Consolidated Appropriations Act, 2021 (CAA)
Reporting on Pharmacy Benefits and Drug Costs (Div. BB, Title II, Sec. 204)
Prescription Drug Data Collection (RxDC)
Reference Year: 2025

Pharmacy Benefits and Drug Costs Reporting – Prescription Drug Data Collection (RxDC) FAQ

HINT: If you click on 'View' and then on "Navigation Pane" you may jump to different sections in the FAQ without scrolling through each page.

The deadline for submission of RxDC to CMS is 6/1/2026 for Reference Year (RY) 2025 data.

UnitedHealthcare (UHC) designed a UHC Request for Information (RFI) tool to gather the information needed for the RxDC submission to CMS. UnitedHealthcare, Level Funded and Surest will submit the required information via the UHC RFI tool, which is on the portal. UMR customers will receive and complete the UMR Request for Information (UMR RFI) which will be emailed by the UMR account team to the UMR customer.

Please note:

- ***For customers following the standard process, there is no fee for this service.***
- ***When UHC is noted, it includes UHC, Surest, and Level Funded, unless otherwise noted.***

About the UHC RFI tool:

- ***RFI tool will be available February 1, 2026, and will close March 31, 2026.***
- ***Data is required for fully insured (FI), level funded, and self-funded (ASO) customers.***
- ***Customers, even those no longer with UnitedHealthcare, who were active anytime during the 2025 reference year should complete the RFI.***
- ***The UHC RFI tool is integrated with employer and broker portals.***
- ***Either the customer or the broker may submit information into the portal via the UHC RFI tool.***
- ***The UHC RFI tool in the portal allows the customer/broker/consultant to input, save, reopen, add, and change the information until it closes on March 31, 2026.***
- ***The customer or broker may check their status real time and download their completed responses. Please note, brokers must be noted as the agent of record in order to gain access to their customer's data in the tool.***
- ***If a customer has plans on both portals, they can access the RFI for all plans from the same portal.***
    - ***Customers with both a fully insured and ASO plan will be required to submit an RFI for each funding arrangement.***
    - ***Customers with UHC / Surest will need to complete the RFI on the portals***
    - ***UMR customers will complete a separate Request for Information (RFI). The UMR RFI will be emailed to UMR customers by the UMR account team starting the week of February 2, 2026.***

Data Submission:

- ***Data and narratives are submitted for data UnitedHealthcare has in our systems for prior reference year.***
- ***P2 — Group Health Plan List***
- ***D1 — Premium and Life Years***

- ***D2 — Spending by Category (where appropriate)***
- ***D3 — D8 — Pharmacy data required for OptumRx integrated PBM***

Outside PBMs, including OptumRx direct:

- *For customers who use other PBM including OptumRx direct (carve out), the customer must work with that PBM or carrier to submit the data by the required June 1, 2026, deadline.*

ASO customers who want to self-report some or all data

Although not recommended, should a customer prefer to submit all or some of their data directly to CMS, they can do so. This is the not recommended approach as it is significantly time consuming and complex compared to the five question UHC RFI / three question UMR RFI.

When should the customer complete the UHC RFI?

If a customer submits all data directly to CMS, and requests UnitedHealthcare provides the data files UnitedHealthcare has in our systems, the customer will not need to complete the UHC RFI.

However, for partial data requests, the customers must complete the UHC RFI (or UMR RFI) since UnitedHealthcare will be submitting certain data for the customer. See chart for guidance:

Option	Self-Report Options	RFI Required?
1	D1: Premium and Life years ONLY	No
2	D1: Premium and Life Years AND D2: Spending by Category AND D3-D8: Prescription Drug Filings ONLY	No
3	D1: Premium and Life Years AND D3-D8: Prescription Drug Filings	No
4	D3-D8: Prescription Drug Filings ONLY	Yes

What is the due date to notify UHC/UMR that my customer is self-reporting?

ASO customers that plan to submit **all data** must contact their UnitedHealthcare representative, no later than March 31, 2026, to request their data. A fee may apply for D3 - D8.

What is the due date to submit directly to CMS if my customer elects to self-report?

June 1, 2026, for the 2025 reference year.

What is the requirement for customers that want to use the Alternative approach to submit all of the data directly to CMS (ASO customers only)?

It is important for the customer selecting this approach to submit **all data directly to CMS**.

