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

February 1, 2023

United Healthcare

CAA Reporting Pharmacy Benefits and Costs (RxDC) Data Collection Fully Insured 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 (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.)*	**Please select Fully Insured radio button**

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 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*	**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*	**Employer:**
	Do you offer another health plan insurer or vendor to your employees? (P2) *This is a non-UHC health plan insurer, e.g., Aetna, Cigna etc.*	**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 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. *Fully Insured external Wellness provider is applicable.*	**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*	