Consolidated Appropriations Act Frequently Asked Questions

External

5/10/21

United Healthcare

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Consolidated Appropriations Act Overview

The Consolidated Appropriations Act, 2021 (H.R. 133) is a $2.3 trillion spending bill that combines $900 billion in stimulus relief for the COVID-19 pandemic in the United States with a $1.4 trillion omnibus spending bill for the 2021 federal fiscal year.

General FAQs

Are Short Term Limited Duration Plans in or out of scope for Consolidated Appropriation provisions? New 4/26/21

Short term limited duration insurance is out of scope for the CAA provisions including No Surprises, except for the broker and service provider compensation reporting for the individual market where STLDI is specifically called out.

Last updated 5/10/2021

No Surprises Act Key Provisions

No Surprises

What was required under No Surprises law that is part of the Consolidated Appropriations Act? Update 3/22

The No Surprises Act prohibits surprise medical bills and is designed to hold consumers harmless in connection with reimbursement disagreements between a health insurer or group health plan and out-of-network providers. In addition, the law requires that certain information about estimated costs be provided to patients in advance of scheduled medical services. These provisions are set to go into effect for plan or policy years beginning on or after January 1, 2022.

The No Surprises Act is a law establishing federal standards to resolve surprise bills for the fully insured individual, small group, and large group markets and for self-insured group plans including Exchanges, grandfathered and transitional relief plans for plan and policy years beginning on and after January 1, 2022. The surprise billing standards also apply to the Federal Employees Health Benefits Program. The law applies to emergency services at out-of-network (OON) hospitals and free-standing emergency facilities, OON providers at in-network (INN) facilities, and OON air ambulance carriers.

The No Surprises Act establishes an Independent Dispute Resolution (IDR) process, also referred to as arbitration, to resolve disputes between OON providers and insurers/health plans and prohibits balance billing by OON providers with certain exceptions. The law does not apply if the member chooses to receive items and services from an OON provider.

The legislation leaves many details to be worked out by the relevant agencies (the Departments of Labor, Health and Human Services, and the Treasury) via rulemaking that is expected throughout 2021.

As with other federal and state laws, UnitedHealthcare is committed to comply with the new requirements and to keep our clients informed on UnitedHealthcare's approach and options for self-funded clients.

Which plans are included, and which plans are excluded from the No Surprise Law? Update 3/22

The federal law applies to individual, small group, and large group fully insured markets and self-insured group plans including grandfathered plans and transitional relief plans. Coverage offered through an Exchange and for federal employees through the Federal Employees Health Benefits Program is also covered by the surprise billing law.

Self-funded UMR plans and Level Funded (All Savers) plans are also included.

Excepted benefits and short-term limited duration insurance are excluded.

How does the No Surprises Act work if member has a high deductible plan with an HSA? Update 3/22

An individual shall not be disqualified from contributing to a health savings account because the individual receives out-of-network benefits covered by the surprise billing provisions or any similar state law.

Also, a high deductible health plan is not disqualified from being used in conjunction with a health savings account because it provides coverage for out-of-network benefits covered by the surprise billing provisions or any similar state law.

What are the key components of the No Surprises law? Update 3/22

The law includes the prohibitions on balance billing, an arbitration process for disputes between health insurers or group health plans and OON providers, and coordination with state surprise billing laws.

What bills does the law apply to? Update 3/22

The law applies to medical bills related to:

1. Out-of-network emergency covered services at a hospital or free-standing facility.
2. Covered items and services provided by an out-of-network health care provider at an in-network facility.
3. Out-of-network air ambulance items and services.

Providers are prohibited from balance billing patients for out-of-network emergency services. In addition, out-of-network providers of ancillary services at an in-network facility are also prohibited from balance billing patients. Ancillary services are those for emergency medicine, anesthesiology, pathology, radiology, neonatology, and laboratory and diagnostic services, and where there is not an in-network provider available.

How are emergency services handled? Update 3/22

Under No Surprises Act, like the ACA, emergency services include coverage for items and services for medical screening to stabilize the patient and transfer them to an INN facility or home.

The Act defines medical services to include additional services provided by an out-of-network provider or facility as part of an out-patient observation or inpatient or out-patient stay with respect to the emergency services visit if the benefits would be otherwise covered.

An out-of-network provider may balance bill the patient for covered services provided after the patient is stabilized, provided the following conditions are met:

- The provider or facility must determine the individual can travel using nonmedical transportation or nonemergency medical transportation.
- The provider must furnish the notice that the additional items/services are out-of-network and the cost and receive an acknowledgement from the patient that they received the notice.
- The individual must be in a condition to acknowledge the notice.

What is a qualifying payment amount? Update 3/22

Member cost-sharing and IDR decisions are based in part on the "qualifying payment amount". If there is a state law methodology to determine the reimbursement rate for the out-of-network item or service that state law will determine the qualifying payment amount. If there is not a state law, the following standards apply:

- Qualifying payment amount is the median contract rate for the item or service. The qualifying payment amount is established for all OON coverage offered by an insurer in the specified market and for all plans of a group plan sponsor.
- The amount is determined based on the individual, small or large group insured market and self-insured market with variations by geography.
- The median contract rate is determined based on the amount paid by the insurer/health plan for a covered OON item or service on January 1, 2019. A cost-of-living adjustment is applied using the Consumer Price Index for all Urban Consumers (CPI-U).

A methodology, yet to be established, will determine the median contract rate in cases where the items and services are newly covered by an insurer/health plan or where there is a new insurer/health plan in that market.

How are prior authorization, coverage limits, and member cost-sharing treated for OON services subject to the No Surprises Act? Update 3/22

Insurers/health plan are prohibited from requiring prior authorization for OON emergency services and may not apply coverage limitations for OON emergency services that are more restrictive than those for INN services.

Insurers/health plans cannot apply cost sharing for OON covered items and services that is greater than cost-sharing applied to INN covered items and services (e.g., 10% coinsurance for same INN and OON covered items and services). All OON cost-sharing must be counted toward any INN deductible and cost-sharing limits.

What do payers have to do when they receive a bill for OON services covered by the No Surprises Act? New 3/22

Insurers/health plans have 30 days after they receive a bill to either pay the provider or deny the claim.

What reimbursement amount are payers required to pay for covered OON items or services subject to the No Surprises Act? New 3/22

Insurers/plans are required to pay the "out-of-network rate." The out-of-network rate is the difference between the member's cost-sharing amount and the following:

- If the insurer/health plan and OON item or service is covered by a state law that establishes the reimbursement rate, that rate will apply.
- If the state does not have an applicable law, either the amount agreed to by the insurers/health plan and provider or the amount set by the IDR process.
- If the state has an All-Payer Model Agreement, the reimbursement is set by that agreement.

When can a provider balance bill an individual? New 3/22

Patients may be balanced billed for out-of-network non-ancillary services at an in-network facility if the provider:

- informs the patient in advanced that they are out-of-network,
- provides an estimate of the charges, and
- secures a written acknowledgement from the patient that they received the notice and understand any cost-sharing will be applied to their out-of-network limits.

Ancillary services are those for emergency medicine, anesthesiology, pathology, radiology, neonatology, and laboratory and diagnostic services, and services where there is not an in-network provider available.

Does the No Surprises Act prohibit balance billing? Update 3/22

Yes, in certain cases OON providers are not allowed to balance bill. OON providers are prohibited from balance billing members for emergency services. OON providers at INN facilities are prohibited from balance billing members with certain exceptions.

OON providers of ancillary services at an INN facility are prohibited from balance billing members. Ancillary services are defined by the No Surprises Act as those related to emergency medicine, anesthesiology, pathology, radiology, neonatology, and laboratory and in situations where an INN provider is not available at the INN facility to provide the services.

An OON provider at an INN facility may balance bill members if they are not providing ancillary services and if they give advance notice to the member that the covered item or service is OON and the estimated cost. The member must acknowledge that they received the notice.

Can ancillary providers balance bill? New 3/22

No. An OON ancillary provider providing services at INN facility cannot balance bill.