- UnitedHealthcare will provide the customer with the data we have in our system.
- The customer will need to submit the entire report directly to CMS themselves. UnitedHealthcare does not include the data in our RxDC submission for customers reporting their own data in the submission.
  Note: If your customer requests the data files to complete the submission, they do not need to complete the UHC RFI or UMR RFI.

What is the requirement for customers that want to use the Alternative approach to submit some of the data directly to CMS (ASO customers only)?

- UnitedHealthcare will provide them with the data we have in our system.
- For partial data requests, the customer may still need to complete the UHC RFI or UMR RFI since UnitedHealthcare will be submitting data for the customer as well. See chart for guidance:

Option	Self-Report Options	RFI Required?
1	D1: Premium and Life years ONLY	No
2	D1: Premium and Life Years AND D2: Spending by Category AND D3-D8: Prescription Drug Filings ONLY	No
3	D1: Premium and Life Years AND D3-D8: Prescription Drug Filings	No
4	D3-D8: Prescription Drug Filings ONLY	Yes

If a customer states they are submitting their data directly to CMS, does UHC submit the D2 on their behalf?

No.

Most Common Questions for the UHC RFI Tool

What information is available to support the RxDC process?

Please note, the links to these documents will be updated by Jan. 15, 2026. As they are finalized the updated link will be added.

The following resources are available on the uhc.com RxDC Page:

- Brainshark Tutorial - external
- UnitedHealthcare's CAA Pharmacy Benefits and Costs FAQ – external
- UnitedHealthcare Pharmacy Benefits and Costs Guide - external
- RxDC RFI Worksheet - external

As a customer, how do I report a technical RFI issue?

Send an email to: CAA RxDC Tech Support (caa_rxdc_tech_support@uhc.com). Include the following information in your email:

- Employer Group Name
- Group Policy Number(s)
- Description of issue and screenshot of error

To sign in to complete the RFI, what access must a customer or broker have?

Anyone at the employer group with **eligibility access** to eServices portal can complete the RFI.

For the broker, they must be listed as the agent or broker of record.

Why can't the broker see their customers profile in the RFI tool?

The brokers must have the group in their profile to see in the UHC RFI tool.

Not seeing a customer's profile may be because they are not listed as the broker of record or some other reasons. To add a group to the broker's profile, the brokers must contact the eservices customer line. The contact information is available on the eservices site.

Why is the customer seeing duplicate RFIs on the RFI tool?

If there are duplicates, check the funding type first.

1. If they are the same funding type, the customer should just complete one RFI. The customer may ignore the second one.
2. When there are two funding types, the customer must complete each one.

What if the customer logs in and sees an incorrect name with the policy number?

Send an email to: CAA RxDC Tech Support (caa_rxdc_tech_support@uhc.com). Include the group Name and correct Group Policy Number.

What if the customer logs in and sees the correct name and policy number but incorrect EIN?

If the EIN is incorrect, complete the RFI.

- Then follow the standard process to correct the EIN.
- If the EIN is corrected prior to Dec. 31, 2025, it should be updated in the RFI when refreshed January 8, 2026.

If a customer provided data to us to do the complete submission for the prior reference years, do they need to provide information again this year?

Yes. Data may change from year to year, so we will collect it each year. If an RFI was completed for the prior year, the information is still available under the Prior Years RFI section in the RFI.

What can a group do if they have termed?

A termed group can still access the portal. They may need to reset their password.

How can I check if my group completed the RFI?

There is a new report the broker may get from their UHC account representative that provides the employers for whom the broker is the Agent or Broker of Record and the status of their UHC RFI.

If the group or broker made an error inputting information in the UHC RFI, how can it be fixed?

- The error can be corrected by logging back into the UHC RFI, select the Employer Group Name to open the RFI, make applicable updates, then re-submit.
- This is available until the RFI closes, March 31, 2026.

Why didn't my customer receive the communication?

- If a customer didn't receive the communications, they should reach out to their UHC account representative.

Should the premium include dental, pharmacy and vision if it is integrated with medical?

Yes.

If any standalone specialty products are not integrated with the medical, they should not be included in the RFI response.

What is the process if a UMR customer did not receive a UMR Request for Information (RFI)?

They should reach out to their UMR account representative.

Refer to the section in the FAQs specific to UMR approach.

If a customer is new as of 1/1/26, do they need to complete the RFI?

Not with UHC. The customer should work with their prior carrier since the reporting is for reference year 2025.

