



# Consolidated Appropriations Act Frequently Asked Questions

**External**

8/24/21

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**United  
Healthcare**

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## Resources

### External

Consolidated Appropriations Act [document](#)

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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.

An Interim Final Rule was released from the Office of Management and Budget on July 1, 2021, that applies to plan years on and after January 1, 2022. In addition to including several model notices, it addressed the following issues. Questions and answers have been added and/or updated throughout the FAQ. **New 7/19/21**

- Definition of “emergency services” including post-stabilization care.
- Determination of “Qualified Payment Amount” (QPA).
- Interaction with state surprise billing laws.
- Required provider and health plan notices.
- Choice of health care providers.
- Federal enforcement priorities for certain CAA provisions.

The Departments intend to issue additional rulemaking in 2021 **New 7/19/21**

- Independent Dispute Resolution IFR (August)
- Provider transparency/patient dispute resolution (TBD)
- Air ambulance reporting (October) – at OMB
- Agent/Broker compensation reporting (October) – at OMB
- HHS enforcement (October) – at OMB

Other anticipated CAA rulemaking may not be completed by end of 2021: **Update 8/24/21**

On August 20, 2021, the Tri Agencies released FAQ 49 that outlined a delay in enforcement policy and implementation deadline extensions for a number of CAA provisions.

The following provisions are asked to use good faith and reasonable interpretation to continue to implement on and after January 1, 2022. Additional rulemaking is forthcoming that will update guidance and provide any changes to implementation requirements.

- Plan ID cards
- Continuity of care
- Provider directories
- Prohibition on gag clauses

The following two provision implementation dates are no longer in place. Additional guidance will update guidance and provide a new effective date. Health plans are encouraged to prepare to meet Pharmacy Benefit and Cost Reporting by December 27, 2022.

- Advance Cost Estimate

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- Rx benefit and cost reporting

There are no planned changes to the No Surprises, no balance bill regulations or independent dispute regulations (IDR) although we do anticipate some additional IDR guidance in October.

## General FAQs

### **How and when will updates on your compliance with the various requirements of the TFR and CAA be disseminated to clients? [New 6/5/21](#)**

New laws impacting UnitedHealthcare's and our customers' businesses are communicated as appropriate including providing periodic summaries to our self-funded customers with respect to new laws or changes to existing laws that impact group health plans. UnitedHealthcare periodically provides educational information about significant legal developments to our customers.

In addition, UnitedHealthcare may provide recommendations to our self-funded customers on benefit design changes that may be required to comply with certain federal mandates, including but not limited to the reforms under the Affordable Care Act, Consolidated Appropriations Act, and Transparency in Coverage.

UnitedHealthcare cannot provide legal advice to customers/plan sponsors and continues to recommend customers/plan sponsors consult with their legal experts regarding their legal requirements.

### **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.

### **Do CAA and No Surprises provisions apply to Medicare Advantage or Medicare Part D? [New 6/18/21](#)**

At this time, UnitedHealthcare understands that the provisions of the Consolidated Appropriations Act (CAA) do not apply to coverage under Medicare Advantage (MA) or Part D. Medicare specific provisions in the CAA are primarily applicable to FFS Medicare. However, some may ultimately have some downstream effect to MA-e.g. Physician Fee Schedule changes. UnitedHealthcare is monitoring for any CMS guidance that is issued related to this Act and will implement any additional requirements as it relates to our Medicare Advantage and Part D plans if/when directed.

### **Is there a requirement that an individual must use their insurance coverage or health plan if they have it to pay for covered health care? [New 6/22/21](#)**

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No. An individual can choose to self-pay if they wish.

**Does UnitedHealthcare use subcontractors or third parties to assist in complying with the law and regulations? New 7/26/21**

UnitedHealthcare leverages external third-party subcontractors to augment our operations and service offerings, when/where appropriate. We have programs in place to ensure these subcontractors meet relevant performance, operational, contractual/compliance and regulatory standards. In general, subcontractors are selected based on the strategic needs of our entire organization and dependent on the subcontractors' abilities to comply with our requirements.

**Will UnitedHealthcare send advance communication to members about changes related to CAA and the No Surprises Act? Will UnitedHealthcare send a communication notifying members about the changes to ID cards? New 8/24/21**

Members will receive a communication regarding ID Cards at the time the deliverable is sent to the member or available via the member porta. This will occur by 1/1/22 for those members renewing in January and February. For members renewing March through December, the information will be available on line by February 28. There will not be advanced communications to the member

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## No Surprises Act Key Provisions

### No Surprises Definitions

#### What is the definition of provider as outlined in the No Surprises Act IFR? **New 7/19/21**

Provider refers to physician or other health care professional acting within the scope of practice under applicable state law. Does not include air ambulance.

#### What is the definition of emergency service facilities as outlined in the No Surprises Act IFR? **New 7/19/21**

Hospital emergency department

Freestanding emergency department – must provide emergency services, be geographically separate and distinct, and licensed separately from a hospital

Urgent care centers – if licensed by the state consistent with the definition of a “freestanding emergency department”

#### What is the definition of a non-emergency facilities? **New 7/19/21**

Hospital

Hospital Outpatient Department

Critical Access Hospital

Ambulatory Surgical Center.

#### What is definition of services that could be considered emergency services? **New 7/19/21**

- Appropriate medical screening examination and stabilization services as required under EMTLA within the capability of the emergency department of a hospital or an independent free-standing emergency department.
- Additional covered benefits furnished by an OON provider or emergency facility (regardless of the department of the hospital where the items/services are furnished) after the patient is stabilized provided certain conditions are met.
- Emergency medical condition (including behavioral health/substance use disorders) is a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson could reasonably expect in the absence of immediate medical attention to place the health of the individual (or unborn child) in serious jeopardy.
- Cannot deny coverage for emergency services based solely on the final diagnosis codes for the item/service. - determination must be based on “presenting symptoms.”
- “Post-Stabilization” Services

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### **What are post- stabilization services? New 7/19/21**

OON emergency services may include additional items/services furnished after stabilization by an OON provider or emergency facility (regardless of the department of the hospital in which furnished) if part of outpatient observation or an inpatient or outpatient stay with respect to the emergency services visit. The post-stabilization items/services furnished by the OON provider/facility are subject to the surprise billing requirements (including the prohibition on balance billing) unless:

- The attending emergency provider or treating physician determines the patient is able to travel using nonmedical transportation or nonemergency medical transportation to an available participating provider or facility located within a reasonable travel distance, taking into consider the individual's medical condition; and
- The patient receives a notice in advance that the services are OON, the estimated charges, and that they may be responsible for the costs; and
- The patient (or representative) must be in a condition to receive the notice and provide informed consent to receive the services (HHS released a model notice/consent).

### **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 require coverage for OON services including air ambulance? **New 7/19/21****

If an insurer/plan covers any INN emergency items/services, the insurer/plan must cover the same items/services regardless of whether they are provided by a non-participating provider/facility, subject to the requirements for cost-sharing, payment amounts, and dispute resolution.

If an insurer/plan covers any INN items/services, the insurer/plan must cover the same items/services provided by an OON provider in connection with a visit to an INN facility, subject to the requirements for cost-sharing, payment amounts, and dispute resolution. This includes all covered items/services in connection with the visit to the facility even if furnished offsite (e.g., laboratory and telemedicine services).