How does the balance billing notice provision work? New 3/22

OON providers at INN facilities that are providing “non-ancillary services” must provide advance notice to members that the services are OON and a good faith estimate of the cost. If the member makes an appointment for the OON services at least 72 hours in advance, the notice must be provided no later than 72 hours before the date of service. If the member schedules the appointment within 72 hours of the date of service, the notice must be provided on the date of service.

The notice may be in writing or electronic at the option of the member. The notice must include the following information:

- That the provider is out-of-network.
- Good faith estimates of the cost for any items and services.
- Consent to obtain OON items and services is voluntary.
- That the member may choose to receive the items or services from an INN provider.
- If applicable, identify INN providers at the facility who can provide the items or services.
- Information about whether prior authorization may be required.

The member must sign an acknowledgement that they received the notice and understand that any cost-sharing will apply to the member’s OON deductible and cost-sharing limits and that they will be responsible for any balance bill

Which providers are considered ancillary? New 3/22

Ancillary services are defined by the No Surprises Act as those related to emergency medicine, such as RAPL (radiology, anesthesiology, pathology, lab) neonatology, and laboratory and specialty services needed to respond to unexpected complications such as those delivered by a neonatologist or cardiologist and also in situations where an INN provider is not available at the INN facility to provide the services. OON providers of ancillary services at INN facilities may not balance bill.

What notice or acknowledgements are required for non ancillary provider to balance bill? New 3/19

OON providers of “non-ancillary” services at INN facilities must provide notice to members in order to balance bill for OON items/services.

If the member schedules an appoint at the INN facility at least 72 hours in advance the notice must be provided no later than 72 hours in advance. If the member schedules the appointment within 72 hours the notice must be provided when the appointment is made.

The notice must disclose that the item/service is not covered, the estimated charges for the item/service, that the member is not obligated to use an OON provider for the item/service, and whether there are INN providers at the facility who can provide the item/service.

The member must sign an acknowledgement that they received the notice and understand that any cost-sharing will be applied toward their OON deductible and cost-sharing limits. By receiving the acknowledgement, the member has not agreed that they will pay those estimated charges.

How does the federal law interact with state no surprise regulations?

The law does not pre-empt state laws that establish a methodology for determining the reimbursement rate for an out-of-network health care item or service. If there is not a state reimbursement methodology, the No Surprises Act provides that the reimbursement will be either the amount negotiated, or agreed to, by the health insurer/group health plan and the provider, or it will be determined through an independent dispute resolution process.

What is the benefit of the No Surprises law? New 3/22

Consumers will be protected from surprise medical bills when they receive out-of-network care in both emergency and nonemergency settings; the protections extend to out-of-network emergency air ambulances. As a result, patients will be protected from surprise bills in situations where they have little or no control over who provides their care.

However, patients are not protected from balance billing where they have a choice of services including where services are provided by an out-of-network provider at an out-of-network facility or place of service. In addition, it does not protect patients from balance billing for ground ambulance services.

How does No Surprises help protect a consumer? New 3/22

Patients are protected from surprise medical bills for nonemergency services provided at an in-network facility but by an out-of-network provider.

For example, today a patient might receive a surprise bill from a nonemergency out-of-network provider that provides ancillary services, such as those delivered by a radiologist, anesthesiologist, or pathologist, or a medical professional that provides specialty services needed to respond to unexpected complications, such as those delivered by a neonatologist.

Under the law, beginning plan or policy years on and after January 1, 2022, consumers will be protected from surprise medical bills in situations where they have little or no control over who provides their care and they have not signed a statement acknowledging that they are aware the additional charges.

For ancillary services no balance bill is ever allowed. However, there is an exception for certain non-ancillary services at an in-network facility where the provider informs the patient in advance that they are out-of-network and gives them an estimate of the charges.

How is the No Surprises Act enforced? Are there penalties? New 3/22

Insurer and health plans: provisions applicable to insurers are enforced by the applicable states and by the applicable federal agency (the Departments of Health and Human Services, Labor, and the Treasury). Provisions applicable to self-funded group plans are enforced by the applicable federal agency.

Providers and facilities: provisions applicable to health care providers and facilities are enforced by the Department of Health and Human Services which may impose fines of up to $10,000 per violation.

States: provisions applicable to providers and facilities (including air ambulance) may be enforced by the states.

What are provider responsibilities? New 3/22

Beginning January 1, 2022, providers and facilities must post and provide on any websites, and provide to any patients with coverage under an insurer/plan a notice of the following:

- The balance billing prohibitions under the No Surprises Act.
- Any applicable state requirements with respect to balance billing.

What is the date used for the start of the 30-day timetable for payment for delegates when the provider sent the claim to UnitedHealthcare and UnitedHealthcare forwards the claim to delegate? New 5/10/2021

There is no change. We follow our current existing process.

Does a customer need to move to the 2022 COC to get the No Surprises Act changes applied at renewal? New 5/10/2021

No, the customer will not have to move to a new COC. Amendments are being prepared for prior year COCs.

How are the out-of-network programs (e.g., R&C, MNRP, OCM, Naviguard, etc.) impacted by the No Surprises Act? New 5/10/2021

UnitedHealthcare's existing Out of Network programs will continue to support determination of the "go out rate" for services impacted by the Consolidated Appropriations Act and the No Surprises Act. Additional rule making may provide additional guidance as to how the "go out

rate" is determined. For other services not related to the federal No Surprises Bill under CAA, UnitedHealthcare's existing programs will apply per benefit plan and comply with any applicable state/federal regulations.

If an OON service is denied as not medically necessary, is it excluded from the IDR process? New 5/10/2021

Medical services are excluded from No Surprises IDR process when the denial is based on medical necessity. The individual would have the appeals process available to them.

If states have prompt pay laws that have a different time requirement (more or less than 30 days), which will UnitedHealthcare follow? New 5/10/2021

Unless there is additional guidance specifying if state or federal guidelines are pre-emptive, UnitedHealthcare will follow the most restrictive timeline.

How we are to calculate provider payment and member cost share for out-of-network providers at a network facility? New 5/10/2021

Member cost share calculations are based on their plans in-network cost share for services provided by an out-of-network provider at an in-network facility.

At this time, there is no direction requirement on what the payment to the impacted provider must be. When they two parties cannot agree on an amount, the final payment to the provider will be through negotiation or IDR.

Air Ambulance

The air-ambulance requirement is not specific as to when we pay OON air ambulance as in-network. In what circumstances would the air ambulance should be covered as in- or out-of-network? New 5/10/2021

Follow the terms of the plan.

Most plans have a dollar limit allowed for in-network air ambulance coverage, is that still permitted under CAA? How does cost share and reimbursement apply? New 5/10/2021

Yes, a limit is approved as long as the limit applies to in-network air ambulance coverage.

Member cost share is based on the plan's in network rates, the provider reimbursement would be negotiated or by IDR

Independent Dispute Resolution

Who can request an Independent Dispute Resolution (IDR)? New 3/22

Either an insurer/health plan or a provider may request independent dispute resolution. There is a 30-day negotiation period to resolve disputes over reimbursement for OON covered items and services. The negotiation period starts after the provider receives payment or a claim denial as discussed above. Four days after the end of the 30-day negotiation period, either the insurer/health plan or the provider can request an IDR.

Does the new Independent Dispute Resolution (arbitration) process replace our current OON programs? New 5/10/2021

IDR does not replace and out-of-network program. Out-of-network solutions help to determine what is applied to the initial reimbursement offer. Additional guidance is anticipated on the federal Independent Dispute Resolution (IDR) and how to address where both federal IDR and a state arbitration process impact the same dispute.

How do the out-of-network (OON) programs work with the No Surprises Bill? New 5/10/2021

UnitedHealthcare's existing Out of Network programs will continue to support determination of the "go out rate" for services impacted by the Consolidated Appropriations Act and the No Surprises Act. Additional rule making may provide additional guidance as to how the "go out rate" is determined. For other services not related to the federal No Surprises Bill under CAA, UnitedHealthcare's existing programs will apply per benefit plan and comply with any applicable state/federal regulations.