Things to remember

As the pharmacy benefits and costs reporting submission deadline approaches, keep the following reminders in mind when having discussions with brokers, consultants, and customers:

1. UnitedHealthcare will update the collection of data to submit for clients based on the current CMS Instructions.
2. UnitedHealthcare submits Pharmacy Benefits & Costs Reporting data directly to CMS by the June 1 deadline, each year for the prior reference year.
3. UnitedHealthcare submits the RxDC report directly to CMS for NA, KA, PS and Surest® ASO customers by June 1 each year. There are two options available for self-funded groups:
    - **Standard approach** (all ASO, Level Funded and fully insured): UnitedHealthcare will submit all data and appropriate narrative for plans administered by UnitedHealthcare and OptumRx carve in (integrated).
        - UHC customers will be requested to complete an UHC RFI on the employer/broker portal beginning February 1, 2026. Deadline for completion is March 31, 2026.
        - UMR customers will receive a UMR RFI beginning on February 2, 2026. Deadline for completion is March 31, 2026. The UMR RFI is sent in an email from the customer's UMR account representative.
        - Customers that do not complete the UHC or UMR RFI will need to submit the information that is not contained in a UHC system directly to CMS by June 1, 2026.
    - **Alternative approach (ASO only)**: the customer may request their data from UnitedHealthcare by March 31, 2026. The customer will then be required to submit the data and appropriate narrative or engage a third party to submit the data directly to CMS for them by June 1, 2026.

Note: Customers who use an outside PBM (Pharmacy Benefits Management) including OptumRx Direct must coordinate with the PBM to ensure all required data is submitted by the deadline.

4. UMR customers will receive the UMR RFI via email starting February 2, 2026. UMR RFIs must be completed by March 31, 2026.
5. **Fully insured:** UnitedHealthcare is responsible to submit required data for all fully insured groups. UnitedHealthcare will be collecting information not in our systems via the UHC Request for Information (RFI) on the portal. If the UHC RFI is not completed by March 31, 2026, the fully insured customer must submit the missing information directly to CMS by June 1, 2026. UnitedHealthcare submits all the data in our system.

6. **Self-funded (ASO):** Customers must provide the information requested in the UHC RFI on the employer/broker portal. Customers may use the RxDC Prescription Drug Costs Reporting (RxDC) Guide as a resource.
7. UnitedHealthcare does not provide the customer or broker copies of RxDC reports submitted directly to CMS.
8. All data files submitted are in the aggregate as defined by CMS.
9. UnitedHealthcare submits the appropriate narrative for each data file submitted.
10. Each data file submission requires a corresponding plan file (example: P2).
11. UnitedHealthcare produces the P2 using information from the 5500 filing and UHC systems.
    - UHC reconciles the Group Health Plan Name based on the Plan Sponsor name in the 5500; where feasible.
    - Group Health Plan Number requires a unique plan identification number.
    - UHC uses the EIN from our system as the unique plan identification number.
    - For companies that use multiple EINs, UHC will use the primary EIN as noted in our UHC systems.
12. UHC is unable to incorporate external data or update data if there are discrepancies. If there are data mismatches, UHC will reconcile with CMS directly.
13. For ASO groups that choose to submit the data directly to CMS themselves, UnitedHealthcare will provide the required data to customers submitting their own data beginning May 15, 2026.

Important: Signing up for access to the CMS submission portal and following the extensive instructions and process CMS provides is more complicated than answering the few questions we ask in the UHC RFI. In fact, the questions in the UHC RFI are also required for the customer that chooses to submit themselves. Remind the customer or brokers that in most cases it is significantly easier to complete the UHC RFI.

What should a customer do if they have questions on how to calculate D1?

Refer to the CMS site for the Pharmacy Benefits and Costs reporting instructions.

If a group moved from the Prime platform to Cirrus, does it matter which policy number they enter the RFI under?

If it is the same funding arrangement, it does not matter. If it went from fully insured to level funded (mid-year) they would have to complete two RFIs (one for each funding arrangement).

If a group changed their Employer Group Name, should they use their old name or their new name when completing the RFI?

They should use the name that was in place at the end of the reference year.

If an employer has union and non-union under one policy, is it still one submission?

Yes.

Rx Reporting Overview of Regulation

What are the reporting benefits and cost requirements?

Section 204 of Division BB, Title II (Section 204) of the Consolidated Appropriations Act, 2021 requires group health plans and health insurance issuers offering group or individual health insurance coverage to submit information about prescription drugs and health care spending to the Department of Health and Human Services (HHS), the Department of Labor (DOL), and the Department of the Treasury (the Tri-Agencies/Departments).