If an insurer/plan has a network of participating providers and covers any air ambulance benefits, the insurer/plan must cover services provided by an ONN air ambulance carrier, even if the insurer/plan does not have any INN air ambulance carriers, subject to the requirements for cost-sharing, payment amounts, and dispute resolution.

### **Are there any restrictions or plan terms that change what OON services are covered?**

**New 7/19/21**

Coverage for emergency services must be provided without any prior authorization requirements or with administrative requirements or coverage limits that are more restrictive than those applicable to INN emergency services.

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Coverage for emergency services must be provided without regard to any other term or condition of the plan or coverage except for: (a) the exclusion or coordination of benefits when it's not inconsistent with any benefits for emergency services); (b) any affiliation or waiting period or (c) any applicable cost-sharing requirements.

Insurers/plans cannot deny benefits for a member with an emergency medical condition that receives emergency services, based on a general plan exclusion that applies to non-emergency items/services (e.g., denying emergency treatment for a dependent pregnant woman based on a general exclusion for dependent maternity care).

### **How is cost sharing handled for OON emergency, OON air ambulance or OON network service at a network facility when member has no choice? [New 7/19/21](#)**

Insurer/plan cannot impose OON member cost-sharing requirements that are greater than those applied to INN services (e.g., if the insurer/plan imposes 10% co-insurance for INN services, the co-insurance for OON services cannot exceed 10%).

Also, OON cost-sharing must be applied to INN deductibles and cost sharing limits.

### **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.

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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.

### **Are transplant services in scope for provisions under the Consolidated Appropriations Act? New 6/22/21**

Yes.

### **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 6/21 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.

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- 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).

### **Will UnitedHealthcare establish and support the Qualifying Payment Amount, Recognized Amount, and Out-of-Network Rates for the Covered Services as outlined in the No Surprises Bill Act? Updated 7/19/21**

Under the No Surprises Act member cost-sharing for covered out-of-network (OON) services is based on the “recognized amount” which is determined as follows:

- In states that have adopted an All-Payer Model Agreement, (APMA), the payment amount pursuant to such agreement (e.g., Maryland).
- If the state does not have an APMA, an applicable state law methodology to determine the payment amount for such items/services.
- If the state does not have an APMA or state law methodology to determine the payment amount, the lesser of the billed amount or qualifying payment amount (QPA).

Air ambulance services – member cost-sharing must be the same as that applied to items/services provided by an INN provider based on the lesser of the billed amount of QPA.

### **How is the qualifying payment amount calculated? New 7/19/21**

The “qualifying payment amount” is defined in the No Surprises Act as the median contract rate for the covered item or service. The 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 group, or large group insured market and self-insured market with geographic variations established by tri-agency rulemaking.

The QPA is the median contract rate paid by the insurer/plan for the item/service on January 1, 2019. A cost-of-living adjustment is applied to that rate using the Consumer Price Index for all Urban Consumers (CPI-U).

- The QPA is established each OON item/service covered by an insurer in a specified market (individual, small group, large group) and for all plans of a self-funded group plan sponsor (or all plans administered by the third-party administrator of the group health plan plan).
- Association coverage provided to individuals – and not related to employment – is treated as individual market coverage for purposes of determining the QPA.
- QPAs are calculated using the contracted rates for the geographic region in which the item/service is furnished.

### **is the median contracted rate? New 7/19/21**

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Contracted rate is the total amount the insurer/plan has agreed to pay (including cost sharing) either directly or indirectly (e.g., through a PBM).

Each contracted rate for an item/service is a single data point –

- Insurer/plan has a contract with a provider group or facility - rate is a single contracted rate.
- Insurer/plan has a contract with multiple providers with separate negotiated rates with each provider - each unique contracted rate is a single contracted rate.
- Insurer/plan has separate contracts with individual providers - each contract is counted, even if they use the same rate.

The contracted rate does not include a single case agreement, letter of agreement or similar arrangement between an insurer/plan and a provider, facility, or air ambulance carrier.

Rates negotiated under excepted benefits, STLDI, account-based plans (e.g., HRAs), and similar arrangements are not in scope.

### **How is the median contracted rate calculated? New 7/19/21**

- The median contracted rate is calculated by arranging in order from least to greatest the contracted rates of: (a) all coverage offered by a health insurer in the same insurance market or (b) all plans of the plan sponsor (or of its TPA) for the same or similar item/service from the same or similar provider/facility in the geographic region.
- If there are an odd number of contracted rates, the median is the middle rate (\$475, \$490, \$510). If there are an even number of contracted rates, the median contracted rate is the average of the middle two rates (\$475, \$490, \$510, \$515 – the median is  $\$500$  ( $\$490 + \$510/2$ )).
- Alternative payment models (i.e., non-FFS)
  - Insurer/plan must use the underlying fee schedule to determine the median contracted rate (the rate the insurer/plan uses to determine the member's cost-sharing responsibility).
  - If there is not a fee schedule, the insurer/plan must use the derived amount (price assigned for internal accounting, provider reconciliation or submitted to CMS for purposes of risk-adjustment).
  - Risk sharing, bonus, penalty, and other incentive-based or retrospective payment adjustments are excluded.

### **How are providers reimbursed? New 7/19/21**

Health insurers and group health plans are required to reimburse the OON provider the difference between the member cost-sharing and the out-of-network rate. The out-of-network rate is defined by the No Surprises Act as the reimbursement rate for the covered OON item or service as determined by applicable state law.

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1. The reimbursement rate determined by a state All Payer Model Agreement.
2. If the state does not have an APMA, the reimbursement rate for the item/service as determined by applicable state law methodology.
3. The amount agreed by the health insurer or group health plan and the health care provider
4. If the state does not have an APMA or applicable state law methodology, the amount negotiated by the insurer/plan and provider or determined by Independent Dispute Resolution (IDR).
5. Air ambulance services – the amount negotiated by the insurer/plan and carrier or determined by IDR (do not consider APMA or state law).

### **Is there a law that limits insurer or health plan liability? New 7/19/21**

Law that provides a methodology for determining the total amount payable by the insurer/plan (i.e., either a specified amount or through an arbitration process).

Law must apply to the specific type of coverage, OON item/service, and OON provider/facility (e.g., if state law does not include OON neonatologist or emergency post-stabilization services, CAA process controls).

### **Are there any state no surprises laws that affect your determination of the Recognized Amount? Update 7/19/21**

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.

A self-funded plan may opt into a state No Surprises law and follow their methodology. However, if they choose not to opt in, the self-funded health plan would follow the federal methodology.

### **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.

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### **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.

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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

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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 fully insured prompt pay laws that have a different time requirement (more or less than 30 days), which will UnitedHealthcare follow? [New 5/18/2021](#)**

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

**How will UnitedHealthcare determine whether the patient consented to services from an out-of-network provider at an In-Network facility, and is therefore not reimbursed under the No Surprises Act? [New 7/26/21](#)**

We are evaluating how and when we will determine if out-of-network providers at an in-network facility have provided required notices to members and have obtained an acknowledgement that they received the notice.

