Consolidated Appropriations Act
Pharmacy Benefits and Costs Reporting (RxDC)

Due June 1, 2023 for 2022 data

Important:
The content in this guide reflects UnitedHealthcare/ OptumRx carve in approach.
The guide includes content from: [1] CMS Reporting Instructions as noted throughout.

February 1, 2023

United Healthcare

Reporting Pharmacy Benefits & Costs Data

The UnitedHealthcare **approach is changing** for National Accounts, Key Accounts, Public Sector and Surest™ self-funded (ASO) clients for the June 1, 2023, submission of 2022 RxDC data.

There will be two approaches available to support this work for ASO clients

1. **Standard** - UnitedHealthcare submits all data
2. **Alternative** - Client submits all data

Standard approach - applies to ASO, Level Funded and fully insured clients

UnitedHealthcare submits all data and appropriate narratives for plans administered by UnitedHealthcare and OptumRx carve in (integrated). There is no fee for clients who follow the standard approach.

- UnitedHealthcare will submit the P2 (Group Health Plan list), D1 (Premium and Life Years), and D2 (Spending by Category) files for all clients who had coverage in the 2022 reference year.
- For clients with OptumRx integrated PBM, UnitedHealthcare will also submit the D3-D8 files.
- For clients who use any other PBM, including OptumRx Direct, the client will need to work with that PBM to submit the D3-D8 files by the deadline.

Action needed – Some required data elements are not stored in UnitedHealthcare systems. To complete the CMS submission, UnitedHealthcare will require client specific data to be collected through a **survey**, which must be completed no later than **March 3, 2023.** This survey was sent to the primary client contact as noted in our systems. If you have not received the survey, reach out to your UnitedHealthcare representative. Due to tight timeframes and work required to complete the submission by June 1, there can be **no extension** of the **March 3 deadline**.

- If the survey is not completed by March 3, UnitedHealthcare will submit the data in our system to CMS on or before the June 1 date. However, the submission will not be complete.
- Data elements not provided to UnitedHealthcare must be submitted to CMS by the health plan (client) or another reporting entity.
- The health plan accepts any risk arising from the health plan's failure to provide any requested information to UnitedHealthcare for reporting.
- Data submitted by UnitedHealthcare to CMS is not provided to the client.

NOTE: Please respond based upon plan(s) administered by UnitedHealthcare.

Alternative approach – available to ASO only

The client may request their data from UnitedHealthcare to submit to CMS directly.

- If the client will submit all data, UnitedHealthcare must receive the request by March 3, 2023.
- There may be a fee for UnitedHealthcare to provide the required data files.
- Please work with your account representative should you choose this approach.

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CMS Data Requirements

Requirements[1]**:** Plans, issuers, and carriers must submit one or more plan lists (P1, P2, P3), eight data files (D1 through D8), and a Narrative response for each data file.

- Identifiers beginning with **P** stand for Plan
  P1: Individual and Student Market plans
  P2: Group Health plan list (most commercial business) required for employer-based health plans that are not FEHB plans
  P3: FEHB plan list

The Plan lists identify the employer group and plans in a submission. The plan lists also collect information such as the beginning and end dates of the plan year, number of members, and the states in which the plan or coverage is offered. As most commercial business requires a P2, we refer to P2 throughout this guide.

- See index for P2 data layout

Please note: Any entity that submits a Data (D) file, must also submit a corresponding P2 file. Therefore, there may be multiple submitters of P2 when multiple reporting entities are in place.

- The P2 identifies each unique Group Health plan and is the common thread to link all data files to a Group Health Plan.
- Clarification from CMS implies that if the Group Health Plan uses multiple TPAs or PBMs, a P2 should be submitted by the Group Health Plan which incorporates all TPAs, PBMs and associated EINs. We are referring to this as the master P2.
- The survey will collect carve out carrier identifying information (name and EIN) which will be reported by UnitedHealthcare when provided by the March 3 deadline.
- Clients with carve out arrangements will need to coordinate with other carriers to support reporting requirements. Each reporting entity will submit a P2 with their corresponding data files. Carve out arrangements may include: OptumRx Direct (carve out), other PBMs, carve out wellness, behavioral and/or carve out stop loss.

