Consolidated Appropriations Act
Pharmacy Benefits and Costs Reporting (RxDC)

Reference Year 2023
Deadline June 1, 2024

Important:
The content in this guide reflects UnitedHealthcare/ OptumRx carve in approach.
The guide includes content from: 2024 CMS RxDC Reporting Instructions(2023 reference year) as noted throughout.

February 23, 2024

United Healthcare

Reporting Pharmacy Benefits & Costs Data

UnitedHealthcare **approach is outlined below** for National Accounts, Key Accounts, Public Sector and Surest™ clients for the June 1, 2024, submission of 2023 RxDC data.

There will be two approaches available to support this work for both Fully Insured(FI) and Self-Funded (ASO) clients

1. **Standard** - UnitedHealthcare submits all data
2. **Alternative** - Client submits all data (ASO only)

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 2023 reference year.
- For clients with OptumRx integrated PBM, UnitedHealthcare will also submit the D3-D8 files.
- For clients who use any other Pharmacy Benefits Manager (PBM), including OptumRx Direct, the client will need to work with that PBM to submit the required files by the deadline.

Action needed – Some required data elements are not stored in UnitedHealthcare systems. To complete the CMS submission, UnitedHealthcare requires client specific data**.** This data will be collected though a Request for Information (RFI).

- If the RFI is not completed, 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 failure to provide requested information to UnitedHealthcare.
- Data submitted by UnitedHealthcare to CMS is not provided to the client.
- The RFI tool on portals opens Feb. 21, 2024, and the deadline for customers/brokers to complete the RFI (or Surest survey) is April 10, 2024.
- Note: UMR and Surest business that has not integrated with UHC will complete a Qualtrics Survey.

Alternative approach – applies to ASO only (not recommended for Level Funded)

The client may request their (D2-D8) data from UnitedHealthcare to submit to CMS directly.

- If the client will submit all data, UnitedHealthcare must receive the request by March 31, 2024.
- There may be a fee for UnitedHealthcare to provide the required data files.
- Data will be sent to the requestor by mid-May 2024.

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

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.

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.
- A **carve out description field is listed in the data layout, however,** UnitedHealthcare will not submit data in this field as it is not required for the 2023 data submission. 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.

Membership reporting: The P2 data layout includes members as of 12/31 of the reference year Retirees and COBRA participants, including their dependents, are considered members if they are covered by a plan that is not a retiree-only plan.[1] UnitedHealthcare will include all members in the policy (including retirees and COBRA) in the submission of the Pharmacy Benefits and Costs data. We do not have the ability to exclude retirees or COBRA 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 2023. If the RFI is not completed, 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

CMS updated the RxDC Reporting instructions for 2024 (2023 reference year) on Feb. 1, 2024.

Reporting Data Definitions[1]

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

Definitions[1]:

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 for all members.
Generally, entities should report amounts that best represent the total cost of providing and maintaining coverage for the reference year. Therefore, actual costs on a retrospective basis should be used instead of funding levels whenever possible. To calculate total annual premium equivalents, an employer with a self-funded plan may use, as the total cost of providing and maintaining coverage, the same types of costs that are taken into account for purposes of calculating COBRA premiums (minus the 2% administration charge, if applicable
**For further details, please refer to RxDC reporting instructions.

Life-years are the average number of members in the plan throughout the year. As noted above, the term member means a person who has health coverage, regardless of whether the coverage is associated with an insurance policy, a group health plan, or an FEHB plan. For example, enrollees, dependents, participants, beneficiaries, COBRA participants, retirees (except for retirees in a retiree-only plan), and FEHB annuitants are all considered members.

D2: Spending by Category

Report allowed claims with dates of service during the reference year. Allowed claims are the total payments made under the plan or policy to health care providers on behalf of members. This includes fee-for-service and capitated payments.**

D3: Top 50 Most Frequent Brand Drugs

- For each 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.

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.

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.

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.

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

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 See UMR Reporting Guide for additional information	71-0847266
UMR, Inc. See UMR Reporting Guide for additional information	39-1995276
Oxford Health Plans LLC	52-2443751
Bind Benefits Inc (DBA: Surest) Use Bind Benefits Inc as the legal entity name for Surest™	81-4560965

* Legal entity for business State of NY

ASA Language

ASA language covers the Consolidated Appropriations Act provisions including that UnitedHealthcare will prepare and file the data for plans administered by UnitedHealthcare. Specific language in the ASA includes “prepare and file pharmacy benefits and drug costs reports.”

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

Alternative approach available to ASO clients who 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 have received the request by March 31, 2024.
- 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 mid-May 2024.
- 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
- OptumRx Direct will report at the aggregated level.

Shared Approach

Data elements not provided to UnitedHealthcare must be submitted to CMS by the group health plan or another reporting entity.

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 2024 to confirm that we are on track to complete the required submission to CMS.
- Your account team will receive a confirmation on June 6, 2024 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.