**Will you assist the Plan in providing a complaint process for plan participants who have a complaint about bills under the No Surprises Act? [New 7/26/21](#)**

UnitedHealthcare has an external review process today for adverse benefit determination and UnitedHealthcare is reviewing the expansion of the review process to include disputes related to adverse determinations under the No Surprises Act.

**No Surprises Service Rate Calculations**

**How we are to calculate provider payment and member cost share for out-of-network providers at a network facility? [New 5/18/2021](#)**

If the insurer/plan has contracted rates for a service code that vary based on a provider specialty, the median contract rate is calculated for each provider specialty (i.e., the practice specialty identified by the insurer/plan consistent with usual business practice).

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.

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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.

### **How are items/services billed if the insurer or health plan has rates that vary by facility?**

**New 7/19/21**

If the insurer/plan has contracted rates for emergency services that vary based on type of facility (hospital emergency department vs. freestanding emergency department), the rate is calculated separately for each facility type.

Insurers/plans may not separately calculate facility contracted rates based on other characteristics (e.g., whether the hospital is an academic medical center).

### **How are items and service billed? New 7/19/21**

Same or similar item or service are items or services billed under the same or comparable code (i.e., CPT, ICD, DRGs or HCPCS).

Separate median contract rates must be calculated for CPT code modifiers for the professional services component (“26”) and the technical component (“TC”).

Where an insurer/plan contracted rates otherwise vary based on applying a modifier code, a separate median contracted rate must be calculated for each service code-modifier combination.

### **How are rates calculate based on provider specialty? New 7/19/21**

If the insurer/plan has contracted rates for a service code that vary based on a provider specialty, the median contract rate is calculated for each provider specialty (i.e., the practice specialty identified by the insurer/plan consistent with usual business practice).

### **Anesthesia services often are based on time, how are these services billed? New 7/19/21**

For anesthesia services, the insurer/plan must calculate a median contracted rate for the anesthesia conversion factor for each service code.

- Items/services furnished during 2022 – apply the CPI-U index factor to the median contracted rate for the anesthesia conversion factor for the same or similar service as of January 31, 2019.
- Items/services furnished after 2022 – adjust the indexed median contracted rate for the anesthesia conversion factor by the percentage CPI-U increase over the prior year.

The indexed median contracted rate must be multiplied by the sum of the base unit (using the value specified in the mostly recently published edition (as of the date of

service) of the American Society of Anesthesiologists Relative Value Guide, time unit, and physical status modifier units of the patient

### **How will UnitedHealthcare calculate the QPA rates? New 8/24/21**

The UnitedHealthcare healthcare economics team is producing the par median rates based on the interim final rule released July 1, 2021. These rates are expected to be laded to support the No Surprises Act claim processing for new and renewal business by January 1, 2022.

### **How are air ambulance services billed? New 7/19/21**

All providers of air ambulance service are considered a single provider specialty (i.e., hospital-based air ambulance providers are treated the same as non-hospital-based providers).

Under time and distance guidance, for air ambulance services, the insurer/plan must calculate a separate median contracted rate for the air mileage service codes (A0435 fixed wing mileage and A0436 rotary wing mileage).

### **How does geography impact rate calculations? New 7/19/21**

QPA is based on the median negotiated contract rates for the same or similar service provided by the same or similar provider in the geographic region where the item/service is furnished.

To calculate the QPA there must be sufficient information in the region to calculate the median contracted rate (i.e., at least three contracts as of January 1, 2019).

The geographic regions are based on Metropolitan Statistical Areas (MSAs) as described by the Office of Management and Budget and published by the U.S. Census Bureau.

MSAs are established along county boundaries and may include counties from more than one state. For purposes of determining the QPA, MSAs that cross state boundaries are divided between the respective states.

The geographic regions for OON services (except air ambulance) are a region for each MSA in a state and one region consisting of all other areas in a state.

- If there is insufficient information, all MSAs in the state are combined for one region and all other areas of the state are a separate region.
- If there is still insufficient information, the geographic regions are one region for all MSAs in the Census division and a separate region for all other areas in the Census division. There are nine Census divisions as published by the U.S. Census Bureau.

The geographic regions for OON air ambulance services are one region combining all MSAs in a state and one region consisting of all other areas in a state.

If there is insufficient information, the geographic regions are one region for all MSAs in the Census division and a separate region for all other areas in the Census division.

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## No Surprises Consumer and Provider Disclosures

### What disclosures to members are required under the a No Surprises Act? **New 7/19/21**

Beginning January 1, 2022, providers/facilities must publicly post, include on any websites, and provide to any patients with coverage under an insurer/plan information about the surprise billing provisions.

Insurers/plans must publicly post, provide on any websites, and include with any EOB for OON items/services subject to the surprise billing provisions.

The notice must include the following information:

- The balance billing prohibitions and requirements under the No Surprises Act.
- Any applicable state requirements with respect to balance billing.
- Information on contacting any applicable state or federal regulatory agency if the individual believes a provider/facility has violated balance billing restrictions.

DOL released a model insurer/plan notice and HHS released a model provider notice.

### What disclosures do insurers or health plans provide to providers on Qualified Payment Amount initial payment or denial? **New 7/19/21**

QPA for each billed item/service. • Statement that the QPA applies for purposes of the recognized or cost-sharing amount. • Statement that each QPA was determined in compliance with the IFR methodology. • Statement that the provider may initiate a 30-day negotiation period and may request IDR after the end of the negotiation period. • Contact information (e-mail/phone number) for insurer/plan contact for negotiations.

### What Qualified Payment Amount-related disclosures must the insurers or health plans give to the providers upon request? **New 7/19/21**

Information about whether the QPA includes rates not set on a FFS basis and whether the QPA for those items/services were determined using a fee schedule or derived amount.

If a new service code, identify the related service code.

Identification of any database used to determine the QPA.

Statement that the rates used to determine the QPA exclude risk-sharing, bonus, penalty or other incentive-based or retrospective payments or payment adjustments.

## Air Ambulance

### Can state law resolve air ambulance disputes? **New 7/19/21**

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No.

**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

**Are we noticing any trends in air ambulance providers increasing their rates prior to implementation of No Surprises? How should members be protected from extremely high air ambulance billing practices? [New 6/21/21](#)**

We have noticed this in some parts of the country. The positive side is under the No Surprise Act, the members' cost share will be based on methodology using 2019 rates. Members are held harmless for any amounts billed by air ambulance providers in excess of cost-sharing.

Because the No Surprises Act applies to out-of-network air ambulance services, the member would pay cost-sharing for such services under the same requirements as would be applied to in-network services. The insurer or plan will negotiate the amount of reimbursement paid for out-of-network air ambulance services and if an agreement is not reached, the dispute will be subject to an Independent Dispute Resolution process.

**Is it likely that ground ambulance might also come in under No Surprise billing at some point? Is the government looking at that? [New 6/21/21](#)**

Ground ambulance is not covered by the No Surprises Act. The Tri-agencies - HHS, DOL and Treasury - are creating an advisory committee to develop options to improve the disclosure of charges and fees for ground ambulance to better inform consumers of options and protect them from balance billing.