Membership reporting: The P2 data layout includes members as of 12/31 of the reference year. UnitedHealthcare will include all members in the policy (including retirees) in the submission of the Pharmacy Benefits and Costs data. We do not have the ability to exclude retirees from reporting.

Discrepancies: Should CMS identify any mismatches in data, UnitedHealthcare will work directly with CMS to resolve.

Narrative[1]**:** A narrative response is required to describe the impact of prescription drug rebates on premium and cost sharing. UnitedHealthcare will submit the appropriate narrative for each data file submitted. Please note, UnitedHealthcare is unable to customize the narrative by client.

Terminated Groups: UnitedHealthcare will follow the standard approach for all groups that were active in 2022. The terminated group contact will receive and be required to respond to the survey by the **March 3 deadline**. If the survey is not completed by **March 3**, UnitedHealthcare will submit the data in our system to CMS. However, the submission **will not be complete**. Data elements not provided to UnitedHealthcare must be submitted to CMS by the terminated group or another reporting entity.

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Reporting Data Definitions[1]

Identifiers beginning with D stand for data and reference the 8 distinct files of data required in the report.

Definitions:

- **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

UnitedHealthcare aggregation methodology:

- All self-funded data files will be aggregated by TPA/market segment/state (principal place of business)
- All fully insured data files will be aggregated by Issuer/market segment/state (where the policy was issued)
- UnitedHealthcare is unable to provide individual client specific reporting

D1: Premium and Life Years [1]

- Premium: For self-funded plans and other arrangements that do not rely exclusively or primarily on premiums, report the premium equivalent amounts representing the total cost of providing and maintaining coverage, including claims costs, administrative costs, Administrative Services Only (ASO) and other TPA fees, and stop-loss premiums. An employer with a self-funded plan may use, as the total cost of providing and maintaining coverage, the same costs that are taken into account for purposes of calculating COBRA premiums (minus the 2% administration charge, if applicable). Report the ASO and other fees paid to the TPA. This amount should also be included in Premium Equivalents.
- Life-years are the average number of members in the plan throughout the year.

D1 Premium Safe Harbor[1]

- **For the 2020 and 2021 reference years only**, the Safe Harbor states: "If you have obtained the required information, you must report it. However, the Departments recognize there may be significant challenges to obtain information about employer premium contributions, especially when a contractual relationship began before the passage of the CAA. Accordingly, the Departments will not take enforcement action related to the requirement to report average monthly premium paid by employers versus members for the 2020 and 2021 reference years if those data elements are reported in RxDC report for the 2022 reference year and all future reference years."

D2: Spending by Category

- Claims paid under medical, includes Behavioral claims
- See appendix for additional details

D3: Top 50 Most Frequent Brand Drugs

- For each RxDC brand name drug, calculate the total number of paid claims in a state and market by adding the number of paid claims for every NDC associated with the RxDC brand drug name.
- CMS will indicate which drugs are considered brand name drugs.
- Rank the drugs in each state and market segment according to number of paid claims, sorted in descending order.
- Identify the 50 brand name drugs with the highest number of paid claims.
- Create a table with the top 50 drugs and include a row for every state, market segment, and EIN of the issuer or TPA.

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Reporting Data Definitions[1]

D4: Top 50 Most Costly Drugs

For each RxDC drug, calculate total spending, net of prescription drug rebates, fees, and other remuneration, in the state and market segment by summing total spending for every NDC associated with the RxDC drug name.

- Rank the drugs in the state and market segment according to total spending, sorted in descending order, and identify the 50 drugs with the greatest total spending.
- Create a table with the top 50 drugs and include a row for every state, market segment, and EIN of the issuer or TPA.
- For each row, report total spending and the other utilization and spending variables in the file layouts.

D5: Top 50 Drugs by Spending Increase

For each RxDC drug, calculate total spending, net of prescription drug rebates, fees, and other price concessions, in the state and market segment by summing total spending for the reference year for the NDCs associated with the RxDC drug name.

- For each RxDC drug, calculate the increase in total spending by subtracting total spending in the state and market segment for the year prior to the reference year from total spending in the state and market segment for the reference year.
- If spending on a drug increased from one year to the next, the difference will be a positive number.
- If spending on a drug decreased from one year to the next, the difference will be a negative number.
- Rank the drugs in each state and market segment according to the increase in total, sorted in descending order.