In addition, the Director of the Office of Personnel Management (OPM) requires Federal Employees Health Benefits (FEHB) carriers to submit Section 204 data to HHS. The Centers for Medicare & Medicaid Services (CMS) within HHS is collecting Section 204 data submissions on behalf of the Tri-Agencies/Departments and OPM.

CMS instructions for submitting data are on the CMS site.

How is the reporting organized? Is there a required standard of reporting?

Data is reported by reference year.

- The data that will be reported June 1, 2026, will be for the 2025 reference year.
- This information must be aggregated at the state/market level, rather than separately for each plan.
- The guidance provides uniform standards and data definitions, including standards for identifying prescription drugs regardless of the dosage strength, package size, or mode of delivery.
- These uniform standards for submitting data are designed to allow the Tri-agencies and OPM to conduct meaningful data analysis and identify prescription drug trends.

What is being reported regarding prescription drug rebates, fees and other remuneration paid by the drug manufacturer?

The total fee must be reported. Fees are not required to be reported separately for each drug therapeutic class.

Reporting includes the following in the total fee:

- Renumeration received by and on behalf of entities providing pharmacy benefit management services regardless of the source (e.g., pharmaceutical manufacturer, wholesaler, retail pharmacy or vendor).

- Discounts, chargebacks, or rebates.
- Cash discounts, free goods contingent on purchase agreement.
- Upfront payments, coupons, goods in kind.
- Free or reduced-price services, grants, or other price concessions.
- Bona fide service fees paid by a drug manufacturer to the PBM that represent fair market value for itemized services performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the arrangement. The definition includes amounts that may be retained by the plan administrator and not shared with the health plan.

Refer to CMS instructions, Section 9.

What is the deadline for submitting the report directly to CMS?

The deadline is annually on June 1, subsequent to the reference year. The reference year is the calendar year immediately preceding the calendar year in which the RxDC report is due.

Example: The RxDC report for the 2025 reference year, which is due in 2026, should contain information based on what happened in calendar year 2025.

Customers that are partial year for the reference year are included for those months.

Customers that are new after December 31 of the reference year are not included and are not required to complete an RFI.

Refer to CMS instructions, Section 1.2, for additional detail.

If a business is acquired during the year by another business, who is responsible for the reporting?

The acquiring entity.

How does data have to be organized for reporting?

Data is submitted separately by market -

- Fully insured small group, large group.
- Self-funded small group, large group
- Federal Employees Health Benefits

Mixed funded plans report based on type of coverage (e.g., self-funded PBM benefit reports under self-funded market and fully insured medical benefit reports under group insurance).

The insurer or group health plan reports as follows:

- Insured group business is reported for the state where the contract is issued (except for association coverage).
- Self-funded group business is reported for the state where the plan sponsor has its principal place of business.
- Health coverage provided through a group trust or MEWA is reported for the state where the employer or association has its principal place of business or the state where the association is incorporated (for associations with no principal place of business).

Can different entities report data for a group health plan?

Yes. A group health plan may have separate entities report data such as a TPA for medical coverage and a PBM for pharmacy benefits, or the group may report the data directly to CMS themselves by requesting data from the TPA, PBM, or other entity.

Does the aggregation state equal the situs state or states where the plan is offered?

For self-funded plans, the aggregation state is the state where the plan has its principal place of business.

For fully insured plans, the aggregation state is the state where the policy was issued.

For more details, refer to CMS Instructions, Section 5.4.

What if a member's plan is situsued in one state, but services are rendered in another (snowbirds, students), would they report both states?

- **Self-funded plans**: The aggregation state is the state where the plan has its principal place of business.
- **Fully insured plans:** The aggregation state is the state where the policy was issued.
- For more details, refer to CMS Instructions, Section 5.4.

Would a mailed or 90-day pharmacy script be considered one script or three scripts?

A 90-day script is one script.

Scope of the RxDC Reporting

To whom does the reporting of pharmacy benefits and costs apply?

The reporting requirement applies to:

- Health insurance issuers offering **group coverage.**
- **Fully insured and self-funded group health plans**, including:
  - Employer and union sponsored group plans.

- Non-federal governmental plans, such as plans sponsored by state and local government.
- Church plans that are subject to the Internal Revenue Code.