## **Independent Dispute Resolution**

**Will UnitedHealthcare offer services to support health plans when they have to reimburse out-of-network providers and facilities in the situations where balance billing is prohibited? [New 6/5/21](#)**

Yes. We will offer services to support this.

**Which entities are used for Independent Dispute Resolution (IDR)? [New 6/5/21](#)**

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 no IDR entities have been certified.

**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](#)**

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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 choose 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

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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.

**What support will be provided to the plan if a health care provider or facility elects to negotiate an out-of-network payment amount or elects to conduct Independent Dispute Resolution (IDR)? New 6/21/21**

UnitedHealthcare can assist self-funded plans with their implementation requirements under the No Surprises Act. Based on our experience with 34 different states' no surprise programs, UnitedHealthcare expects significant activity for each claim submitted to IDR. These activities can be managed by UnitedHealthcare for you. There is significant research, data gathering and reporting included requirements to:

- Assess provider billing behavior
- Assess provider negotiation history with UnitedHealthcare
- Assess how provider batches its claims for IDR
- Determine offer based on analysis and reporting on various factors, which may influence the final decision:
  - Qualifying payment amounts comparable to items or services furnished in the same region

- Level of training, experience, and quality and outcomes measurements of the provider
  - Market share held by the provider
  - Acuity of the individual receiving such item or service or the complexity of furnishing such item or service to such individual
  - Teaching status, case mix, and scope of services of the nonparticipating facility that furnished such item or service
- Prepare persuasive brief
  - Analyze published decisions, refine strategy if needed

Customers should be making decisions now if they would like UnitedHealthcare to handle this for them. There will be an associated fee.

UnitedHealthcare expects that the Departments of Health and Human Services, Labor, and the Treasury will issue rulemaking later this year to further clarify the IDR process.

### **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

### What was the change in the FAQ 49 that came out on August 20? **New 8/24/21**

For ID cards, plans are asked to use good faith and reasonable interpretation to meet the 1/1/22 date. Additional guidance is anticipated in 2022. Enforcement is based on a safe harbor.

### Does the law require any changes to ID cards? **Update 8/24/21**

Yes. 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.

Enforcement of the regulations is delayed pending additional guidance; plans are asked to use good faith and reasonable interpretation of the existing guidance.

### Do deductibles that are per occurrence (i.e. per hospitalization) or the overall plan deductible need to be reflected on the ID card? **New 6/30/21**

Per occurrence deductibles are usually treated as a copay. Copays are not included in the CAA regulation and therefore, per occurrence deductibles would not be included on the ID card.

### Which of the following plans will require new ID cards to be issued? **New 6/30/21**

- **Grandfathered plans** – require the new ID card
- **Retiree plans** – do not require the new ID card
- **Collectively bargained plans** – require the new ID card
- **COBRA** – not required since new cards are typically no issued as the member uses the card they had when they were an active employee.

### Are there font style or font size requirements? **New 4/2/21**

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.

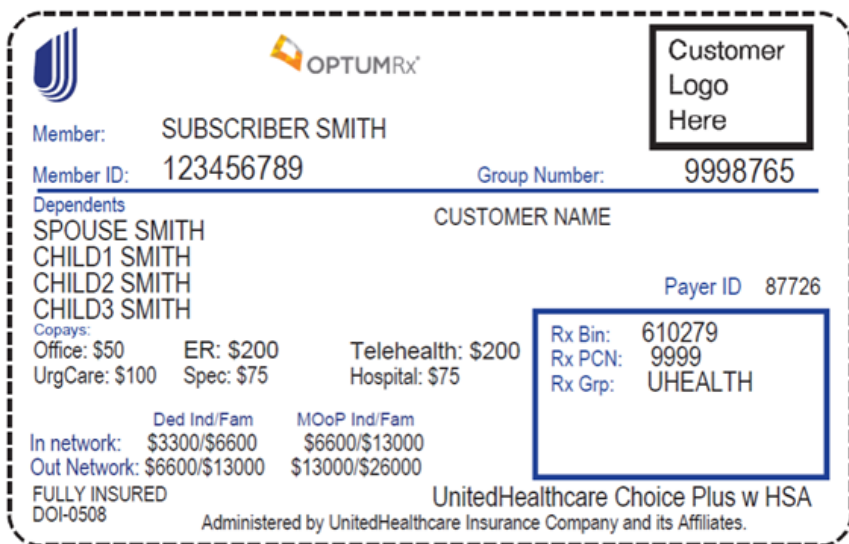
### What does the new ID Card look like? **New 8/3/21**

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A sample card is shown below. There are several different sample cards depending on plan structure (for example, if there are multiple tiers for medical and/or pharmacy).



**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 6/17**

Cards will be updated and issued upon renewal to new members and members that change plans as is our normal business practice. UnitedHealthcare will not proactively issue new cards to all members. Existing members that wish to have a new ID card will be able to download an electronic version via myuhc.com or request a new card by contacting Customer Care.

A customer may request a full reissuance of ID cards if they so choose.

Cards will be issued via our standard process prior to the customer renewal date.

Customers renewing after January 1, 2022 will not have ID cards with the new format proactively sent to their members prior to their 2022 renewal date. However, they may have an updated electronic version of their ID card available online prior to their renewal date. Cards for these groups will be issued via our standard process.

**Will UnitedHealthcare will send advance communication to members notifying members about the changes to ID cards coming on 1/1/22? New 8/3/21**

UnitedHealthcare will send members communications with the Advance Cost Estimate and ID Card at the time the deliverable is sent to the member. The information will also be posted on the member portal by 1/1/22.

There will not be advanced communications to the member.

**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? Update 6/7**

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ID cards will be issued in accordance with existing requirements. Electronic versions of ID cards with the new requirements will be available online beginning Jan. 1, 2022 on plan renewal dates.

**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 electronic ID Cards must be reissued on renewal on or after 1/1/22 and printed cards will be sent in accordance with existing requirements. When online ID cards are printed, they will include the new CAA ID card requirements.

**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.

**What date you need renewal decisions in order to produce ID cards in a timely fashion? New 6/7/21**

The full ID card cycle – from our receipt of clean eligibility data to card production to members receiving their card in the mail – usually takes three weeks. The initial eligibility load and quality assurance steps takes three to five days, assuming clean eligibility data.

The process and timeline for generating ID cards is the same for new hires as it is for initial plan setup.

**ID CARD FOR APPS**

The mobility of our mobile app may eliminate the need for a printed card, since the member can use the app to show or email the ID card image to the provider.

Members may also print a temporary ID card directly from our member website, **myuhc.com**, 12 hours to 24 hours after the file is released to print.

**Are there any changes to the administrative fees as a result of the ID card changes? New 6/7/21**

There is no additional cost for us to mail family ID cards directly to members' homes via the United States Postal Service as plans renew on or after January 1, 2022. We are still reviewing other requirements under CAA and self-funded customers can expect timely and relevant information regarding potential administrative costs as more details become available.

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**Are Medical and Pharmacy Deductibles required to be separate on the ID Card? New 6/18/21**

If Medical and Pharmacy have different deductibles, they need to be listed separately. If pharmacy is part of the Medical deductible, it does not need to be listed.

All tiering should be included on Medical and Pharmacy deductibles as well as out-of-pocket maximum (OOPM).