What is the process if the insurer / health plan and the out-of-network provider/facility do not agree on an amount? New 3/22

Included in the law is an Independent Dispute Resolution (IDR) process, sometimes called arbitration, which was established to determine the provider reimbursement amount if the health insurer or group health plan and the out-of-network provider are unable to negotiate a reimbursement rate (and if there is not a state law methodology to establish the reimbursement amount).

- The health insurer or group health plan and the provider will make an offer and the IDR entity will chose either the insurer/plan offer or the provider offer. The party whose offer was not selected will pay any costs associated with the IDR process.
- In choosing either the insurer/plan offer or the provider offer, the IDR entity shall consider the median contracted rate for the item or service. In addition, the IDR entity may request information on the following in order to reach a decision:

- The level of training, experience, and quality and outcomes measurements of the provider or facility.
- The market share of the provider or facility and plan or insurer in the geographic area.
- The acuity of the patient.
- The teaching status, case mix, and scope of services of the facility.
- Demonstrations of good faith efforts by the provider or facility to participate in the insurer or plan network.

The IDR entity is specifically prohibited from considering billed charges, provider usual and customary fees, or government program rates like Medicare or Medicaid.

There are federal rules and processes yet to be developed, and questions about scope and applicability as it relates to state laws still to be answered. We will continue to update our customers as more is known.

What are timing requirements before going to IDR/arbitration? New 3/22

1. Provider or facility submits bill to insurer/health plan for OON service.
2. No later than 30 days after bill submission–Insurer/plan makes payment to the provider or facility or denies claim.
3. 30-day negotiation period after payment/ claim denial.

   Insurer/plan negotiates with provider or facility if there is a disagreement about the reimbursement amount.
4. 4 days after end of negotiation period–either insurer/health plan or provider or facility may request IDR by submitting notice to HHS and other party.

   HHS or parties select IDR entity.

   Insurer/health plan and the provider can continue negotiation during IDR
5. 10 days after IDR entity selection insurer/health plan and provider/facility submit offer and supporting documentation to IDR entity.
6. 30 days after IDR entity selection–IDR entity chooses insurer/health plan or provider/facility offer and notifies parties.
7. Any payments must be made no later than 30 days after IDR decision.

What will the IDR entity consider in making a final decision? New 3/22

In choosing either the insurer/plan offer or the provider offer, the IDR entity shall consider the median contract rate for the item and service and may request the following information to consider in making a decision.

- The level of training, experience, and quality and outcomes measurements of the provider or facility.
- The market share of the provider or facility and plan or insurer in the geographic area.
- The acuity of the patient.
- The teaching status, case mix, and scope of services of the facility.
- Demonstrations of good faith efforts by the provider or facility to participate in the insurer or plan network.

However, the IDR entity is specifically prohibited from considering billed charges, provider usual and customary fees, or government program rates like Medicare or Medicaid.

In making a decision, what may the IDR entity consider for air ambulance services? New 3/22

In choosing either the insurer or group plan offer or the offer of the air ambulance carrier, the IDR entity shall consider the median contracted rate for the item or service. The IDR entity may also request the following information to consider in reaching a decision:

- The quality and outcomes measurements of the provider that furnished the services.
- The acuity of the patient or complexity of furnishing the services.
- The training, experience, and quality of medical personnel furnishing services.
- The ambulance vehicle type, including the clinical capability level of the vehicle.
- The population density of the pick-up location such as urban, suburban, rural, or frontier.
- Demonstration of good faith efforts to participate in the insurer or plan network.

However, the IDR entity is specifically prohibited from considering billed charges, provider usual and customary fees, or government program rates like Medicare or Medicaid.

If an OON services is denied as not medically necessary, are they excluded from the IDR process? New 3/22

The services are excluded from IDR if they are determined as not medically necessary.

Can a person without health coverage initiate the dispute process? New 3/22

Yes.

Who are the IDR entities/arbitrators? New 3/22

The Departments of Health and Human Services, Labor, and the Treasury will issue regulations detailing the IDR process and how entities can be certified to provide IDR services. These regulations have not been released and not IDR entities have been certified.

Can the health plan choose who they want or do not want as IDR? New 3/22

The law allows payer and provider to pick and agree on the IDR entity, otherwise HHS will choose.

How are IDR entities compensated? New 3/22

Whoever's offer is not selected pays the IDR entity. Other administration or operational costs for the negotiation would be paid by the party incurring them.

Can claims be batched when requesting dispute resolution? New 3/22

Certain claims may be combined for purposes of the IDR process:

- The items and services were furnished by the same provider or facility.
- Payment for the items and services are required to be made by the same insurer or plan.
- The items and services are related to the treatment of a similar condition.
- The items and services were furnished during the 30-day period following the date on which the original IDR determination was furnished.

If the IDR selects the providers proposed rate, is a self-funded customer responsible to cover the difference? New 5/10/2021

The person whose proposed payment rate is not accepted under IDR must pay the IDR costs and the additional amount required. How that is covered by the self-funded customer is outlined in their agreements.

ID Cards

Does the law require any changes to ID cards? New 3/22

Yes. In-network and out-of-network deductibles and cost-sharing limits must be included on the insurer or plan ID Card.

Beginning on and after January 1, 2022, as plans renew, the ID Card must include:

1. Plan deductibles for network and out-of-network deductible amounts.

2. Maximum limits on out-of-pocket costs including network and out-of-network limits, as applicable.
3. Phone number and web address for a member to get assistance including help to find a network provider.

Are there font style or font size requirements? New 4/2

There are no ID Card font or size requirements from the Consolidated Appropriations Act (CAA); however, existing state specific font and size requirements would need to be adhered to.

Will every ID card need to be replaced with the new format or will maintenance ID cards and online cards suffice? When will the new cards need to be issued? New 4/2

Both medical and Rx deductibles and coinsurance amounts must be added to ID cards. Cards need to be issued even if there is no change to the plan. The timing for card distribution is effective on plan renewal date.

In the situation where there are no changes to the plan and ID cards aren't scheduled to be re-issued, when are ID cards required to be distributed under CAA? New 4/2

The ID cards with the required information must go out on plan renewal.

If there are state and federal requirements for Plan ID cards, which is pre-emptive? New 4/2

Both federal and state requirements must be met. We are waiting for further rulemaking.

Under CAA, do plan ID cards need to be re-issued on 1/1/22, or is it staggered based on the plan renewal date? New 4/2

The ID Cards must be reissued on renewal on or after 1/1/22.

Does the deductible and OOP need to be on the front of the ID Card, or can it be on the back? New 5/10/2021

The regulation doesn't specify. Therefore, the deductibles could be put either on the front or the back of the ID Card. However, state requirements must be followed for fully insured or plans subject to state requirements.

Out of Network Programs

How do the out-of-network (OON) programs work with the No Surprises Bill? New 5/10/2021

UnitedHealthcare's existing Out of Network programs will continue to support determination of the "go out rate" for services impacted by the Consolidated Appropriations Act and the No Surprises Act. Additional rule making may provide additional guidance as to how the "go out rate" is determined. For other services not related to the federal No Surprises Bill under CAA, UnitedHealthcare's existing programs will apply per benefit plan and comply with any applicable state/federal regulations.

Naviguard

Can Naviguard play a role supporting negotiations under No Surprises Act? New 3/22

Naviguard has been anticipating and are supportive of legislation that protects consumers from surprise billing. Naviguard remains uniquely positioned to support employers and their employees with our proprietary claim pricing methodology, robust advocacy, negotiation expertise and enforcement against egregious OON provider billing practices if/when they occur.

Arbitration as defined by this new law is complex and requires insights and expertise to present a compelling case. Naviguard will act as an ally from start to finish by providing high-touch advocacy and market insights. Naviguard helps ensure a balance of plan savings with successful outcomes through the tightly aligned combination of the negotiation and independent dispute (IDR) processes.

How does Naviguard determine claim pricing? New 3/22

The Naviguard claim pricing is objectively derived, market-based and defensible.