D6: Rx Totals

Report information about prescription drugs covered under the pharmacy benefit.

D7: Rx Rebates by Therapeutic Class

A therapeutic class is a group of drugs that have a similar mechanism of action or treat the same condition. Therefore, they are assigned the same RxDC therapeutic class name. If an NDC has more than one ingredient and those ingredients belong to different therapeutic classes, the RxDC therapeutic class name is the combination of the therapeutic classes.

D8: Rx Rebates for the Top 25 Drugs

For each RxDC drug, calculate total rebates, fees, and other remuneration in the state and market segment by summing total rebates, fees, and other remuneration for every NDC associated with the RxDC drug name.
Rank the drugs in the state and market segment according to total rebates, fees, and other remuneration, sorted in descending order. Identify the 25 drugs with the greatest amount.

**Stop Loss: Premium equivalents (self-funded coverage) D1

For self-funded plans and other arrangements that do not rely exclusively or primarily on premiums, report the premium equivalent amounts representing the total cost of providing and maintaining coverage, including claims costs, administrative costs, Administrative Services Only (ASO) and other TPA fees, and stop-loss premiums.
An employer with a self-funded plan may use, as the total cost of providing and maintaining coverage, the same costs that are taken into account for purposes of calculating COBRA premiums (minus the 2% administration charge, if applicable).

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Legal Entity and EIN

Following please find the Legal Entity and EIN combinations for UnitedHealthcare, OptumRx (carve-in) and other business entities.

Legal Entity	EIN
United HealthCare Services, Inc.	41-1289245
UnitedHealthCare Service LLC *	47-0854646
OptumRx, Inc.	33-0441200
HealthSCOPE Benefits, Inc	71-0847266
Oxford Health Plans LLC	52-2443751
Bind Benefits Inc Use Bind Benefits Inc as the legal entity name for Surest™	81-4560965

* Legal entity for UnitedHealthcare of NY

ASA language

ASA will be updated upon renewal with language covering the Consolidated Appropriations Act provisions including that UnitedHealthcare will prepare and file the data for plans administered by UnitedHealthcare.

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Alternative approach available to ASO clients who will submit data to the CMS portal directly

The self-funded client may opt to submit all data directly in the CMS portal. To support the submission, the client may make a request for summarized data files and narrative through their UnitedHealthcare representative.

- If the client will submit all data, UnitedHealthcare must receive the request by **March 3, 2023**.
- There may be a fee for UnitedHealthcare to provide the required data files, when it includes pharmacy data.
- Data is only provided to the client if they will complete the filing with CMS directly.
- When a client chooses this option, that employer group will not appear in the aggregate report that UnitedHealthcare submits.

Please note:

- Clients may be required to sign a non-disclosure agreement (NDA).
- The requested data and appropriate narrative will be provided to the client or their delegate in late May 2023.
- Self-funded groups with carve-out arrangements will need to obtain and then submit data and narrative from those entities, where applicable.
- Data Requests can be made for each of the following summarized files:
  - D2: Spending by Category
  - D3 to D8 (In total)
- For OptumRx Direct (carve out) business, the client must obtain data from OptumRx directly.

OptumRx Direct

- Clients with OptumRx Direct (carve-out) will work directly with their OptumRx representative on the submission of pharmacy data
- OptumRx Direct (carve-out) clients received a request from OptumRx to confirm the D2 approach
  - The UnitedHealthcare (D2) data is aggregated at the medical benefit/vendor level
- OptumRx Direct will report at the aggregated level. Therefore, clients would be combined with all other ORx clients who had their D2 files aggregated by the medical vendor

Shared Approach – Not Supported

There is no shared approach option for June 1, 2023. For the 2020/2021 data submission, the standard ‘shared” approach submitted P2, D2 through D8 and appropriate narrative. In the shared approach, the Group Health Plan submitted P2 and D1.

Submission Confirmation and CMS Reference links

Confirmation of completion of submission of RxDC data to CMS:

- UnitedHealthcare will send a communication to our internal teams in mid-May to confirm that we on track to complete the required submission to CMS.
- Your account team will receive a confirmation on 6/2/2023 that the submission is complete.