**Does the CAA ID card provision apply to Medicare Advantage or Medicare Part D? New 6/17/21**

At this time, UnitedHealthcare understands that the provisions of the Consolidated Appropriations Act (CAA) do not apply to coverage under Medicare Advantage (MA) or Part D. Medicare specific provisions in the CAA are primarily applicable to FFS Medicare. However, some may ultimately have some downstream effect to MA-e.g. Physician Fee Schedule changes. UnitedHealthcare is monitoring for any CMS guidance that is issued related to this Act and will implement any additional requirements as it relates to our Medicare Advantage and Part D plans if/when directed.

**Will UnitedHealthcare send advance communication to members about changes related to CAA and the No Surprises Act? Will UnitedHealthcare send a communication notifying members about the changes to ID cards? New 8/24/21**

Members will receive a communication regarding ID Cards at the time the deliverable is sent to the member or available via the member porta. This will occur by 1/1/22 for those members renewing in January and February. For members renewing March through December, the information will be available online by February 28. There will not be advanced communications to the member.

**Besides the insert in the ID Card explaining the new CAA changes. Is UHC sending any additional communications to members? New 8/24/21**

No other messaging on ID card changes is planned. Employers have been communicated on the changes that are coming.

**If the customer opts NOT to send new ID Cards, are we posting the communication digitally for members on myuhc.com? New 8/24/21**

Actual cards will only be sent if the customer is due to get a fully mailing based on their agreement. However, the information will be posted on the member portals and cards and an explanation of changes will be on the portal.

## 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.

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### Does R&C, MGRP, ENRP, OCM, Shared Savings, Naviguard meet the Consolidated Appropriations Act requirements? **New 6/22/21**

All out-of-network programs when triggered in a No Surprises Act circumstance, will follow the guidance set down by the No Surprises Act.

- OCM (emergent), ENRP, and Naviguard (emergent) will follow the No Surprises Act.
- R&C, MGRP, OCM (non emergent) and Naviguard (non emergent) will not be triggered in NSA situations so will not have to follow the NSA.

### How does the federal No Surprises Act apply to balance billing? Does it pre-empt state regulations? **New 6/18/21**

The federal No Surprises Act specifically states providers cannot balance bill. Providers who are not satisfied with our initial offering may request negotiation. If an agreement isn't reached during the negotiation period, the provider may initiate the Independent Dispute Resolution (IDR) process. If the providers offer is the one selected by the IDR entity, then the self-funded customer or insurer pays the additional costs; the member does not incur any additional costs beyond their cost share. ASO group potential exposure increases based on any increase in final payments since member contribution remains the same.

There are a number of states that have their own version of a No Surprises regulation. UnitedHealthcare regulatory is working on a 50-state review, which will provide guidance as to where the Federal No surprises act may apply. The state regulations are not mandated for self-funded groups and to date only six states have a self-funded opt in program in place. Additional

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guidance is anticipated in July that will inform how the federal and state regulations will interact beginning 1/1/2022.

### **What programs are impacted by the Federal No Surprises Act? New 6/18/21**

The No Surprises Act applies to the following services and claims where a member has ‘no choice’:

1. Out-of-network emergency covered services at a hospital or freestanding facility.
2. Covered items and services provided by certain out-of-network health care providers at an in-network facility.
  - Ancillary services with or without member consent (e.g., anesthesiology, imaging, radiology, pathology, etc.) provided by out-of-network providers at in-network facility
  - Out-of-network care provided at in-network facility without patient’s informed/written consent.
3. Out-of-network air ambulance items and services.

The following out-of-network programs may apply to services defined in the No Surprises Act:

- Naviguard (emergent)
- Outlier Cost Management (Emergent)
- ENRP
- Wrap Network/Fee negotiation (Shared Savings Program)
- Shared Savings Program Enhanced (Wrap/Fee Negotiation/Outlier Cost Management Emergent)

Programs still apply per the benefit plan (Certificate of Coverage or Summary Plan Description). Depending on additional rule making, some out-of-network programs may be more effective in working within No Surprises.

Final rule making may impact how programs initially price claims.

### **Are out-of-network programs impacted when a member has a claim when they chose to go out-of-network? New 6/18/21**

When a member has a choice (i.e. out-of-network benefit level), claims are not impacted by the No Surprises Act. The following programs will operate as normal and apply per the benefit plan:

- Naviguard (non-emergent)
- MNRP
- Outlier Cost Management (OCM) Non-Emergent

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- Physician R&C
- Facility R&C
- Wrap Network & Fee Negotiation (Shared Savings Program)

### **What OON programs work for both No Surprises Act as well as claims for members who choose to go out-of-network for services not covered under No Surprises Act? New 6/18/21**

Focus should be on selecting an out-of-network program that would work in all instances -1) for those covered under the No Surprises Act and 2) for those that can be affected for members choosing to go out-of-network.

### **How does the No Surprised Act affect the Affordable Care Act and the greater of three payment requirements for ER Services? New 6/18/21**

The Affordable Care Act required out-of-network emergency care to be paid at the greatest of:

1. The amount the insurer pays in-network providers for the same services
2. The amount calculated by the insurer to be the “usual, customary, and reasonable charges” for such services.
3. The amount that would be paid under Medicare for such services.

Going forward payments to out-of-network providers for services addressed by the No Surprises Act an initial payment will be made to the out-of-network provider (which UnitedHealthcare refers to as the “go out rate”). The provider will have option to accept payment or request negotiation if the initial payment is not satisfactory and access an Independent Dispute Review (IDR) process if the payer and provider cannot agree on a negotiated amount.

### **How will the out-of-network initial payment affect a member's cost share? New 6/18/21**

The member's cost share will now be based upon the Recognized Amount. The Recognized Amount can be based on the following:

1. State required reimbursement amount
2. Available state APCD amount
3. Qualifying Payment Amount

For No Surprises services, the member may not be balance billed for any charges for coverage beyond the qualified payment amount. Members cost share will remain fixed and will not be adjusted if a payer negotiates an additional amount or if an arbiter/IDR entity awards a higher amount through IDR. The additional cost, if any, must be covered by the plan. However, for non-ancillary provider, if the member signs consent for the services to be rendered by a non-par provider, then the provider can balance bill the member.

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### **What would a situation under No Surprises, where a provider may balance billed a member? New 6/18/21**

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.

### **What does UnitedHealthcare offer to self-funded customers as preferred out-of-network programs going forward? New 6/18/21**

UnitedHealthcare no longer recommends R&C programs. These legacy programs leverage benchmarks that start with provider's billed charges. Over the past number of years, provider billed charges have escalated to a point that these R&C programs are no longer affordable.

Out-of-network programs that ensure that market-based typically accepted rates are used for reimbursement offer an advantage.

UnitedHealthcare encourages clients to select out-of-network programs that address both No Surprises "no choice" scenarios and for "choice" scenarios. Naviguard is UnitedHealthcare's lead out-of-network offering as it will continue to leverage proprietary reimbursements grounded in market dynamics, provide member advocacy for services not impacted by the No Surprises Act (i.e. ground ambulance, member choice claims), in addition to supporting the negotiation and IDR requirements of the NSA.

## 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.

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### 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.