- **FEHB plans**
- Health insurance issuers offering **individual market coverage**, including:
  - Exchanges
  - Student health plans
  - Plans sold exclusively outside of the Exchanges
  - Individual coverage issued through an association

Out of Scope

The reporting requirement does NOT apply to:

- Account-based plans, such as health reimbursement arrangements (HRA, HSA)
- Employee Assistance Programs (EAP).
- Except benefits including but not limited to short-term limited-duration plans.
- Hospital or other fixed indemnity insurance.
- Disease-specific insurance.
- Non-commercial plans such as Medicare Advantage and Prescription Drug plans, Medicaid managed care plans, state children's health insurance program plans and Basic Health Program plans.
- Retiree only plans with more than 1 active employee.

What is a retiree only plan?

A retiree only plan is a group health plan with no more than one active employee. A retiree only plan would have its own SPD and Form 5500 as outlined by the Department of Labor (DOL).

Does the Pharmacy Benefits and Costs reporting apply to retiree only plans?

Retiree plans are in scope if they have more than one active employee. Most retiree only plans do not have any active employees and are out of scope.

UnitedHealthcare will include all customer data in the policy (including retiree) in the Pharmacy Benefits and Costs data submission.

- Member counts may include retiree data submission.
- Premium data is averaged across the entire policy.
- Note: if the retiree only plan rolls under a master policy that includes both active and retirees, the data will be included for all the plans in the policy.

Does pharmacy benefits and costs include COBRA membership-count?

We do not include COBRA in the counts.

Does cost sharing assistance a drug manufacturer provides to a member have to be included in the reporting?

To the extent these amounts impact total annual spending by health plans or by participants, beneficiaries, and members/enrollees, the amounts must be included in the total health care spending data.

Does the number of enrollees include all members/enrollees even if they were not enrolled for the entire plan year?

Yes. The count is based on the number of plan participants covered on the last day of the reference year for the reporting.

Are customer networks included in the data submitted?

We will include all data requested, including CSP (for example: Progyny) as long as we pay the claims.

UnitedHealthcare Approach to RxDC Reporting June 1

Will UnitedHealthcare take in and submit other vendor data?

No, UnitedHealthcare will only submit data for plans administered by UnitedHealthcare.

Does UnitedHealthcare sign a contractual agreement regarding UnitedHealthcare's support for submitting the CAA Pharmacy Benefits and Costs data?

UnitedHealthcare does not have to sign a separate contractual agreement. The ASA language covers UnitedHealthcare responsibility. Therefore, there is no requirement to sign other agreements for our clients.

The Parties agree to comply with all applicable federal, state, and other laws and regulations in its performance under this Agreement.

Refer to the CMS instructions, Section 1.1, Compliance with Laws, and Regulations.

In what format will UnitedHealthcare provide the data directly to CMS?

In the required csv format

If a customer wishes to streamline the P2 health plan number to accommodate their vendors, can UnitedHealthcare accept a custom group health plan number from the customer and use in in our P2 submission rather than use the EIN?

No. UnitedHealthcare is unable to accept any customization of data.

How will UHC aggregate and submit the D2?

- If this is a fully insured plan - it's aggregated at the issuer level - "Group by same Issuer."
- If this is a self-funded plan it's aggregated at TPA level - "Group by same TPA."

What communications are sent to customers reminding them to complete the RFI?

UnitedHealthcare sends communications through the Connect electronic newsletter to customers, brokers, and consultants regarding collection of data needed for UnitedHealthcare to submit data directly to CMS for the RxDC reporting requirement.

UnitedHealthcare representatives may also send the RxDC RFI email to their customer contacts and key brokers to ensure they receive the communication.

The customer accepts the risk for data elements not provided to UnitedHealthcare. In addition, the customer or another reporting entity will need to submit RxDC data and narrative directly to CMS by June 1, 2026.

CMS instructions for submitting data are on the CMS site.

What is UnitedHealthcare's approach to supporting RxDC reporting for June 1?

Under the Consolidated Appropriations Act (CAA), health insurers offering group or individual health coverage, and self-funded (ASO) group health plans are required to report data annually regarding prescription drugs and health care spending to the Departments of Health and Human Services, Labor, and Treasury (Tri-Agencies). This information must be submitted directly to CMS by June 1, 2026, for reference year 2025 data, through a web portal set up by the Centers for Medicare & Medicaid Services (CMS).

The UnitedHealthcare approach for customers:

Standard approach (all ASO, Level Funded and fully insured groups): UnitedHealthcare will submit all data and appropriate narrative for plans administered by UnitedHealthcare and OptumRx carve-in (integrated).