CMS Site and Reference links

CMS Site	Content
CMS Reporting Instructions	Contains details regarding reporting instructions and deadlines
CMS - Sign In	CMS.gov sign in link
HIOS RxDC User Manual (cms.gov)	HIOS RxDC User Manual
HIOS Portal User Manual (cms.gov)	HIOS Portal User Manual
CMS Help Desk	Contact: MSD CMS_FEPS@cms.hhs.gov or at 1-855-267-1515

Other Resources

Use the **CAA Frequently Asked Questions document** in the Pharmacy Benefits and Costs section to answer more of your questions.

Appendix

P2 Group Health Plan List[1]

UnitedHealthcare will submit

Does not apply to ASO

Each row should have a unique combination of Group Health Plan Number, plan year beginning date, and plan sponsor EIN.

P2 Column Name	Field Type	Instructions
Group Health Plan Name	String	Do not include FEHB plans.
Group Health Plan Number	String	Enter a **unique** plan identification number. You can use the identification number in your own database or any other numbering sequence as long as there is a unique plan ID number for every plan. You may use the Form 5500 Plan Number.
HIOS Plan ID	String	Fully-insured small group plans only. Enter the 14-digit HIOS Plan ID(s). Do not use dashes. Ex: 12345NY1234567. You may enter more than one value in the same cell. If there is more than one value, separate them with a semicolon.
Form 5500 Plan Number	String	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.

P2 Column Name	Field Type	Instructions
States in which the plan offered	String	Enter the state(s) in which the plan or coverage is offered using 2-character state postal code.[15] If there is more than one state, separate them with a semicolon. For example: AL; AK; MA. If a plan is offered in every state and in DC, enter "National". If a plan is offered nationally and also in the territories, enter "National" as well as the 2-character postal code for the territories, separated by a semicolon. For example: National; PR; GU.
Market Segment	String	Valid Values: Small group market Large group market SF small employer plans SF large employer plans For mixed-funded plans, enter both markets and separate them with a semicolon.
Plan Year Beginning Date	Date	MM/DD/YYYY If a plan has a non-calendar plan year and renews during the calendar year, use two rows in the plan list file. (One row for the plan year that ended in the reference year and another for the plan year that began during the reference year.)
Plan Year End Date	Date	MM/DD/YYYY If a plan has a non-calendar plan year and renews during the calendar year, use two rows in the plan list file. (One row for the plan year that ended in the reference year and another for the plan year that began during the reference year.)
Members as of 12/31 of the reference year	Integer	The number of members with coverage, including dependents, on the last day of the reference year. If a plan ended before the last day of the reference year, enter 0.
Plan Sponsor Name	String	Enter the plan sponsor or client name. If there is more than one value, separate them with a semicolon.
Plan Sponsor EIN	String	Enter the 9-digit EIN. Include leading zeros if your EIN is fewer than 9 digits. Do not use dashes. Ex: 001234567. If there is more than one value, separate them with a semicolon.
Issuer Name	String	If there is more than one value, separate them with a semicolon.

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P2 Group Health Plan List[1]

UnitedHealthcare will submit

UnitedHealthcare will submit for OptumRx Carve In

Submit 1 (standard/ OptumRx carve in)

P2 Column Name	Field Type	Instructions
Issuer EIN	String	Enter the 9-digit EIN. Include leading zeros if your EIN is fewer than 9 digits. Do not use dashes. Ex: 001234567. Ex: 001234567. If there is more than one value, separate them with a semicolon.
TPA Name	String	If there is more than one value, separate them with a semicolon.
TPA EIN	String	Enter the 9-digit EIN. Include leading zeros if your EIN is fewer than 9 digits. Do not use dashes. Ex: 001234567. If there is more than one value, separate them with a semicolon.
PBM Name	String	If there is more than one value, separate them with a semicolon.
PBM EIN	String	Enter the 9-digit EIN. Include leading zeros if your EIN is fewer than 9 digits. Do not use dashes. Ex: 001234567. If there is more than one value, separate them with a semicolon.
Included in D1 Premium and Life Years? (1= Yes; 0 = No)	Integer	Valid Values: 0 1
Included in D2 Spending by Category? (1= Yes; 0 = No)	Integer	Valid Values: 0 1
Included in D3 Top 50 Most Frequent Brand Drugs? (1= Yes; 0 = No)	Integer	Valid Values: 0 1
Included in D4 Top 50 Most Costly Drugs? (1= Yes; 0 = No)	Integer	Valid Values: 0 1
Included in D5 Top 50 Drugs by Spending Increase? (1= Yes; 0 = No)	Integer	Valid Values: 0 1
Included in D6 Rx Totals? (1= Yes; 0 = No)	Integer	Valid Values: 0 1
Included in D7 Rx Rebates by Therapeutic Class? (1= Yes; 0 = No)	Integer	Valid Values: 0 1
Included in D8 Rx Rebates for the Top 25 Drugs? (1= Yes; 0 = No)	Integer	Valid Values: 0 1