- The pricing methodology is adaptable to balance cost savings with a manageable level of inquiries.
- Naviguard has experience negotiating with OON providers positions assisting in the resolution of inquiries in advance of independent dispute resolution.

Patient Protections

Are there protections related to how much members would pay for out-of-network coverage? New 3/22/2021

- Cost-sharing for out-of-network items and services covered by the No Surprises Act must be counted toward the patient's in-network limits.
- Cost-sharing for out-of-network items and services may not be greater than cost-sharing applied to in-network items and services
- Prior authorization is not permitted for emergency services at an out-of-network facility and any cost-sharing limits for such services cannot exceed what would be applied to in-network emergency services.

In addition, In-network and out-of-network deductibles and cost-sharing limits must be included on the insurer or plan ID Card.

Does the law require an external appeal process if a member receives an adverse determination notice? New 3/22/2021

Yes. Group health plans and insurers must provide an external review process with respect to adverse determinations. UnitedHealthcare already has a formal internal and external review process in place today.

Is the external appeals requirement a change to the current external appeals process? New 3/22/2021

UnitedHealthcare has an external review process today. However, we will need to expand the review process to include external review of disputes related to adverse determinations related to the No Surprises Act.

Continuity of Care

What is required under CAA regarding continuity of care? New 3/22

The CAA allows certain patients the opportunity to continue care if their provider or facility is no longer in the insurer/plan network. The plan/issuer must permit members who are continuing care patients with an opportunity to request and election to continue to have benefits provided

under the plan/coverage under the same terms and conditions as they would have been covered had no change occurred. The timing starts on the date a notice of the right to elect continuing care is provided to the member and ends either 90 days later or the date on which the patient is no longer undergoing continuing care by that provider or facility.

Continuing care includes the following:

- Serious and complex conditions.
- Course of institutional or inpatient care.
- Scheduled nonelective surgery including post-operative care.
- Course of treatment for pregnancy.
- Terminally ill patients.

When do the continuity of care provisions go into effect? New 4/26/21

This regulation is effective for plan years beginning on or after Jan. 1, 2022.

What are a plan's requirements if the plan the member is enrolled in is terminated? New 4/26/21

The plan must notify each member under the care of a network physician or facility of the opportunity for transition of care under the same terms and conditions as if they were still covered by the plan. If approved, Continuity of Care end a) 90 days after the plan notifies the member or b) the date the member is no longer undergoing continuing care by that provider or facility, whichever is earlier or occurs first.

How is continuity of care defined? New 4/26/21

This applies to any of the following: 1) An individual undergoing a course of treatment for a serious and complex condition, 2) an individual undergoing inpatient or institutional care, 3) an individual with scheduled non-elective surgical care, including necessary post-operative care, 4) an individual who is pregnant and being treated, and 5) an individual who is terminally ill and is receiving treatment for such illness by a provider or facility.

What is a serious or complex condition? New 4/26/21

The CAA defines a serious and complex condition as an acute illness, a condition serious enough to require specialized medical care to avoid reasonable possibility of death or permanent harm or a chronic illness or condition that is life-threatening, degenerative, potentially disabling or congenital and requires specialized medical care over a prolonged time.

For Continuity of Care, can a customer allow a period longer than 90 days? New 5/10/2021

No. There is no regulatory reason for the provider to continue accepting the in-network rate beyond 90 days.

How do we identify members that could be impacted by continuity of care? Does UnitedHealthcare look at claim history? New 5/10/2021

When there is a provider termination, UnitedHealthcare plans to send a notice to all members impacted by the termination, which may be based on claim history.

Members will not be proactively identified by claims history or other mean as qualifying or not qualifying for continuity of care. The member should notify UnitedHealthcare if they believe they fall within a specified continuity of care category.

What constitutes a serious and complex condition? Would this apply to treatments in behavioral health as well? New 5/10/2021

CAA defines both what a "continuing care patient" is and the conditions necessary to trigger continuity of care. If a patient meets the definition and has a condition, then they would be eligible for continuity of care if they request it.

Continuity of Care provision applies to behavioral health as well has medical. As with other care there is a definition of what is a continuing care patient and the member receiving behavioral health care would need to fit within that definition.

Does the provider have to accept the plan's payment, or can they balance bill the member? New 5/10/2021

Provider needs to accept the plans payment and agree to any network terms and conditions

Is there a payment methodology used to make payment since the network rate doesn't apply? New 5/10/2021

The network rate applies.

Advance Cost Estimate

What is the requirement for a plan or issuer to provide an advanced explanation of benefit notification? New 3/22

Beginning in 2022, all health care providers and facilities will be required to ask patients when they schedule a visit if they have coverage through a health insurer, group health plan or the Federal Employees Health Benefits Program (FEHB). If the patient has coverage, the provider or facility is required to provide a notice to the insurer, plan or FEHB of the estimated cost of the services that are reasonably expected to be provided in connection with the visit.

Upon notification from a provider or facility for the cost of the services the insurer, the plan or FEHB must provide member a notification through mail or electronic means, as requested by the member.

The notice must disclose:

- Whether the provider or facility is in-network - disclose the contracted rate for item or service;
- If the provider/facility is not in the network - disclose how the member can obtain information on network providers and facilities;
- The provider or facility's good faith estimate of charges;
- A good faith estimation of the amount the plan or coverage is responsible for paying;
- A good faith estimation of what the members would be expected to pay;
- A good faith estimation of the member's cost share accumulations to date;
- Whether the item or service is subject to any medical management;
- A disclaimer that the cost share amounts are estimates;
- Other information the plan or coverage determines appropriate.

Do we need to receive additional active consent for electronic delivery, or can we follow prior given consent for EOB delivery? New 3/22

If the normal communication method with members is electronic, the advance explanation of benefit communication may be electronic. Members may request electronic delivery by signing up for it as a preference on myuhc.com.

Does the Advance Cost Estimate requirement apply to all services or are some excluded? New 5/10/2021

Yes. The Advance Cost Estimate applies to insurers and health plans.

Beginning in 2022, all health care providers and facilities will be required to ask patients when they schedule a visit if they have coverage through a health insurer, group health plan or the Federal Employees Health Benefits Program (FEHB). If the patient has coverage, the provider or facility is required to provide a notice to the insurer, plan or FEHB of the estimated cost of the services that are reasonably expected to be provided in connection with the visit. Upon

notification from a provider or facility of cost of the services, the insurer, the plan or FEHB must provide member a notification through mail or electronic means, as requested by the member

Is there a consequence if the estimate provided on the advanced EOB doesn't match the final bill? New 3/22

There is no penalty in the CAA although the EOB must indicate the estimated amount is just an estimate and final charges may differ.

Can a member appeal an Advance Cost Estimate? New 5/10/2021

No. The Advance Cost Estimate is not a bill, it's just an estimate.

External Review

What is the requirement external review? New 3/22

Group health plans and insurers must provide an external review process to determine whether the plan's adverse determination with respect to the surprise medical bill was correct. UnitedHealthcare has a formal internal and external review process in place today.

Can a person without coverage can initiate the dispute process? New 5/10/2021

Yes.

Will UnitedHealthcare make any changes to the current External Review disputes process? New 5/10/2021

Will need to expand our review process to include external review to respond to disputes for adverse actions.

Choice of Health Care Provider

What does the CAA law require regarding a member's choice of providers? New 4/26/21

The law applies to commercial individual and group health plans including grandfathered plans. Under the law:

1. When a plan requires or provides for Primary Care Provider (PCP) designation, members can choose their own PCP provided the PCP is in-network and available to accept patients. Also, there is no requirement for plans to include a PCP designation.

2. When a plan allows, members can designate a Pediatrician as a PCP for a dependent child.
3. Plans must allow direct access to OBGYN care. An OBGYN is required to adhere to all policies and procedures around referrals and authorizations.

Does the law require insurers or health plans to change how they define a PCP? New 4/26/21

Some insurers or health plans may be required to modify their definition of PCP. For example, some grandfathered plans may not allow a Pediatrician to be selected as a PCP. The law changes that.