UnitedHealthcare will submit the P2 (group health plan), D1 (premium and life years), and D2 (spending by category) and the appropriate narratives for all customers with active coverage during the reference year.

- For customers with OptumRx integrated PBM, UnitedHealthcare will also submit the D3-D8 files.
- For customers that use any other PBM, including OptumRx Direct, the customer will need to work with that PBM to submit the D3-D8 files.
- There is no fee for customers that use the standard approach.

Annually, UnitedHealthcare will collect data from each customer to complete the RxDC submission. To obtain the data, UnitedHealthcare requests all customers to complete an UHC RFI or UMR RFI to collect the necessary data elements by March 31, 2026.

If the UHC RFI or UMR RFI response is not completed by March 31, 2026, UnitedHealthcare plans to submit the data in its system on or before the June 1, 2026, reporting deadline. However, the submission will not be complete.

UnitedHealthcare will send a reminder message to the customers explaining if they did not complete the RFI in the employer/broker portal, they would be obligated to submit P2 and D1 data as outlined in the communication.

Alternative approach (ASO / Level Funded only): The customer is able to request its data from UnitedHealthcare and submit the data and appropriate narrative or engage a third party to submit the data for them.

Note: Customers that use an outside Pharmacy Benefits Manager (PBM), including OptumRx Direct, must coordinate with the PBM to ensure all required data is submitted by the deadline.

Can fully insured and Level Funded self-report directly to CMS themselves?

Fully insured and Level Funded groups **cannot** self-report. UnitedHealthcare will submit on behalf of these customers. However, UnitedHealthcare is requesting certain data be submitted via the UHC RFI from fully insured and Level Funded customers to support the submission.

What are ASO UnitedHealthcare legal entities EINs?

Legal Entity	EIN
United HealthCare Services, Inc.	41-1289245
UMR, Inc.	39-1995276
Surest (BIND Benefits, Inc.)	81-4560965
OptumRx, Inc.	33-0441200
HealthSCOPE Benefits, Inc.	71-0847266

If the customer has an EIN that is changing, what should they do?

If the customer has changed the EIN for any reason, they should contact their UnitedHealthcare representative, and the EIN can be updated through the normal process. If corrected by Dec. 31, 2025, the updated EIN will be in the January 8, 2026, refresh. If not, the system will be updated, but not for the RxDC 2026 reporting.

What should be used for Group Health Plan Name?

Group health plan name (GHPN) 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.

When submitting information or providing UHC with information so we can submit it for the customer, what is required is 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. Note: This may not match the name on the UnitedHealthcare ID card.

For customers with direct or carve out OptumRx, will UnitedHealthcare or Optum submit the report?

It's OptumRx responsibility to submit D3-D8 data.

Rx Data Reporting Calculation

How do the reports require insurers and health plans to report Average Monthly Premiums Paid, Earned Premium, and Premium Equivalents?

The premium must be reported by average monthly premium, by premiums impacted by fees and remuneration, and by any reduction in premiums and out-of-pocket costs as follows:

1. **Average monthly premium:**
    - Paid by employers on behalf of members/enrollees; and
    - Paid by members/enrollees.

2. **Premiums impacted by rebates, fees, and any remuneration** paid by a drug manufacturer to the plan or coverage or administrators or service providers, including:
    - Amounts paid for each therapeutic class of drug, and
    - Amounts paid for each of the 25 drugs that yielded the highest amount of rebates and other remuneration.

3. **Any reduction in premiums and OOP costs** associated with rebates, fees, or other remuneration.

Refer to CMS instructions, section 6.1, for definitions of "Average monthly premium", Earned Premium", and "Premium equivalents".

What should be included as part of the 2025 reference year for the June 1, 2026, submission?

Average Monthly Premium Paid (AMPP) Member/Employer should represent premium in the reference year only, for all months the employer had services/coverage with UnitedHealthcare.

What is a reference year?

The Pharmacy Benefits and Costs report for 2025 reference year means the information in the report is based on what happened in calendar year 2025. This report will be submitted directly to CMS by June 1, 2026.

Refer to CMS instructions, Section 1.2.

How are the reports submitted for non-calendar year plans?

Both calendar year plans January 1, 2025, to December 31, 2025 (1/1/25 – 12/31/25) and non-calendar plans (e.g., 7/1/24 – 6/30/25 renewed 7/1/25 – 6/30/26) are required to submit a full year of data related to the 2025 reference year.