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Reporting Data Definitions[1]

D2: Spending by Category

- Claims paid under medical, includes Behavioral claims

Spending Category	Abbreviation (Not case sensitive)
Hospital	Hospital
Primary care	Primary care
Specialty care	Specialty care
Other medical costs and services	Other medical costs and services
Medical benefit drugs: known amounts (informational)	Known medical benefit drugs
Medical benefit drugs: estimated amounts (informational)	Estimated medical benefit drugs

Instructions state to NOT report spending on pharmacy benefit drugs anywhere in D2 Spending by Category.

Include in Other medical costs and services	Exclude
• Radiology and laboratory services that are billed independently by the laboratory (Radiology: 70000–79999; laboratory and pathology: 36415; 36416; 80000–89999) • Non-hospital based skilled nursing and hospice services • Ambulance services not billed by a hospital facility • Home health care • Dental services and supplies • Vision services and supplies • Durable medical equipment • Wellness services billed on a claim. Do not include wellness services that are not covered services under a plan or policy. For the purposes of the RxDC report, wellness services are defined as activities primarily designed to implement, promote, and improve health.	• Claims with a valid revenue code on the UB-04 form. • Wellness services not billed on a claim

- **Hospital:** spending on services provided by hospitals to members and billed by the facility.
- **Primary care:** spending on clinical health care services provided by a primary care provider in doctor's office or outpatient care center.
- **Specialty care:** spending on clinical health care services provided by specialists.
- **Other medical costs and services:** spending for all other professional and facility clinical health care services and equipment not reported as hospital, primary care, or specialty care.
- **Medical Benefit Drugs:** known amounts (informational): spending on drugs covered under a medical benefit that are separately billed or otherwise known exactly. The amounts reported here are also included in the hospital, primary care, specialty care, or other medical costs and services categories.
- **Medical benefit drugs:** estimated amounts (informational): estimated portion of bundled or alternative payment arrangements (or other non-fee for service amounts) that can be attributed to drugs covered under a medical benefit. The amounts reported must also be reported in the hospital, primary care, specialty care, or other medical costs and services categories.
- **Cost Sharing:** deductibles, coinsurance, and copays, including amounts that may have been paid through a health savings or reimbursement account.

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Form 5500 Plan Number[1]

Form 5500 Number – Mandatory for fully insured and ASO filing

Location: P2
If applicable, enter the 3-digit plan number reported on the IRS Form 5500 filed with DOL. If there is more than one value, separate them with a semicolon.

It is the Group Health Plan's responsibility to file the Form 5500. For reference, here is the link to the U.S. Department of Labor Form 5500 Search Tool: https://www.efast.dol.gov/5500Search/
5500 data is expected to be found in the 5500 site for most employer groups.

State Aggregation [1]

The state aggregation rules for RxDC are like the requirements in the MLR reporting form instructions. In general, a reporting entity should report fully-insured business in the state where the policy was issued.

For **self-funded plans**, the reporting entity should generally report the data in the state where the plan sponsor has its principal place of business. When a plan covers members in multiple states, or when coverage is sponsored by a group trust, association, or multiple employer welfare arrangement (MEWA), the reporting entity should follow the instructions below.

Coverage in Multiple States:
For self-funded coverage that is not provided through a group trust, association, or MEWA, report the data in the state where the plan sponsor has its principal place of business.
For fully-insured plans, report the data in the state where the policy was issued.
For FEHB carriers that are not associated with an issuer, TPA, or other third-party vendor and that offer coverage in multiple states, report the data in the state where the policy was issued or where the carrier has its principal place of business