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## 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 was the change in the FAQ 49 that came out on August 20? New 8/24/21**

For continuity of care, plans are asked to use good faith and reasonable interpretation to meet the 1/1/22 date. Additional guidance is anticipated in 2022. Enforcement is based on a safe harbor.

### **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? Update 8/24/21**

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

For continuity of care, plans are asked to use good faith and reasonable interpretation to meet the 1/1/22 date. Additional guidance is anticipated in 2022. Enforcement is based on a safe harbor.

### **When does continuity of care apply to self-funded plans? New 7/30/21**

Continuity of care may apply when a provider is no longer in the network. The member then has the right to request continuity of care for certain health care situations which if authorized would end after 90 days or the date the person is no longer under care.

It does not apply to plan changes or if the health plan moves to another plan administrator that does not have the provider in network. At that time if the plan had a transition of care program that would apply.

### **How does UnitedHealthcare identify members that may be eligible for continuity of care under the CAA? New 6/22/21**

UnitedHealthcare sends a notice to all members who are impacted by a provider who is terminated from the network using our standard lookback process.



Members who may be eligible would need to request continuity of care. UnitedHealthcare uses our experience, applies appropriate clinical guidelines, allows the plan to use existing evidence-based standards and same definitions for eligibility for continuity of care that are applicable for reasons other than provider termination.

### **Under the continuity of care provision, does the provider have to accept the payment or can they balance bill? New 6/22/21**

The provider needs to accept the payment and agree to any network terms and conditions.

Under the continuity of care provision, the provider must accept the network payment rate.

### **Will UnitedHealthcare provide definition of what conditional may be eligible for continuity of care? New 6/22/21**

Those are outlined in the CAA.

### **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.

**Will UnitedHealthcare allow certain participants to receive up to 90 days of continued coverage at in-network cost-sharing rates when their provider moves out-of-network? What impact will this have on the client's plan documents? New 6/5/21**

Yes. As with other federal and state laws, UnitedHealthcare intends to comply with the new requirements and keeping customers informed on UnitedHealthcare's approach and options for self-funded customers.

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

Plan documents will be updated and adjusted, as necessary, to reflect compliance with the regulations. UnitedHealthcare submits a draft to the quality review team to make sure it is accurate before releasing the final version to the customer.

**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.

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**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 as 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 plan's 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.

**What if coverage terminates before the end of 90-days? Are we still required to cover member for transitional care beyond their termination date? [New 6/4/21](#)**

For fully insured group/health plans, we would continue coverage beyond the termination date. The No Surprises Act does not require continuation of coverage when individual insurance coverage terminates.

## **Advance Cost Estimate**

**What change became effective with the release of FAQ 49? [New 8/24/21](#)**

Advance Cost Estimate implementation dates are moved pending additional guidance.

**What is the requirement for a plan or issuer to provide an advanced explanation of benefit notification? [Update 8/24/21](#)**

Advance Cost Estimate implementation dates are moved pending additional guidance likely in 2022.

Once the Tri Agencies announce an effective date, 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

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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.

### **Who is required to provide an Advance Cost Estimate, sometimes called advanced EOB?** **New 7/15/21**

The guidance applies to health insurers offering group or individual coverage. and group health plans - both grandfathered and non grandfathered, fully insured, and self- funded plans.

As outlined in the No Surprises Act, the Advance Cost Estimate must be provided to the enrollee, participant, beneficiary, or their authorized representative.

### **What information will be included in the Advance Cost Estimate? New 7/30/21**

- Member Name, address
- Subscriber and plan ID number
- Scheduled Service date
- Procedure codes, diagnosis codes planned to be included in the scheduled service

### **Insurer/health plan - when provider is in-network**

- In addition to including the information the provider sent the ACE will include;
- The providers estimate of charges

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- In Network Rate/Allowed Amount
- Amount member may owe: Members cost share (copay, deductible, coinsurance)
- Any portion of the charges not covered
- Program benefit summary and out-of-pocket to date
- Disclaimers

#### **Insurer/health plan - when provider is out-of-network**

- In addition to including the information the provider sent the ACE will include;
- Estimate of what the provider will charge
- Amount member may owe: Members cost share (copay, deductible, coinsurance)
- Any portion of the charges not covered
- Program benefit summary and out-of-pocket to date
- Disclaimers

We will share a sample letter once finalized.

#### **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 the Advance Cost Estimate applicable if the individual and not the plan has financial responsibility? New 6/22/21**

Yes. Advance Cost Estimate is a requirement for all planned services, regardless of financial responsibility.

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**Does the CAA Advance Cost Estimate requirement apply to services beyond medical, such as dental or vision, chiro, radiology, and pharmacy? [New 6/22/21](#)**

Generally, if a benefit is covered by an insurer or group health plan, then the service would be covered. However, benefits that qualify as 'excepted benefits' such as standalone dental or vision or specified disease policies do not apply to the Advance Cost Estimate requirement.

**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.

**What date is used to create pricing for the Advance Cost Estimate? [New 7/15/21](#)**

Pricing is based on the date of request submission.

**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.

**Will you share data with third parties to enable them to produce Advance EOBs? [New 6/4/21](#)**

Our obligation is to ensure the Advance cost estimate will be provided to the member as we receive the notification of a scheduled service.

**What are your plans for accommodating the transparency rule's requirement to provide advanced EOBs to members in 2022? [New 6/5/21](#)**

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, plan or FEHB must provide the member with a notification through mail or electronic means, as requested by the member.

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](https://myuhc.com).

There are federal rules and processes yet to be developed, and questions about scope and applicability as it relates to state laws have yet to be answered. UnitedHealthcare will continue to provide updates as details are released. As with other federal and state laws, UnitedHealthcare is committed to complying with the new CAA requirements and to keep our customers informed on UnitedHealthcare's approach and options for self-funded arrangements.

In addition, UnitedHealthcare intends to comply with the relevant provisions of the Transparency in Health Care Coverage Final Rule by the individual due dates for compliance. The required disclosures will be available to our members.

### **Based on the new Advance Cost Estimate requirements, will there be any impact on the administrative fees for self-funded customers? New 6/5/21**

UnitedHealthcare is committed to supporting compliance with requirements of both the Transparency in Coverage Rule and the CAA. UnitedHealthcare is adopting administrative and operational processes to implement the new requirements consistent with any additional guidance or rulemaking that may be provided by federal regulatory agencies. Customers can expect timely and relevant information regarding potential administrative costs as more details become available.

### **Will UnitedHealthcare include carve-out pharmacy benefit managers or excepted benefits in the Advance Cost Estimate provided to members? New 6/5/21**

Advance Cost Estimate also known as Advanced EOB will not include excepted benefits. Excepted benefits are such as "stand alone" or "carve out" dental or vision are not in scope for this document.

## **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.

### **Is there a change to the current external review process? New 6/22/21**

UnitedHealthcare has an external review process today and is expanding the review process to include external review to respond to disputes for adverse actions.

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

Yes.

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### **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.

### **If the plan is non-grandfathered, describe how additional External Appeals requirements for Covered Services will be supported? Does UnitedHealthcare provide a contract with an Independent Review Organization for external review? New 6/21/21**

To comply with specific state, federal, accreditation or contractual requirements for state-specific licensure or physician specialty match, we access experts who are: 1) board-certified by the American Board of Medical Specialties in the same or similar specialty as the physician requesting the service; 2) currently licensed in the necessary state; and 3) do not have license restrictions, federal or Health Care Financing Administration sanctions.