Under the CAA, if a member is required to select a PCP, what are the requirements? New 3/22/2021

If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, requires the member to have a primary care provider, each member may designate any participating primary care provider who is available to accept such individual.

This process is already in place at UnitedHealthcare.

What are requirements for a child who is required to have a PCP designated for primary care? New 3/19

For a child, the member may designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the plan or issuer.

This process is already in place at UnitedHealthcare.

What are the requirements around direct access for OBGYNs? New 3/19

Health plans may not require authorization or referrals for coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. The OBGYN must agree to adhere to the plan's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services related to a treatment plan.

When a plan allows, can an OBGYN refer patients for care or request prior authorization for care similar to a PCP? New 4/26/21

Yes.

Does UnitedHealthcare have gender edits that would impact a transgender male from seeing an OBGYN or getting certain preventive care? New 5/10/2021

UnitedHealthcare has removed gender edits from our claims systems

Price Comparison Tools

Under the CAA, what is the price comparison tool requirement? New 3/22/2021

A group plan must offer price comparison guidance via phone or a web-based service tool. This tool must allow an enrollee to be able to compare cost across network providers in a specific geographic region for the current year for specific items or services.

Are there requirements for providers to help members understand costs? New 3/22/2021

Beginning in 2022, health care providers are required to ask patients if they have coverage from a health insurer, group health plan, or the Federal Health Employees Benefits Program when they schedule an appointment. The providers are required to provide the insurer or plan with a "good faith" estimate of charges for the items and services that will be provided during the patient's visit.

Provider Directories

Are all provider directories included in the directory requirements? New 3/22

The medical / surgical / physical, vision, dental, and behavioral directories are all included. The Pharmacy directory is not included in the requirements.

What Lines of Business are included in the provider directory requirements? New 3/22

E&I and Exchanges are included in the provider directory requirements. Medicare and Medicaid are not in scope.

What information is required to be in a directory under CAA? New 3/22

The provider directory must include the following information for each health care provider or hospital/facility that the plan has a contractual relationship with to provide items and services under the plan's coverage including:

- Name
- Address
- Specialty
- Phone number
- Digital contact information, which means email address and/or URL

UnitedHealthcare currently displays these data elements for providers and facilities.

What are the provider data verification requirements? How is this different from today? New 3/22

UnitedHealthcare or their delegates must verify provider and facility directory data at least every 90 days. We will continue to ask providers to verify their data through My Practice Profile (MPP) attestations, roster submissions, and CAQH data every 90 days.

What will happen if a provider's data cannot be verified? New 3/22

If a provider's data cannot be verified 180 days after the last verification date, the provider will be suppressed from the online provider directory. Once the data is verified the provider will be added back into the directory.

Will the un-verified provider be suppressed from all directories? New 3/22

No, the provider will only be suppressed from the directories in scope for the CAA, which are the E&I and Exchange directories.

Will the un-verified provider be terminated? New 3/22

No, the provider will remain in our network and will not be terminated.

What provider types are included in the directory requirements? New 3/22

The online provider directory shall display all providers and facilities with direct or indirect contractual relationship with UHC. Indirect contractual relationship is understood to mean a delegated entity. A delegated entity is one in which the entity [facility, delegate, provider group, etc.] receives compensation directly from the Plan to provide covered items and services, a 'direct contractual relationship' exists. If the Entity sub-contracts with Providers in order to meet its contractual obligations to the Plan, an 'indirect contractual relationship' is created between the Plan and the sub-contracted Provider.

Except for a few state regulatory requirements, we also only include in the directory providers in which a member can schedule an appointment with a specific provider. As a result, Hospital Based Providers are not included in the directory. We also do not include providers addresses where the provider does not regularly schedule appointments.

How do we define the provider directory update turnaround time requirement? New 3/22

The online provider directory must display updated provider demographic data (name, address, specialty, telephone number, and digital contact information) within 2 business days of the health plan receiving the updated information from the provider. This applies to changes to any of the data elements that are specified as required, adding a new provider, and removing a termed provider.

For demographic updates (telephone number and digital contact information) the starting point is the day we receive the update from the provider.

For contractual updates (name, address, specialty, adding a new provider) the starting point is the latter of Credentialing Approval Date and Contract Effective Date. If Contract Effective Date is back dated, then latter of Credentialing Approval Date and date contract was signed.

2 business days means the end of the second business day after the starting point. For example, if the credentialing approval occurs on a Monday morning, the data has to appear in the directory by end of day Wednesday.

What if a states directory requirement differs from the CAA directory requirement? New 3/22

The more restrictive requirement will take priority. For example, the CAA requires a 2-business day directory update TAT, but a specific state may require a 30-day TAT. The CAA 2-day TAT will take priority for that state. But if a state requires additional data elements that outlined in the CAA, we still must display those additional data elements for that state.

If UnitedHealthcare uses a vendor for a Provider Directory Tool (e.g., US Health and HealthMarkets), what is our responsibility under CAA to ensure the vendor is compliant with the regulation? New 5/10/2021

We'd need to make sure they are compliant. Any information must flow to UnitedHealthcare, as the insurer, or to the health plan if they designate responsibility to us.

Provider Nondiscrimination

Section 108 in the CAA requires the agencies to issue rules no later than January 1, 2022 to provide protection against provider discrimination. There are also regulations under the Affordable Care Act (ACA) that apply to Public Health Service Act (PHS). The guidance states that issuers and health plans may not discriminate against any provider's participation if they are acting within the scope of their license or certification under the state's law. Plans are not required to contract with any willing provider nor do the regulations prevent plans from establishing different reimbursement rates based on quality or performance measures.

All Payer Claims Database

The No Surprises Act requires the Department of Labor to establish and periodically update a standardized reporting format for voluntary reporting by group health plans to a State All Payer Claims Database and to provide guidance to states on data collection.

Content Coming

Transparency

The CCA is focused on increasing transparency by removing gag clauses from provider contracts with insurers and plans restricting disclosures of price and quality information. The CAA also requires new disclosures of direct and indirect compensation for brokers and consultants to employer-sponsored health plans and enrollees in plans on the individual market.

In addition, CAA establishes reporting with respect to insurer and plan coverage of mental health and substance use disorder benefits and reporting on pharmacy benefits and drug costs.

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Gag Rule

What are the requirements for insurers and health plans under the Gag Rule? New 3/22

A group health plan or insurer may not enter into an agreement with a health care provider, network or association of providers, third party administrator (TPA), or other service provider offering access to a network of providers that would directly or indirectly restrict a group health plan or insurer from providing provider-specific cost or quality of care information or data, electronically accessing de-identified claims and encounter information or data for each enrollee or sharing that information or data with a business associate.

or sharing that information or data with a business associate.

Is there an effective date for removal of Gag Clauses? New 5/10/2021

The CAA did not include an effective date specific to this requirement.

Today we have nondisclosure agreements (NDA) in place when we release this type of data – will NDAs still be required? Does the NDA need to be changed? New 5/10/2021

UnitedHealthcare and UMR will still require nondisclosure agreements (NDA). The Consolidated Appropriations Act (CAA) impacts agreements we enter in to directly with the customer but does not prohibit reasonable restrictions on public disclosure of information. NDAs solely between UnitedHealthcare or UMR and a vendor are not affected by the CAA.

We are working to ensure NDAs with all customers are executed consistent with the prohibition on “gag clauses” in the CAA.

Does the Gag provision apply to pharmacy providers? Does it apply to OptumRx? New 5/10/2021

Yes, the CAA prohibition on gag clauses in the CAA applies to agreements with pharmacies and applies to the network agreements OptumRx has with pharmacies.

Is there an impact to the ancillary lines of business for the Gag clauses (dental, vision, hearing)? New 5/10/2021

Excepted benefits would be out of scope for the prohibition on gag clauses in the CAA. This includes standalone group dental and vision plans on a separate insurance policy/contract from the medical plan. However, group dental or vision coverage embedded in a medical plan or on a rider that is integral to a medical plan is in scope. This include pediatric dental/vision EHB plans. When dental or vision are automatically included when medical coverage is purchased, the prohibition on gag clauses in the CAA applies.

