TPA."

What communications are sent to customers reminding them to complete the RFI? Update 12/31/24

UnitedHealthcare sends communications through the Connect electronic newsletter to customers, 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. UnitedHealthcare only submits 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 UHC RFI, but some information is missing? Update 12/31/24

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 UHC RFI.
- Corresponding files and narrative for D2 and D3 to D8 for carve in pharmacy.

For any data that was not provided to UnitedHealthcare via the UHC RFI, including if the customer left the D1 RFI 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 (including Surest and Level Funded and UMR will evaluate any new instructions and communicate any changes 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 12/31/24

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, 2025, for reference year 2024 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 12/31/24

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 submission. To obtain the data, UnitedHealthcare requests all customers to complete an UHC or UMR RFI to collect the necessary data elements by the March 31 deadline.

If the UHC or UMR RFI response is not completed by the March 31, 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 12/31/24

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.
- The customer will need to submit the entire report themselves. UnitedHealthcare does not include the data in our RxDC submission for customers reporting their own data in the submission.
- Note: If your customer requests the data files to complete the submission, they do not need to complete the UHC or UMR RFI. However, for partial data requests, the customer will need to complete the UHC or UMR RFI since UnitedHealthcare will be submitting data for the customer as well.

Will there be an option to have customers opt out of UHC reporting certain data, such as the D1, on their behalf? Update 12/31/24

Yes. Customers must contact their UnitedHealthcare representative **NO LATER THAN MARCH 31**, 2025.

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 requesting certain data be submitted via the UHC RFI from fully insured and Level Funded customers to support the submission.

What are ASO UnitedHealthcare legal entities EINs? Update 11/25/22

Legal Entity	EIN
United HealthCare Services, Inc.	41-1289245
UMR, Inc.	39-1995276
Surest (BIND Benefits, Inc.)	81-4560965
OptumRx, Inc.	33-0441200
HealthSCOPE Benefits, Inc.	71-0847266

If the customer has an EIN that is changing, what should they do? New 11/22/24

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. If corrected by Dec. 31, 2024, the updated EIN will be in the Jan. 8, refresh. If not, the system will be updated, but not for the RxDC 2025 reporting.

What should be used for Group Health Plan Name? New 4/11/24

Group health plan name (GHPN) is the employee plan name under ERISA (Employee Retirement Income Security Act) for which an employer provides medical care to employees or their dependents directly or through insurance, reimbursement, or otherwise.

When submitting information or when providing UHC with information so we can submit for the customer, what is required is the Group Health Plan Names associated with a medical plan. If multiples, plan names may be separated with a semicolon. This will also be the name associated with the Form 5500 Filing (this may not match the name on the UnitedHealthcare ID card)

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

Its OptumRx responsibility to submit D3-D8 data.

Rx Data Reporting Calculation

How do the reports require insurers and health plans to report Average Monthly Premiums Paid, Earned Premium, and Premium Equivalents? Update 12/31/24

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 as part of the 2024 reference year for the June 1, 2025, submission? Update 11/25/24

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

What is a reference year? Update 11/22/24

The Pharmacy Benefits and Costs report for 2024 reference year means the information in the report is based on what happened in calendar year 2024. This report will be submitted to CMS by June 1, 2025.

Refer to CMS instructions, Section 1.2.

How are the reports submitted for non-calendar year plans? Update 12/1/24

Both calendar year plans Jan. 1 to Dec. 31 (1/1/24 – 12/31/24) and non-calendar plans (e.g., 7/1/23 – 630/24 renewed 7/1/24 – 6/30/25) are required to submit a full year of data related to the reference year (2024).

For the P2 filing, calendar year plans will be reflected by a single record while non-calendar year plans will be reflected by two records distinguishable by the beginning and end periods of the plan.

For the 'D' filings, both calendar year and non-calendar year plans will contain data for the reference year the plan was in force with UnitedHealthcare.

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

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 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.

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.

What count of members (enrollees, beneficiaries) is required? Update 12/31/24

For the P2 the number of plan participants covered on 12/31 of the reference year.

For D1, the average number of members during the reference year, which is called life years.

The June 1, 2025, submission is for the 2024 reference year.

How is monthly premium calculated? Update 12/31/24

Average monthly premium paid by members:

- Calculate the average monthly premium (or premium equivalent) by taking the total annual premium (or premium equivalents) paid by members during the reference year and dividing by 12. Divide by 12 even if the coverage was not in effect for the entire calendar year.
- Fully insured and self-funded must be calculated and reported separately

Average monthly premium paid by employer:

- Calculate the average monthly premium (or premium equivalent) by taking the total annual premium (or premium equivalents) paid by the employer on behalf of members during the reference year and dividing by 12. Divide by 12 even if the coverage was not in effect for the entire reference year.
- Fully insured and self-funded must be calculated and reported separately

What does the member premium include? Update 12/31/24

Include:

- Premium insured by UHC or premium equivalents administered by UHC that is paid by members for medical and pharmacy coverage.

