CAA Reporting Pharmacy Benefits and Costs (RxDC) Data Collect ASO, ASO with FI, and Level Funded Worksheet for June 1, 2023

February 1, 2023

United Healthcare

CAA Reporting Pharmacy Benefits and Costs (RxDC) Data Collection ASO, ASO with FI and Level Funded Worksheet

To support the submission of RxDC data due June 1, 2023, UnitedHealthcare must collect P2 and D1 data not contained in our systems. To collect the required information, UnitedHealthcare is requesting completion of an online survey. The following questions will appear in the survey. **You may use this worksheet to prepare.**

Key points:

- The survey must be completed by **March 3, 2023.**
- Once you have completed the survey you cannot go back and make changes. Please notify your UnitedHealthcare representative that you've made an error as there are steps we need to take to override the original response. Your UnitedHealthcare representative will notify you of next steps.
- Completion of the survey will allow UnitedHealthcare to create a master P2 record including all TPAs, PBMs and vendors you do business with. If you do not provide all TPA, PBM and vendor information, the customer or their delegate will need to create the master P2. If another party will submit the master P2, please leave the carve out TPA, PBM and vendor fields blank. You do not need to populate UnitedHealthcare or OptumRx carve in name or EIN, we have this information on file.
- Completion of the survey will also allow UnitedHealthcare to create and submit a UnitedHealthcare specific D1. If you do not wish to have UnitedHealthcare submit the D1, please enter zero (0) in the D1 survey questions. Please notify your UnitedHealthcare representative of intent to file D1 as there are steps they will take to ensure we have documented your intent.
- 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 (ASO), Fully Insured (FI), 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. Multiple UHC Policy numbers should be separated by a semi-colon*	
	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. Please only provide 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)*	
	What are your ASO and other TPA fees paid? (D1) *This is **not applicable for Fully** insured (FI)* *This is a numeric field: no special characters, or slashes.* *Report the ASO and other fees paid to the TPA.* ***Note**: for Level Funded enter '0' in the amount field*	**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.* *Reference the CMS Reporting Instructions, page starting on 21 and 22* ***Note**: if you are a group that selected 'Both' ASO/FI take the average across all plans*	**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.* *Reference the CMS Reporting Instructions, page starting on 21 and 22* ***Note****: if you are a group that selected 'Both' ASO/FI take the average across all plans*	**Employer:**
Do you offer outside TPAs to your employees? (P2) *This is a non-UHC health plan insurer, e.g., Aetna, Cigna etc.* ***Note:*** *Should be able to submit upwards 5 additional health plan vendors* *This field is intended to capture outside TPAs and Issuers.*	**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 other pharmacy benefit plans to your employees? (P2) *This is in reference to non-integrated vendors, e.g., Walgreen, CVS - Caremark etc.*	**If yes, complete the questions a and b**
a) What is the other 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 other 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 other/carveout/external wellness benefits where claims are paid by the external TPA? (P2) **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 other wellness plan vendor name? *Text Field; max 2048 characters, no slashes*	
b) What is the other 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 other/carveout/external behavioral health benefits? (P2)	**If yes, complete the questions a and b**
a) What is the other behavioral plan vendor name? *Text Field; max 2048 characters, no slashes*	
b) What is the other 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) *(does not apply to Level Funded)*	**If yes, complete the questions a, b and c**
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*	