Broker and Service Provider Compensation

What disclosure approach does UnitedHealthcare support as way to be inclusive of all affiliates? New 3/22

Currently there is no legal requirement for groups to provide disclosures on compensation ahead of time. The Appropriations Act now indicates that information must be disclosed no later than 60 days when there is a change. Based on the new disclosure requirements beginning on and after January 1, 2022, we are working on our approach as we anticipate additional guidance. UnitedHealthcare is working to finalize the process.

Can disclosure notices be in electronic format? New 3/22

Yes. A written request can be electronic if that is the normal means of communication.

Group Health Plans

Who must disclose compensation under the new rule? New 4/26/21

The law applies to Covered Services Providers (CSPs) which are defined as an entity that receives $1,000 or more in direct or indirect compensation in connection with providing brokerage or consulting services to an ERISA-covered group health plan.

Brokerage and consulting services subject to the new rules include:

- Brokerage services with respect to the selection of health insurance products (including vision and dental), recordkeeping, medical management, benefits administration, stop-loss insurance, pharmacy benefit management, wellness services, transparency tools and vendors, preferred vendor panels, disease management, compliance services, EAPs, TPAs; or

- Consulting services related to the development or implementation of plan design, insurance selection (including vision and dental), record-keeping, medical management, benefits administration, stop-loss insurance, pharmacy benefit management, wellness design and management, transparency tools, group purchasing organizations, preferred vendor panels, disease management, compliance, EAPs, and TPA services.

What information must be disclosed? New 4/26/21

Plan fiduciaries are required to obtain the following information from CSPs in advance of entering or renewing a contract for brokerage or consulting services.

- Description of the services to be provided to the covered plan under the contract or arrangement.
- If applicable, a statement that the service provider (or an affiliate or subcontractor) will provide, or expects to provide, fiduciary services to the covered plan.
- A description of all direct compensation the service provider (or an affiliate or subcontractor) expects to receive in connection with the provision of services.
- A description of all indirect compensation the service provider (or an affiliate or subcontractor) expects to receive in connection with the provision of services (including incentives paid to a brokerage firm not solely related to the covered plan), a description of the arrangement between the payer and the recipient; a description of the services for which the compensation is received, and the identity of the payer.
- If compensation is paid to service provider, the service provider's affiliate, or the service provider's subcontractor on a transaction basis (such as commissions or finder's fees), a description of any such arrangement and identification of the payers and recipients of such compensation (including the status of a payer or recipient as an affiliate or a subcontractor).
- A description of any compensation that the service provider (or an affiliate or subcontractor) expects to receive in connection with termination of the contract or arrangement, and how any prepaid amounts will be calculated and refunded upon such termination.
- A description of how any direct or indirect compensation will be received by the service provider (or an affiliate or subcontractor).

What is Direct and Indirect Compensation? New 4/26/21

- Direct Compensation is compensation directly from a covered plan.

  Example: Service fees paid to a CSP from the plan's assets for assistance in selection of an insurer or TPA (even if the payment is only facilitated or passed through a third party).

- Indirect Compensation is compensation from any source other than the plan, the plan sponsor, the CSP or an affiliate.

  Example: Bonus payments and commissions made by carriers to an agency or broker directly from the carrier's general account as incentive compensation related to sales activities.

What is a Good Faith Estimate? New 4/26/21

In those situations where a good faith estimate of a CSP's compensation cannot be determined in advance, the CAA allows the use of a formula to disclose the compensation, so long as it allows the plan fiduciary to review the reasonableness of the compensation.

Are there Penalties for Non-compliance or Risks? New 4/26/21

Yes. Both CSPs and plan fiduciaries could be exposed to liability if the new CAA disclosure requirements are not complied with. If the fiduciary does not ask for the disclosure, and/or the CSP does not provide it, the contract would violate ERISA's prohibited transaction provisions, subjecting both the CSP and the plan fiduciary to potential penalties or other consequences, such as retroactive termination of the contract between the CSP and the plan.

When do the New Requirements go into Effect? New 4/26/21

These disclosure rules apply to any contract executed on or after December 27, 2021 (one year after enactment). It is not yet clear how these rules will apply to extensions or renewals of existing arrangements.

Individual Market

Do the new requirements apply to Individual Market CSPs? New 4/26/21

Yes.

The CAA also requires health insurance issuers offering individual ACA coverage as well as short-term limited duration insurance in the individual market to disclose all direct or indirect agent/broker compensation to a prospective enrollee:

- Prior to finalizing plan selection; and
- Again, in documentation confirming the individual's enrollment (i.e., provided in or with the policy/COC, welcome packet or similar).

Also requires health insurance issuers to report annually to HHS both direct and indirect agent compensation prior to the beginning of the annual open enrollment period.

Will UnitedHealthcare have to make changes to comply with the new Individual Market rules?

Since this is new for the Individual Market, UnitedHealthcare may need to update producer agreements and program systems to accurately collect, document and report the required CSP compensation to both the policyholders and the Department of Health and Human Services.

Does the compensation apply to direct and indirect compensation such as sports tickets or trips? New 4/26/21

Yes, the receipt of sports tickets or trips by brokers or consultants must be disclosed.

Are dental and vision plans required to report on broker and service provider compensation? New 4/26/21

Yes. They are included in the requirement for group health plans. However, they are NOT included in the requirement for the individual market.

Do excepted benefits have to report on broker and service provider compensation? New 4/26/21

No. Except for dental and vision, excepted benefits are excluded in the requirements for group and individual markets.

Does the compensation reporting apply to Short Term Limited Durations Plans? New 4/26/21

Yes, for individual plans only. It does not apply to group plans.

Reporting

Will UnitedHealthcare or our self-funded customers need to feed data to the agencies to put together their reports? What will we need to do to prepare to provide the data? New 3/22

At this time, we have no specifics on what data is needed or what we will be required to provide. Once the agencies request data from us, from customers or providers, each group would be expected to respond. UnitedHealthcare will continue to watch for updates related to this requirement.

Pharmacy Benefits and Cost Reporting

What are the reporting benefits and cost requirements? New 4/26/21

Health plans offering group or individual health insurance coverage, except for church plans, must report plan specific prescription drug spending and medical cost data annually to the Departments of Health and Human Services, Labor, and the Treasury. This applies to insurers and to self-funded plans.

What does this requirement go into effect? New 4/26/21

The first report will be due no later than Dec. 27, 2021 and then yearly after that, but no later than June 1 each year.

Who does the insurer or health plan submit the pharmacy coverage and cost report to? New 4/26/21

The report must be submitted to the Departments of Health and Human Services, Labor, and the Treasury.

What do these reports require for reporting of pharmacy costs? New 4/26/21

- Claims paid for the top 50 brand prescriptions most frequently dispensed by drug.
- Annual amount spent by top 50 most costly prescription drugs by total plan/coverage spend.
- The amount spent for the top 50 prescription drugs with the greatest plan spending over the prior plan year.

What do the reports require for reporting of medical services costs and spend? New 4/26/21

For medical services the reporting must be broken down by:

- **Type of costs** - including hospital, provider and clinical primary and specialist services, prescription drugs, other medical costs including wellness.
- **Spending by prescription drugs** by health plan coverage and member.

How do the reports require insurers and health plans to report premium costs? New 4/26/21

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 enrollees; and
    - Paid by 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.

Insurers and health plans provide the reports to HHS, DOL and Treasury and they will make the reports that were submitted available on the Health and Human Services (HHS) website for the general public.

Mental Health Parity NQTL Reporting

What is Mental Health Parity and Addiction Equity Act (MHPAEA)? New 3/22

MHPAEA is a federal law that requires benefits for mental health and substance use disorders (MH/SUD) to be delivered and administered on a basis that is comparable to or similar to how medical/surgical (M/S) benefits are delivered and administered (i.e., the limits are in “parity”). Generally, MHPAEA requires most health plans (there are a few exceptions) to apply limits on benefits – whether financial, quantitative or non-quantitative – comparably and no more stringently for MH/SUD benefits as they do for Medical/Surgical (M/S) benefits.