UnitedHealthcare has an external review process today for adverse benefit determination and UnitedHealthcare is reviewing expansion of the review process to include disputes related to adverse determinations under the No Surprises Act.

## **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

**Does UnitedHealthcare allow a member to select their own PCP from any PCPs accepting patients? Can a pediatrician be a PCP for a dependent? Is direct access permitted to OB/GYNs? New 6/22/21**

Yes. UnitedHealthcare does this today for commercial customers including those who are grandfathered.

When a UnitedHealthcare plan requires or allows PCP designation, the member can "designate any participating primary care provider" in the network who is available to accept the



member. For children, if the plan requires or allows PCP designation, the child/member can designate an in-network pediatrician as their PCP.

UnitedHealthcare has no restrictions for a member to access an OB/GYN without going through their PCP.

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## Price Comparison Tools

### **Under the CAA, what is the price comparison tool requirement? Update 8/24/21**

The regulations on price comparison tools outlined in the Consolidated Appropriations Act have been determined to be duplicative of those that are outlined under the Transparency in Coverage final rule. Therefore, no consumer tools are required by January 1, 2022. The requirements will begin under the TIC on and after January 1, 2023.

### **How will you use price transparency as an opportunity to improve the consumer experience? New 6/4/21**

UnitedHealth Group has long supported actionable price and quality transparency for consumers. UnitedHealthcare currently offers industry leading transparency tools to a significant portion of UnitedHealthcare's business. To prepare for the new rule, UnitedHealthcare is working to ensure a price transparency tool and machine-readable rate files are available for all UnitedHealthcare platforms, pricing structures, and plan designs for individuals and their authorized representatives at the appropriate time, consistent with the requirements if and when they become effective.

UnitedHealthcare is continuing to closely monitor the legal and regulatory landscape for new developments and will share additional information with customers as it is available.

### **Will UnitedHealthcare provide the required transparency cost comparison tool, both via phone and online? New 6/4/21**

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.

There are federal rules and processes yet to be developed, and questions about scope and applicability as it relates to state laws have yet to be answered. UnitedHealthcare will continue to provide updates as details are released. As with other federal and state laws, UnitedHealthcare is committed to complying with the new requirements and to keep our customers informed on UnitedHealthcare's approach and options for self-funded arrangements.

At present, the transparency tools on our member website, **myuhc.com** help members to comparison shop for health services and understand how costs differ from doctor to doctor. With **myuhc.com** and the mobile app, members can evaluate health care costs for an entire episode of care and make the choices that best suit their budget.

### **How does UnitedHealthcare's transparency cost comparison tool work today? New 6/4/21**

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Our cost comparison approach provides episode-of-care estimates composed of one or more treatment steps occurring over time, and each treatment step may include one or more procedures. Rather than searching by procedure and then having to assemble all the procedures to get an estimate, members can compare and understand steps and costs in the treatment(s) they are evaluating.

Using the most accurate methodology for calculating costs, estimates are based on provider fee schedules, which are in turn based on UnitedHealthcare-contracted rates. In the small number of cases when that information is not available, estimates are based on historical claims with the care provider.

Estimates also reflect the member's health plan benefits and display member cost share based on the member's plan design and real-time progress towards deductibles and out-of-pocket maximums. Members can also evaluate available quality and efficiency information for network physicians by following links provided in their search results. Encouraging consumers to visit high-quality health care providers has important implications for individuals, employers, and the health care system.

Collaboration with care providers is critically important when building cost estimators and other consumer support tools to ensure they enhance the overall patient experience – and accurately portray expected costs and treatment options – rather than focus solely on costs.

Real-time integration with core systems helps our service advocates support members who call to discuss the cost estimates. Our advocates are qualified representatives who will be available to provide direct, hands-on guidance, as they see the same cost information as the members.

**Will UnitedHealthcare provide a price comparison tool via internet websites and via telephone that allow a participant to compare the amount of cost sharing that they will be responsible for by participating provider and geographic region? Update 7/26/21**

Under the CAA, 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. At present, the transparency tools on our member website, myuhc.com help members to comparison shop for health services and understand how costs differ from doctor to doctor. With myuhc.com and the mobile app, members can evaluate health care costs for an entire episode of care and make the choices that best suit their budget.

**Can you describe the price comparison tool UnitedHealthcare has to support the CAA requirement for 1/1/22? Update 7/26/21**

At present, the transparency tools on our member website, myuhc.com help members to comparison shop for health services and understand how costs differ from doctor to doctor. With myuhc.com and the mobile app, members can evaluate health care costs for an entire episode of care and make the choices that best suit their budget.

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Our innovative approach provides episode-of-care estimates composed of one or more treatment steps occurring over time, and each treatment step may include one or more procedures. Rather than searching by procedure and then having to assemble all the procedures to get an estimate, members can compare and understand all steps and costs in the treatment(s) they are evaluating.

Using the most accurate methodology for calculating costs, estimates are based on provider fee schedules, which are in turn based on UnitedHealthcare-contracted rates. In the small number of cases when that information is not available, estimates are based on historical claims with the care provider.

Estimates reflect the member's health plan benefits and display member cost share based on the member's plan design and real-time progress towards deductibles and out-of-pocket maximums. Members can also evaluate available quality and efficiency information for network physicians by following links provided in their search results. Encouraging consumers to visit high-quality health care providers has important implications for individuals, employers and the health care system.

Collaboration with care providers is critically important when building cost estimators and other consumer support tools to ensure they enhance the overall patient experience – and accurately portray expected costs and treatment options – rather than focus solely on costs.

### **Describe how UnitedHealthcare will provide the telephone tool and at what location?**

**Update 7/26/21**

Currently, our service advocates support members who call to discuss the cost estimates. Our advocates are qualified representatives who will be available to provide direct, hands-on guidance, as they see the same cost information as the members.

### **Is there a dedicated team for members to go to for assistance with the tool? Update 7/26/21**

No. All UnitedHealthcare service teams provide support for transparency tools available via our member website, myuhc.com, and mobile tools.

### **What internet website will be used for the price comparison tool? New 7/26/21**

UnitedHealthcare's existing transparency tools are available on our member website, myuhc.com, provide a personalized member experience with search results that integrate health and financial information, such as deductible and coinsurance amounts, benefit design and guidance specific to the member and their plan design. Members can comparison shop for health services and understand how costs differ from doctor to doctor. Our integrated suite of transparency tools is available to members on myuhc.com and via our mobile app, which provides instant access to member's critical health information anytime, anywhere.