- Member payments for COBRA coverage, including the 2% administrative fee.
- Spousal and tobacco surcharges if applicable.

Exclude:

- Premium or premium equivalents paid by employers or other plan sponsors on behalf of members.

What does the employer premium include? Update 3/7/24

Include:

- Premium or premium equivalents paid by employers and other plan sponsors on behalf of members (including dependents) for medical and pharmacy coverage administered by UHC.
- Premium or premium equivalents paid by group trust, association, or MEWA plans if separate employers or other plan sponsors make premium contributions.

Exclude:

- Premium or premium equivalents paid by members.

How should customers calculate the total monthly premium paid by members and paid by the customer? Update 12/31/24

An example is shown below. If the customer was only with UHC for part of a year, the amounts paid by members and customer would only show for those months for the reference year and a zero for other months. However, the amount would still be divided by 12 based on the CMS instructions.

Average Month Calculation -- Example: Full Calendar Year

	Total Premium (or premium equivalents)		
Month	Paid by Members	Paid by Employers[1] (on behalf of members)	Paid by Plan (Total)
January	$ 5,675	$ 13,243	**$ 18,918**
February	$ 6,426	$ 14,994	**$ 21,420**
March	$ 6,426	$ 14,994	**$ 21,420**
April	$ 6,784	$ 15,829	**$ 22,614**
May	$ 6,784	$ 15,829	**$ 22,614**
June	$ 6,784	$ 15,829	**$ 22,614**
July	$ 7,497	$ 17,494	**$ 24,991**
August	$ 7,497	$ 17,494	**$ 24,991**
September	$ 7,497	$ 17,494	**$ 24,991**
October	$ 6,932	$ 16,174	**$ 23,106**

November	$ 6,932	$ 16,174	**$ 23,106**
December	$ 6,932	$ 16,174	**$ 23,106**
Total	**$ 82,167**	**$ 191,724**	**$ 273,892**
	Total A	***Total B***	
Average Monthly Premium Paid:	**$ 6,847.29**	**$ 15,977.00**	**$ 22,824.29**

In this example:

- Employer has a medical policy with UHC for full calendar year.
- Coverage period - 1/1/24 – 12/31/24.
- Calendar period – 1/1/24 – 12/31/24
- Employer paid portion is 70% of the total plan premium (or premium equivalents) paid.
- Divide by 12 even if the coverage was not in effect for the entire 12 months of the reference year.

- **Average Monthly Premium Paid by Members = Total A divided by 12**

  Calculation: $82,167 / 12 = **$6,847.29** ← **Amount to populate RFI**

- **Average Monthly Premium Paid by Employers = Total B divided by 12**

  Calculation: $191,724 / 12 = **$15,977.00** ← **Amount to populate RFI**

  Notes:
  - For self-funded plans, this is total plan costs minus premiums paid by members.
  - Based on Reference Year 2023 instructions (which at this time are continued for 2024. If there are any changes, UHC will comply and communicate to stakeholders.)
  - For RFIs containing multiple policies **all** policies should be included in the calculation.

UMR Approach for Data Collection and RxDC Reporting

What is UMR's approach for RxDC data collection? Update 12/31/24
UMR Account Management representatives will distribute a request for information (RFI) to their customer for completion. RFI will be due back to UMR by March 31.

When will UMR's RFI be ready for customer distribution?

February 3, 2025

How will UMR's customers data be collected from the RFI? (for internal FAQ only) Update 12/31/24
UMR Account Management representatives will enter the customer's RFI responses into a UMR RxDC data collection SharePoint site and store the completed RFI in the UMR AM Internal SharePoint site.

Where does Account Management go for question regarding UMR RFI process (for internal FAQ only)? Update 12/31/24
Email the UMR Healthcare reform team at healthcarereform@umr.com

RxDC Resources

What resources are available to help customers/brokers complete the UHC RFI? Update 12/31/24

- Brainshark Tutorial – external – will be available by Jan. 25, 2025
- UnitedHealthcare's CAA Pharmacy Benefits and Costs FAQ – external
- UnitedHealthcare Pharmacy Benefits and Costs Guide - external
- RxDC RFI Worksheet - external

Where can customers find more information about Pharmacy Benefits and Costs reporting also referred to as RxDC? Update 12/31/24

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.

What are the links to CMS for training, instructions, and other support to do reporting? Update 12/31/24

- CMS Reporting Instructions for 2024 (2023 reference year)
- CMS Training Resource Library
- CMS RxDC FAQS
- CMS RxDC Home page

Also the following guide UHC has developed:

- Pharmacy benefits and costs ASO guide