- Parity does not:
    - Mandate coverage directly
    - Eliminate clinical management of MH/SUD benefits

- Require reimbursement for mental health service to be the same as medical

What are the key components of MHPAEA? New 3/22

MHPAEA addresses parity limits in two broad categories and applies different standards to each, as described below. The 2021 Consolidated Appropriations Act (Act) focuses on non quantitative treatment limitations (NQTL).

1) **Financial Requirements / Quantitative Treatment Limitations (QTL)** – are subject to both a "substantially all" AND a "predominant" test.

   Examples of Financial Requirements include:

   - Deductibles
   - Coinsurance / Copayments
   - Penalties for lack of prior auth
   - Maximum out of pocket
   - Excludes lifetime and annual dollar limits

   Examples of Quantitative Treatment limits include:

   - Visit limits
   - Day limits
   - Treatment and Episode limits

Self-funded customers are responsible for ensuring plans are compliant with MHP rules. If a self-funded customer would like assistance with testing **Financial/Quantitative Treatment Limits (QTL)** from OptumInsight for a fee, contact your Account Management Team.

2) **Non-Quantitative Treatment Limitations (NQTL) –** Parity also applies to plan limitations which are not expressed as numeric limits and include rules on how services are accessed (e.g. geographic service area or network limitations) and under what conditions services are covered (such as medical necessity and prior authorization requirements): Examples include:

   - Medical management standards limiting or excluding benefits based ON medical necessity/appropriateness e.g. prior auth, concurrent review, retrospective review
   - Experimental/investigational exclusions
   - Formulary design

- Standards for admission to participate in a network, including reimbursement rates
- Step therapy requirements
- Methods for determining UCR or R&C charges

These NQTLs applied to MH/SUD benefits must be comparable to and applied no more stringently applied to MH/SUD benefits than those NQTLs applied to M/S benefits.

Who is responsible for MHPAEA compliance? New 3/22

- Generally, group health plans and insurers are responsible for MHPAEA compliance for its applicable fully insured and other applicable plans.
- **Self-funded plan customers** are responsible for their plans in meeting compliance obligations.

Does the Consolidated Appropriations Act change MHPAEA requirements? **New 3/22**

No, the Act continues MHPAEA's requirements to ensure applicable health plans meet parity guidelines. However, it does expand reporting requirements for the NQTL compliance.

How does the Act differ or add to MHPAEA requirements?

- Plans and issuers must perform and document comparative analyses of the design and application of NQTLs on MH/SUD and M/S benefits.

Federal or state regulators with enforcement authority may begin requesting such documentation on or about February 11, 2021.

- UnitedHealthcare will provide such documentation to appropriate regulators upon request for its applicable plans.
- **Self-funded Plan customers should visit with their legal counsel** to review MHPAEA requirements and documentation specific to their plan designs.

What type of information does a self-funded plan customer need to provide to comply with the Consolidated Appropriations Act (CAA)? New 3/22

- The legislation requires self-funded plans to provide NQTL documentation to the federal regulators (or state regulators who have enforcement authority for insured plans) upon request beginning on February 11, 2021.

- NQTL documentation typically includes a side by side analysis of M/S and MH/SUD of non-quantitative treatment limitations (NQTL) which could include prior auth, concurrent review, retrospective review, network adequacy, credentialing, etc.

Does UnitedHealthcare or Optum provide support to self-funded customers relevant to the Act? New 3/22

Upon request, UnitedHealthcare can provide the MHP NQTL Standards document that details the compliant standard UHC and Optum processes and procedures for network, medical/surgical and behavioral health to demonstrate parity. The intent of this document is to provide self-funded customers a suggested framework should a request be received from a regulator for NQTL compliance documentation. Self-funded customers that elect custom/non-standard elections will need to conduct additional plan review to ensure those elections are reflected accurately and confirm that each response aligns with their plan documents.

- To assist self-funded customers, an MHP NQTL Standard Medical and MH/SUD Standards document is now available that documents the compliant standard UHC and Optum processes and procedures for medical/surgical and behavioral health to demonstrate parity. The intent of this document is to provide self-funded customers a suggested framework to respond to regulator inquires if received.
- Any non-standard or custom plan deviations by self-funded customers are not considered in the MHP NQTL Standards Documentation. Plan specific information is included in the Administrative Service Agreement or Summary Plan Description.

- **The MHP NQTL Medical/Surgical and MH/SUD Standards Document** includes UnitedHealthcare and Optum Behavioral standards:
    - Network Management information can be utilized for all self-funded customers.
    - Medical Necessity information can be utilized for self-funded customers that have medical necessity language in their Summary Plan Description.
    - Notification information can be utilized for self-funded customers that have notification language in their Summary Plan Description.
    - The Optum Behavioral Health standards content would not apply to customers that have an alternate vendor outside of Optum Behavioral Health.
- As the plan fiduciary, the self-funded customer (or consulting firm, on behalf of the customer) is responsible for compliance with MHP requirements, NQTL parity comparative analysis and documentation confirming that the mental health/substance use disorder is no more stringent then medical/surgical. Customers should consult with their own legal counsel concerning completion of such analysis and documentation and comparison to their plan specifics.

What is the carrier's methodology for determining which medical/surgical inpatient benefits and which mental health and substance use disorder (MH/SUD) inpatient benefits are subject to utilization management (a/k/a medical necessity review) requirements? New 4/26/21

Utilization Management is not a standalone NQTL; rather, it is comprised of several different techniques or means by which the plan evaluates whether a service or benefit is clinically appropriate, medically necessary and a covered service under the benefit plan. UnitedHealthcare does not consider case management to be NQTL as it does not limit the scope or duration of treatment.

The plan's Utilization Management program includes the following NQTLs:

- Development and application of Medical Necessity Criteria (including clinical guidelines)
- Development and application of methodology used to determine whether services are Experimental, Investigational or Unproven (EIU)
- Prior Authorization a/k/a pre-service review
- Concurrent Care Review• Retrospective Review

Does the insurer or health plan use a different methodology for determining which M/S out-of-network inpatient benefits and which MH/SUD out-of-network inpatient benefits are subject to Utilization Management requirements? New 4/26/21

If the plan has out-of-network benefits, prior authorization for out-of-network benefits applies substantially the same process and uses the same criteria as prior authorization for in-network benefits, with three differences:

- First, the member is responsible for obtaining the prior authorization per the plan documents; however, the out-of-network provider can obtain the prior authorization on behalf of the member.
- Second, although the plan seeks the same type of clinical information from out-of-network providers and facilities, because they are not contracted with the plan the out-of-network providers and facilities have no obligation to cooperate with the plan's requests for information, documents, or discussions for purposes of prior authorization review.
- Third, depending on federal or state regulations, the provider may bill non-reimbursable charges to the member if certain processes are followed.

Are there any exclusions for unproven treatment or services? New 4/26/21

Yes. Under the terms of the governing plan document (e.g. SPD, COC, EOC), there is typically a standard exclusion for services determined to be experimental, investigational, or unproven.

What are the medical management standards used by the plan to limit or exclude benefits based on medical necessity, or based on whether the treatment is experimental, investigational, or unproven? New 4/26/21

Under the terms of the governing plan document (e.g. SPD, COC, EOC), there are typically standard exclusions for services determined to be not medically necessary and experimental, investigational, or unproven. The standard plan includes a requirement that services and treatments, including supplies or pharmaceutical products, must be medically appropriate or medically necessary in order to be a covered health care service, as defined by the Summary Plan Description (SPD) or Certificate of Coverage (COC). Determination of whether a service is medically appropriate begins with the definition of "medically appropriate" under the plan terms and then application of applicable clinical policy and criteria to the specific service to evaluate whether the service meets clinical criteria and is considered medically necessary. This definition applies equally to M/S and MH/SUD benefits. There is no other, separately applicable definition of "medically necessary" or "medically appropriate".