For the P2 filing, calendar year plans will be reflected by a single record while non-calendar year plans will be reflected by two records distinguishable by the beginning and end periods of the plan.

For the 'D' filings, both calendar year and non-calendar year plans will contain data for the reference year the plan was in force with UnitedHealthcare.

If a plan decides to self-submit, then they should go to the CMS instructions for details on how to self-report.

What should be included in the average monthly premium paid (AMPP) calculation?

The following should be included in the associated premium amounts in the Average Monthly Premium Paid (AMPP) member/employer amounts.

1. Pharmacy, Dental, Vision, Behavioral provided by a UHC company and integrated with the Medical Plan
2. Stop Loss policy underwritten by a UHC company.

What should NOT BE INCLUDED in the average monthly premium paid (AMPP) calculation?

The following should be EXCLUDED from the associated premium amounts in the Average Monthly Premium Paid (AMPP) member/employer amounts. This data should be submitted by the non-affiliated reporting entity contracted to provide the services/coverage.

1. Pharmacy, Dental, Vision, and Behavioral that is not integrated (carved out or standalone). This includes OptumRx direct (carve out).
2. Stop Loss policy not underwritten by a UHC company.
3. Additional Medical Plans with a company other than UHC.

What is considered "wellness" under the Rx Reporting requirement?

For the purposes of the RxDC report, wellness services are defined as activities primarily designed to implement, promote, and improve health.

- If a wellness service is billed on a claim, include it in the "Other medical costs and services" spending category in data file D2 Spending by Category.

- If a wellness service is not billed on a claim or is not a covered service under a plan or policy, do not include it anywhere in the RxDC report.

Go to CMS instructions, Section 7.2.

Does cost sharing assistance a drug manufacturer provides to a member have to be included in the reporting?

To the extent these amounts impact total annual spending by health plans or by participants, beneficiaries, and members/enrollees the amounts must be included in the total health care spending data.

What is total annual spending based on?

The total spend is based on claims incurred as defined under the Medical Loss Ratio (MLR) regulation including cost sharing.

- Spending excludes certain MLR reporting adjustments to incurred claims (drug rebates/price concessions, payments recovered through fraud reduction, and payments for risk adjustment programs).
- Spending is net of any drug rebates, fees or other renumeration.
- The calculation is based on claims incurred paid through March 31 of the year immediately following the reference year.

For more details about Hospital and Medical spend (excluding spend under a PBM), refer to CMS instructions, Section 7.

For more details about PBM spend, refer to CMS instructions, Section 8.4.

What count of members (enrollees, beneficiaries) is required?

- For the P2 the number of plan participants covered on 12/31 of the reference year.
- For D1, the average number of members during the reference year is called life years.
- June 1, 2026, submission is for the 2025 reference year.

How is monthly premium calculated?

Average monthly premium paid by members:

- Calculate the average monthly premium (or premium equivalent) by taking the total annual premium (or premium equivalents) paid by members during the reference year and dividing by 12. Divide by 12 even if the coverage was not in effect for the entire calendar year.
- Fully insured and self-funded must be calculated and reported separately.

Average monthly premium paid by employer:

- Calculate the average monthly premium (or premium equivalent) by taking the total annual premium (or premium equivalents) paid by the employer on behalf of members

during the reference year and dividing by 12. Divide by 12 even if the coverage was not in effect for the entire reference year.
- Fully insured and self-funded must be calculated and reported separately.

What does the member premium include?

Include:
- Premium insured by UHC or premium equivalents administered by UHC that is paid by members for medical and pharmacy coverage.
- Member payments for COBRA coverage, including the 2% administrative fee.
- Spousal and tobacco surcharges if applicable.

Exclude:
- Premium or premium equivalents paid by employers or other plan sponsors on behalf of members.

What does the employer premium include?

Include:
- Premium or premium equivalents paid by employers and other plan sponsors on behalf of members (including dependents) for medical and pharmacy coverage administered by UHC.
- Premium or premium equivalents paid by group trust, association, or MEWA plans if separate employers or other plan sponsors make premium contributions.

Exclude:
- Premium or premium equivalents paid by members.

How should customers calculate the total monthly premium paid by members and paid by the customer?

An example is shown below for the full calendar year. If the customer was only with UHC for part of a year, the amounts paid by members and customers would only show for those months for the reference year and a zero for other months. However, the amount would still be divided by 12 based on the CMS instructions.

