



Consolidated Appropriations Act Pharmacy Benefits and Drug Costs Reporting Guide

Reference Year 2025
RFI deadline 3/31/2026
(for RxDC filing due to CMS 6/1/2026)

Important:

The content in this guide reflects UnitedHealthcare and OptumRx carve-in/integrated approach.
The guide's content is based on the most recent [CMS RxDC Reporting Instructions](#).
This guide will be updated if additional requirements are received from CMS.

December 2025



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UNITEDHEALTHCARE PROPRIETARY AND CONFIDENTIAL. Customers should discuss plan changes with their legal counsel and tax professionals.

Reporting Pharmacy Benefits & Drug Costs Data

UnitedHealthcare **approach is outlined below** for National Accounts, Key Accounts, Public Sector, Level Funded, Small Business and Surest customers for the June 1, 2026, submission of 2025 Prescription Drug Data Collection (RxDC) data.

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

1. **Standard** - UnitedHealthcare submits all data directly to CMS
2. **Alternative** - Customer submits all data directly to CMS {ASO only excluding Level Funded (LF), LF follows Standard approach}

Standard approach applies to ASO, LF and FI customers; no fee is charged to customers following this approach.

UnitedHealthcare submits all data and appropriate narratives directly to CMS for plans administered by UnitedHealthcare and OptumRx carve-in/integrated.

- UnitedHealthcare will submit the P2 (Group Health Plan list), D1 (Premium and Life Years), and D2 (Spending by Category) files for all customers who had coverage in the 2025 reference year.
- For customers with OptumRx carve-in/integrated PBM, UnitedHealthcare will also submit the D3-D8 files.
- For customers who use any other Pharmacy Benefits Manager (PBM), including OptumRx Direct, the customer will need to work with that PBM to submit the required files directly to CMS by the deadline.
- For customers where UnitedHealthcare does not underwrite/pay the stop loss, the customer will need to work with their stop loss vendor to submit the stop loss data directly to CMS by the deadline.
- **Terminated Groups:** UnitedHealthcare will follow the **standard approach** for all groups that were active in 2025. If the Request for Information (RFI) is not completed, UnitedHealthcare will submit the data it has in its systems directly to CMS. However, the submission **will not be complete**. Data elements not provided to UnitedHealthcare through the RFI process must be submitted directly to CMS by the terminated group.

Action Required: Some RxDC required data elements are not stored in UnitedHealthcare's systems. To complete the RxDC submission, UnitedHealthcare requires customer specific data. This data will be collected through a RFI.

- If the RFI is not completed by the customer, UnitedHealthcare will submit the data it has in its systems directly to CMS on or before the June 1st due date. However, the submission **will not be complete**.
- Data elements not provided to UnitedHealthcare through the RFI process must be submitted directly to CMS by the health plan (customer) or another reporting entity.
- The health plan (customer) accepts any risk arising from the failure to provide requested information to UnitedHealthcare.
- Data submitted directly to CMS by UnitedHealthcare will not be provided to the customer.
- The UHC RFI opens **February 1, 2026**. The UHC RFI must be completed by customers/brokers by **March 31, 2026**.
- 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**.



Alternative approach applies to ASO only (not available for FI or LF customers).

The customer may request their (D1-D8) data from UnitedHealthcare to submit directly to CMS.

- If the customer is submitting all data directly to CMS, UnitedHealthcare must receive the request by **March 31, 2026**.
- There may be a fee for UnitedHealthcare to provide the required data files.
- Data will be sent to the requestor by May 15, 2026.

CMS Data Requirements

Requirements: Plans, issuers, and carriers must submit one or more plan lists (P1, P2, P3), eight data files (D1 through D8), and a Narrative response, where appropriate.

▶ 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, excluding 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 require 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 a P2 when multiple reporting entities file with CMS.

- 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**. Customers with carve out arrangements are required 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. 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: A narrative response is required to describe the impact of prescription drug rebates on premium and cost sharing. UnitedHealthcare will also submit narrative responses, where appropriate. Please note, UnitedHealthcare is unable to customize the narrative by customer.

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Reporting Data Definitions

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 customer specific reporting.

D1: Premium and Life Years:

Premium Equivalents: 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 the [CMS 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 National Drug Code (NDC) associated with the RxDC brand name drug.
- 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 (Continued)

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.

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Legal Entity and EIN

The table below includes the Self-Funded (ASO) Legal Entity and EIN combinations for UnitedHealthcare, OptumRx (carve-in) and other business entities. These can be used to populate the company name when self-reporting.

Legal Entity	EIN
United HealthCare Services, Inc.	41-1289245
UnitedHealthCare Service LLC *	47-0854646
OptumRx, Inc.	33-0441200
HealthSCOPE Benefits, Inc.	71-0847266
UMR, Inc.	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 only	

ASA Language

ASA language covers the Consolidated Appropriations Act provisions including that UnitedHealthcare 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.”

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Alternative approach available to ASO customers who self-report to CMS directly

Self-funded customers that elect to self-report data directly to the CMS HIOS portal may make a request for summarized data files and narrative through their UnitedHealthcare representative.

- If the customer is submitting all data directly to CMS, UnitedHealthcare must have received the request by **March 31, 2026**.
- There may be a fee for UnitedHealthcare to provide the required data files, when it includes pharmacy data.
- Data is only provided to the customer if they complete the filing directly with CMS.
- When a customer chooses this option, that employer group will be excluded from the aggregate reports that UnitedHealthcare submits directly to CMS.
- Customers may be required to sign a non-disclosure agreement (NDA).
- The requested data and appropriate narrative will be provided to the customer or their delegate by May 15, 2026.
- ASO groups with carve-out arrangements or plans not administered by UnitedHealthcare 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:
 - ▶ D1: Premium and Life Years
 - ▶ D2: Spending by Category
 - ▶ D3 to D8 (In total)
- For OptumRx Direct (carve-out) business, the customer must obtain data from OptumRx directly.

OptumRx Direct

- Customers with OptumRx Direct (carve-out) will work directly with their OptumRx representative on the submission of pharmacy data.
- OptumRx Direct (carve-out) customers received a request from OptumRx to confirm the D2 approach.
- OptumRx Direct will report at the aggregated level.

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Submission Confirmation and CMS Reference links

Confirmation of completion of submission of RxDC data to CMS:

- The confirmation number will be posted in the news section on uhc.com.
- Your account team will receive a confirmation by June 1, 2026, 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
Prescription Drug Data Collection (RxDC)	Primary filing resources for instructions and templates HIOS access guide and user manual
CMS Help Desk	Contact: 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.

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