Determination of whether a service is experimental or investigational or unproven begins with the definition of "Experimental or Investigational Service(s)" as well as the definition of "Unproven Service(s)" under the Plan terms. And then, application of applicable clinical policy and criteria to the specific service to evaluate whether the service is considered Experimental or Investigational or Unproven. The plan SPD or COC defines "Experimental or Investigational Service(s)" and "Unproven Service(s)". The definitions apply equally to both M/S and MH/SUD benefits.

The specific medical necessity criteria and standards used to review requests for coverage and services vary by condition and are drawn from numerous sources. For more information refer to UHC.com.

What is the process for handling appeals and grievances? New 4/26/21

The appeals process is outlined in the members plan document. All applicable state and federal appeals requirements including letters, notifications and timing are followed for both to Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD).

What programs are available to detect fraud, waste and abuse and are they consistent for to Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD)? New 4/26/21

Although UnitedHealthcare does not consider the fraud, waste, and abuse program to be an NQTL, since the program does not limit the scope or duration of treatment, UnitedHealthcare's

standard program for fraud, waste and abuse applies to both M/S and MH/SUD plans as outlined below.

The Plan utilizes a comprehensive program for the detection of potential fraud, waste, and abuse. The program is structured to ensure compliance with all state and federal contractual and regulatory requirements.

Payment Analytics

Payment analytics are developed in response to industry information from entities like the Centers for Medicare & Medicaid Services ("CMS") or the National Health Care Anti-Fraud Association ("NHCAA") or from internal data mining/research indicating there is a known Fraud Waste Abuse (FWA) scheme, vulnerability, or area where we know there is frequently FWA.

Reimbursement Policies

Reimbursement policies outline the strategies and goals of improving or enforcing adherence to coding and billing standards. The Plan uses the Reimbursement Policy Process to improve or enforce provider adherence to coding and billing standards.

Fraud, Waste and Abuse Investigations

Payment Integrity receives internal and external referrals or tips related to potential allegations of FWA. Claims also stop for potential FWA. In both instances, investigations or reviews are conducted to validate the claim and/or referral/tip.

Where can a comprehensive list of nonquantitative limits comparing Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD) be found? New 4/26/21

These are in the standard NQTL documentation available from the customer's account team. The documentation includes topics that may not be considered NQTL (e.g., case management, fraud, waste, and abuse, etc.)

Custom Networks

Content coming

FSA Carryover and Tax Provisions

FSA Carryover

What temporary changes for FSA did the Appropriations Act, signed on 12/27/2020, allow customer to opt-in to? Update 2/2

These temporary changes for both health and dependent care are optional for all employers. Employers may select to implement one or a combination of any they choose. None are mandates.

- **FSA Rollovers.** The Act allows health and dependent care FSA participants to carry over unused balances from a plan year ending in 2020 to a plan year ending in 2021 and from a plan year ending in 2021 to plan year ending in 2022.
- **FSA Grace Period Extension.** The Act allows a health and dependent care FSA grace period for a plan year ending in 2020 or 2021 to be extended 12 months after the end of such plan year.
- **Health FSA Reimbursements.** The Act permits a health FSA to allow an employee who ceases participation in the plan during 2020 or 2021 (for example, due to termination of employment) to continue to receive reimbursements from unused balances through the end of the plan year in which such participation ceased (including any grace period).
- **Dependent Care FSA Participation.** The Act permits dependent care FSA participants whose qualifying child turned age 13 during the pandemic to continue to receive reimbursements for such child's dependent care expenses for (1) the remainder of the plan year and, (2) to the extent a balance remains at the end of the plan year, the following plan year until the child turns age 14 (but only with respect to the unused amount). The plan year described in (1) must have had a regular enrollment period that was on or before January 31, 2020.
- **FSA Election Changes.** The Act permits health and dependent care FSA election changes for plan years ending in 2021, regardless of whether the employee has a permitted election change event. This extends the election change relief for FSAs provided in IRS Notice 2020-29 by one year.
- Amendments need to be adopted by the last day of the year after the plan year in which the amendment is effective. 2020 carryover amendments need to be made by December 31, 2021.

How will UHC administer the options available? New 1/14

- Amounts that are unused in 2020 may be carried over to 2021 and amounts that are unused in 2021 may be carried over into 2022: UHC will allow all unused amounts remaining in the 2020 (or 2021) plan year for carryover, regardless of how it was applied. Unused amounts from any plan year prior to 2020 will not be included. Any other request will require internal BAR review
- Health and dependent care FSA grace periods for plan years ending in 2020 and/or 2021 may be extended until 12 months after the end of the plan year: UHC will extend the Grace Period for the customer.
- Plan participants who cease participation in the plan during 2020 and/or 2021 (terminated participants) may continue to be reimbursed if they have unused amounts in their health and/or dependent care FSA: Like dependent care FSA, termed members could incur claims after termination and spend remaining balances down.
- Plan participants will be permitted to make prospective changes to their health and/or dependent care FSAs during 2021 (without regard to change in status): We will manage those choices via our standard eligibility process.
- Reimbursement of expenses under a dependent care FSA for dependents who aged out during the COVID-19 pandemic. This will allow reimbursement for children who turned 13 on or after March 1, 2020 (which is the start of the pandemic) until the end of the pandemic.

If a customer were to implement the carryover rule for 2020 or 2020 & 2021, what are the implications when a participant moved to a qualified high deductible health plan (HSA plan)? New 1/14

If a customer allows the full carryover of unused 2020 funds (or 2021 funds) or elects the full 12-month Grace Period, then any member who may have moved to a qualified HDHP will be impacted. Both options allow members to incur claims and use their FSA funds. This is considered 1st dollar coverage under the HDHP. If a member already elected a limited FSA, we can move remaining balances to that limited FSA upon request. A decision will need to be made to communicate the impact to HSA members who did not already elect a limited FSA for 2021 or in 2022.

Will plan documents needs to be updated to allow for these changes? New 1/14

Yes. Amendments need to be adopted by the last day of the year after the plan year in which the amendment is effective. 2020 carryover amendments need to be made by December 31, 2021

How do I notify UnitedHealthcare which options we are electing? Update 2/2

UnitedHealthcare is requesting that you notify your UHC Representative by February 15th, 2021.

UnitedHealthcare will manage the changes as a plan change. Therefore, all plan documents will need to be updated.

Once we are notified, will systems be updated to reflect the choses made? For example: if 12 months grace period extension was selected, CAMS would show the updated grace period length/date? New 2/2

UnitedHealthcare manages any changes as a plan change as customers provide their decisions. All plan documents need to be updated.

Each update should be submitted as plan change and we will manage customer directed options as their choices come in.

What did the final rule, which came out on May 4, 2020, require for FSA and HRA/HIA plans? Update 1/13

The DOL and IRS final rule extended timely filing for HRA and FSA until 60 days past the declared end of the Presidents federal Covid-19 Emergency period. The final rule calls this the Outbreak Period (Covid-19 President's declared emergency period plus 60 days).

This is a mandatory change for fully insured and self-funded ERISA plans that will allow members to continue to submit expenses incurred in 2019 or 2020 through the end of the Outbreak Period. This applies to HRA/HIA and health FSA's. This applies to all plans with runout in effect on or after March 1, 2020. If the end of the pandemic is declared **by the president**, the timely filing deadline will be 60 days from that date for any plan year impacted by the final rule. Reminder, this also includes plans ending 12/31/20 who renewed for 1/1/21.

This does not apply to dependent care FSAs since a dependent care FSA is not an ERISA plan.

Did the CAA extend the FSA run out period? New 3/22

Yes, standard ending is now open with additional grace periods.

Is the FSA extension an employer choice or a requirement? New 3/22

This is optional at the employer's choice and if implemented the plan sets the terms.

Does the FSA guidance apply to Exchanges or just group plans? New 3/22

This guidance for FSA extension is only for employer plans.

Does the consumer have to continue to work for employer and just not continue participate in FSA to use funds? Or can they leave the employer and still use FSA Funds? New 3/22

The member can continue to use funds after termination.

Reduce the Exclusion Trigger for Qualified Medical Expenses

Content coming.

Extend Health Coverage Tax Credits

Content coming.