Average Month Calculation -- Example: Full Calendar Year

	Total Premium (or premium equivalents)		
Month	**Paid by Members**	**Paid by Employers[2] (on behalf of members)**	**Paid by Plan (Total)**
January	$ 5,675	$ 13,243	**$ 18,918**
February	$ 6,426	$ 14,994	**$ 21,420**
March	$ 6,426	$ 14,994	**$ 21,420**
April	$ 6,784	$ 15,829	**$ 22,614**
May	$ 6,784	$ 15,829	**$ 22,614**
June	$ 6,784	$ 15,829	**$ 22,614**
July	$ 7,497	$ 17,494	**$ 24,991**
August	$ 7,497	$ 17,494	**$ 24,991**
September	$ 7,497	$ 17,494	**$ 24,991**
October	$ 6,932	$ 16,174	**$ 23,106**
November	$ 6,932	$ 16,174	**$ 23,106**
December	$ 6,932	$ 16,174	**$ 23,106**
Total	**$ 82,167**	**$ 191,724**	**$ 273,892**
	Total A	***Total B***	

Average Monthly Premium Paid:	**$ 6,847.29**	**$ 15,977.00**	**$ 22,824.29**

In this example:

- Employer has a medical policy with UHC for full calendar year.
- Coverage period - 1/1/25 – 12/31/25
- Calendar period – 1/1/25 – 12/31/25
- Employer paid portion is 70% of the total plan premium (or premium equivalents) paid.
- Divide by 12 even if the coverage was not in effect for the entire 12 months of the reference year.

- **Average Monthly Premium Paid by Members = Total A divided by 12**

  Calculation: $82,167 / 12 = **$6,847.29** ← **Amount to populate RFI**

- **Average Monthly Premium Paid by Employers = Total B divided by 12**

  Calculation: $191,724 / 12 = **$15,977.00** ← **Amount to populate RFI**

Notes:

- For self-funded plans, this is total plan costs minus premiums paid by members.

- Based on most recent CMS instructions.
- For RFIs containing multiple policies **all** policies should be included in the calculation.

UMR Approach for Data Collection and RxDC Reporting

What is UMR's approach for RxDC data collection?
UMR Account Management representatives will distribute a request for information (RFI) to their customer for completion. UMR RFI must be completed by March 31, 2026.

When will UMR's RFI be ready for customer distribution?
February 2, 2026.

How will UMR's customers data be collected from the RFI? (for internal FAQ only)
UMR customers will complete a separate Request for Information (RFI).

- The UMR RFI will be emailed to UMR customers from their SAE starting the week of February 2, 2026.
- The UMR RFI must be completed by March 31, 2026

Where does Account Management go for questions regarding UMR RFI process (for internal FAQ only)?
Email the UMR Healthcare reform team at healthcarereform@umr.com.

What does "majority" of the Group Health Plan's benefits mean?

Until further clarification by CMS, the term "majority" is interpreted by UMR to mean the entity that administers the bulk of the health plan's benefits.

If UMR administers the claims for a separate Optum Behavioral Health contract will this data be included in the UMR filing?

If the claims data is stored in UMR's system, the data will be included in the medical cost spending (D2) file.

RxDC Resources

The following resources are available on the uhc.com RxDC Page

- Brainshark Tutorial – external
- UnitedHealthcare's CAA Pharmacy Benefits and Costs FAQ – external
- UnitedHealthcare Pharmacy Benefits and Costs Guide - external
- RxDC RFI Worksheet - external

Where can customers find more information about Pharmacy Benefits and Costs reporting, also referred to as RxDC?

Go to the CMS website at https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/prescription-drug-data-collection

Customers may sign up for email announcements and register for training webinars at the Registration for Technical Assistance Portal (REGTAP) at https://regtap.cms.gov/rxdc.php.

If a customer is unable to locate an answer to their question in REGTAP, they may contact the help desk at 1-855-267-1515 or go to CMS_FEPS@cms.hhs.gov.

- Remember to include “RxDC” in the body of the email for faster service.
- Generally, a response is provided on the same day and a full resolution within 1-2 weeks.

What are the links to CMS for training, instructions, and other support to report through CMS portal?

- CMS Reporting Instructions
- CMS Training Resource Library
- CMS RxDC FAQS
- CMS RxDC Home page

UnitedHealthcare resource support:

- Pharmacy benefits and costs guide
- UHC RxDC Worksheet
- Data Resource Connect
- Brainshark Video (covers how to complete RFI to provide data for UHC to submit data for UHC administered medical and pharmacy coverage by June 1).