CAA Reporting Pharmacy Benefits and Costs (RxDC) Data Collection Worksheet for June 1, 2023

February 1, 2023

United Healthcare

CAA Reporting Pharmacy Benefits and Costs (RxDC) Data Collection Worksheet

To support the submission of RxDC data due June 1, 2023, UnitedHealthcare must collect data not contained in our systems. To collect the required information, UnitedHealthcare is requesting you fill out an online survey. The following questions will appear in the survey. **You may use this worksheet to prepare.**

Key points:

- Please respond based upon plan(s) administered by UnitedHealthcare.
- The survey must be completed by **March 3, 2023.**
- Once you have completed the survey you cannot go back and make changes.
- The survey takes approximately **15 mins** to complete.

Survey Worksheet

Employer Group or Broker to enter following key fields into the online survey

Submitter Information Section

	QUESTION	WORKSHEET RESPONSE
	Name of person completing the survey:	
	Email of person completing the survey:	
	Person's role with the company (e.g., HR rep, Benefit Coordinator, Broker):	
	Is your group Self-Funded, Fully Insured, Both or Level Funded? ***("Both"** should be used when the employer group has both a self-funded and fully insured health plan(s) administered by UnitedHealthcare.)*	

Survey Worksheet

Employer Group or Broker to enter following key fields into the online survey

Group Health Plan Information Section

	QUESTION	WORKSHEET RESPONSE
	Legal Company Name:	
	EIN: *Numeric field for EIN, max character= 9, no special characters* *This will be used to populate the Group Health plan number in the P2*	
	UHC Policy Number(s): *Text field, max character = X, no special characters. This is the policy number associated with your United Healthcare policy.*	
	Do you file a form 5500 report with the IRS? (P2) *If applicable, enter the 3-digit plan number reported on the IRS Form 5500 filed with the Department of Labor. If there is more than one value, separate them with a semicolon.*	
	What is your Group Health Plan Name? (P2) *"Group health plan name" 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.* *This will also be the name associated with the Form 5500 Filing (this may not match the name on the UnitedHealthcare ID card)*	
	What are your ASO and other TPA fees paid? (D1) *This is **not applicable for Fully insured**.* *This is a numeric field: no special characters, or slashes.* *Report the ASO and other fees paid to the TPA.*	**Amount:**
	What is the Average Monthly Premium Paid by Members? (D1) *Report the average monthly premium per member per month (PMPM) paid by members.* ***Include:** Premium paid by members, APTCs Premium equivalents paid by members for self-funded coverage* ***Exclude:** Premium paid by employers or other plan sponsors on behalf of members. Premium equivalents paid by employers or other plan sponsors on behalf of member* *If members do not pay a premium, enter $0 (zero) in the Members field.*	**Members:**

Survey Worksheet

Employer Group or Broker to enter following key fields into the online survey

Group Health Plan Information (Continued)

QUESTION	WORKSHEET RESPONSE
What is the Average Monthly Premium Paid by Employer? (D1) *For group health plans and FEHB plans, report the average monthly premium PMPM paid by employers on behalf of members.* ***Include:*** *Premium paid by employers and other plan sponsors on behalf of members (including dependents). Premium equivalents for self-funded coverage. Premium paid by group trust, association, or MEWA plans if separate employers or other plan sponsors make premium contributions.* ***Exclude:*** *Premium paid by members.*	**Employer:**
Do you offer outside TPAs to your employees? (P2) *This is for ASO only* ***Note:*** *Should be able to submit upwards 5 additional health plan vendors*	**If yes, complete the questions a and b**
a) What is the outside TPAs name? *Text Field; max 2048 characters, no slashes*	
b) What is the outside TPAs EIN? *Numeric Field; 9-digits, no dashes or slashes or special characters*	
Do you offer another health plan insurer or vendor to your employees? (P2) *This is for Fully Insured only*	**If yes, complete the questions a and b**
a) What is the health plan insurer or vendor name? *Text Field; max 2048 characters, no slashes* ***Note:*** *Should be able to submit upwards 5 additional health plan vendors*	
b) What is the health plan insurer or vendor EIN? *Numeric Field; 9-digits, no dashes or slashes or special characters* ***Note:*** *Should be able to submit upwards 5 additional health plan vendors*	
Do you offer pharmacy benefit plans to your employees? (P2) *This is in reference to non-integrated vendors*	**If yes, complete the questions a and b**
a) What is the pharmacy plan vendor name? *Text Field; max 2048 characters, no slashes* ***Note:*** *Should be able to submit upwards 5 additional pharmacy vendors*	
b) What is the pharmacy plan vendor EIN? *Numeric Field; 9-digits, no dashes or slashes or special characters* ***Note:*** *Should be able to submit upwards 5 additional pharmacy vendors*	

Survey Worksheet

Employer Group or Broker to enter following key fields into the online survey

Group Health Plan Information (Continued)

	QUESTION	WORKSHEET RESPONSE
	Do you offer carveout/external wellness benefits where claims are paid by the external TPA? (P2) *This is for ASO only* **Include:** external Wellness carriers only when the carriers pay wellness services through a claim. **Exclude:** do not include wellness services that are not covered services under a plan or policy. Do not include wellness services not billed on a claim.	**If yes, complete the questions a and b**
	a) What is the wellness plan vendor name? *Text Field; max 2048 characters, no slashes*	
	b) What is the wellness plan vendor EIN? *Numeric Field; 9-digits, no dashes or slashes or special characters* ***Note:** Should be able to submit upwards 3 additional Wellness vendors*	
	Do you offer carveout/external behavioral health benefits? (P2)	**If yes, complete the questions a and b**
	a) What is the Behavioral plan vendor name? *Text Field; max 2048 characters, no slashes*	
	b) What is the Behavioral plan vendor EIN? *Numeric Field; 9-digits, no dashes or slashes or special characters* ***Note:** Should be able to submit upwards 3 additional Behavioral Health vendors*	
	Do you have an external contract with Stop Loss Vendor? (P2) *(ASO only, does not apply to Level Funded or Fully Insured)*	**If yes, complete the questions a and b**
	a) What is the Stop Loss vendor name? (P2) *Text Field; max 2048 characters, no slashes*	
	b) What is the Stop Loss vendor EIN? (P2) *Numeric Field; 9-digits, no dashes or slashes or special characters*	
	c) What is your Stop Loss Premium? (D1) *Report the stop loss premium paid to the insurer.* *This amount should also be included in Premium Equivalents.* *Numeric Field; 9-digits, no dashes or slashes or special characters*	