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Describe your process for addressing participant or provider complaints that may be made against the plan under the Act

**For the cost estimator tool, what covered items and services or how many covered items and services need to be included for 2022? New 8/3/21**

1. The CAA provision for 1/1/2022 price comparison requirement states a cost share estimator tool must be made available via a web-based tool and over the phone if requested. There are no set number of services applicable to this legislation. It is UnitedHealthcare position our current cost estimator tool complies with the CAA provision.
2. The Transparency in Coverage 1/1/2023 consumer price transparency tool provision requiring the first 500 services be made available via a web-based tool or in writing if requested in based on a list of 500 services itemized by the governance that must be included. Our current cost estimator tools may or may not already include the prescribed 500 services. Should a service not exist today, it would then be added to the price transparency tool to be compliant with the legislation
3. The Transparency in Coverage 1/1/2024 consumer price transparency tool provision requiring all service be made available via a web-based tool or in writing if requested would cover all services that UnitedHealthcare would offers and provide cost share estimates for members.

It's important to remember that the cost comparison tool required for 1/1/22 is a provision under CAA, while the price comparison tool requirements for 2023 and 2024 are requirements under the Transparency in Coverage Rule.

**Why can't the cost estimator tool be included on the pre-member site? New 8/3/21**

The consumer price transparency tool for 1/1/2023 and 1/1/2024 as well as the CAA price comparison tool for 1/1/2022 is personalized for cost estimates for services associated with the specific member. Therefore, it cannot be used on a pre-member site.

## Provider Directories

### **What was the change in the FAQ 49 that came out on August 20? New 8/24/21**

For directories, plans are asked to use good faith and reasonable interpretation to meet the 1/1/22 date. Additional guidance is anticipated in 2022. Enforcement is based on a safe harbor.

### **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.

### **Please share UnitedHealthcare's roadmap for making available to participants up-to-date provider directories? New 6/5/21**

UnitedHealthcare will provide 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

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Digital contact information, which means email address and/or URL

UnitedHealthcare currently displays these data elements for providers and facilities.

Ultimately, it is the responsibility of the member to verify the network status at the time services are rendered. We encourage members to access our online directories for the most current network information. While our hard-copy directories are updated semi-annually, our online directories are updated every week with a full replacement file. Claims are processed according to the network status of the provider in our system. If that status is incorrect and the claim is appealed, we investigate to ensure we have the correct status. If not, we would reprocess the claim.

UnitedHealthcare will continue to ask providers to verify their data through My Practice Profile (MPP) attestations, roster submissions, and CAQH data regularly. If a provider's data cannot be verified, the provider will be suppressed from the online provider directory. Once the data is verified the provider will be added back into the directory.

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

#### **How will directory accuracy and updates be handled? New 6/5/21**

UnitedHealthcare will ask providers to verify their data through MPP attestations, roster submissions, and CAQH data every 90 days. 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.

The online provider directory must display updated provider demographic data (name, address, specialty, telephone number, and digital contact information) within two business days of the health plan receiving the updated information from the provider. For example, if the credentialing approval occurs on a Monday morning, the data has to appear in the directory by end of day Wednesday.

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 the Credentialing Approval Date and the Contract Effective Date. If the Contract Effective Date is back dated, then the latter of the Credentialing Approval Date and the date the contract was signed applies.

Claims are processed according to the network status of the provider in our system. If that status is incorrect and the claim is appealed, we investigate to ensure we have the correct status. If not, we would reprocess the claim.

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### **Will a member who relied on incorrect information received be liable only for in-network cost-sharing amounts? New 6/5/21**

Ultimately, it is the responsibility of the member to verify the network status at the time services are rendered. We encourage members to access our online directories for the most current network information. While our hard-copy directories are updated semi-annually, our online directories are updated every week with a full replacement file.

Claims are processed according to the network status of the provider in our system. If that status is incorrect and the claim is appealed, we investigate to ensure we have the correct status. If not, we would reprocess the claim.

### **If a member asks about the status of a specific provider, does that guarantee that the member is in network when the member goes for care? New 7/20/21**

If a member calls UnitedHealthcare to expressly confirm that a specific provider is in network, UnitedHealthcare will confirm the status and send a written or electronic confirmation which is good for a specified number of days. This will mean if the information was conveyed in error, we would cover the benefit at network benefit level based on the confirmation.

However, the written response and confirmation does apply when the member calls for other reasons such as changing their PCP, to check on benefits, or ask general information about provider type (e.g., who are the cardiologists or gastroenterologists in the network), or can you provide a list of facilities or surgical centers. For those general calls, the member should confirm with the provider or directory prior to the visit if they are in network.

### **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.

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**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.

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Last updated 8/24/2021

## 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.

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## 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.

### **Will UnitedHealthcare comply with the Secretary of Labor's standardized reporting format for voluntary reporting to State All Payer Claims Databases? New 6/5/21**

The provision requires the Secretary of Labor to develop a standardized data reporting form for group health plans to voluntarily report data to state All Payer Claims Databases (APCD). We will evaluate and respond to any customer requests to assist with the voluntary reporting of data to a state APCD when the form is established.

As with other federal and state laws, UnitedHealthcare is committed to complying with the new requirements and keeping customers informed on UnitedHealthcare's approach and options for self-funded customers.

UnitedHealthcare is adopting administrative and operational processes to implement the new requirements consistent with any additional guidance or rulemaking that may be provided by federal regulatory agencies. Customers can expect timely and relevant information regarding potential administrative costs as more details become available.

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## 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.

## Gag Rule

### **What was the change in the FAQ 49 that came out on August 20? [New 8/24/21](#)**

For gag clauses, plans are asked to use good faith and reasonable interpretation to meet the 1/1/22 date. Additional guidance is anticipated in 2022. Enforcement is based on a safe harbor.

UnitedHealthcare has already handled removal of gag clauses.

### **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.

### **Do any contracts you are a party to contain a claim prohibiting disclosure of pricing terms (“gag clause”) which will be prohibited under the No Surprises Act? [New 7/26/21](#)**

While most of our provider contracts are in compliance, UnitedHealthcare is assessing our provider contracts to determine if they meet the required regulation and revising them as necessary to meet the requirements under the law.

### **Is there an effective date for removal of Gag Clauses? [Update 8/24/21](#)**

The CAA did not include an effective date specific to this requirement. For gag clauses, plans are asked to use good faith and reasonable interpretation to meet the 1/1/22 date. Additional guidance is anticipated in 2022. Enforcement is based on a safe harbor.

**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.

**Who is responsible for handling the attestation for removal of all Gag rules in key documents? New 5/24/21**

UnitedHealthcare is working to remediate any existing contracts that contain gag clauses restricting disclosures of price and quality from health care provider or network/association of providers contracts with UnitedHealthcare and contracts between a group health plan third party administrator (TPA) or other service providers offering access to a network of providers. All new contracts prohibit these clauses.

When required by law including any subsequent regulations, UnitedHealthcare, as the health insurance issuer providing group health insurance coverage, will provide an appropriate attestation to the Secretary.

UnitedHealthcare will also provide relevant information to self-funded group health plans to assist them in making necessary attestations. If the self-funded group has other networks, they will need to gather information from them to complete the attestation.

**Will UnitedHealthcare support self-funded clients’ requirement to attest to the removal of gag clauses? New 5/24/21**

Yes, as the TPA UnitedHealthcare will provide the information to the self-insured customer so they can attest. If the self-funded group has other networks that are not administered through UnitedHealthcare, the group will need to gather that information to complete the attestation.

**Will UnitedHealthcare support self-funded clients’ requirement to attest to the removal of gag clauses? Update 6/4/21**

Yes, as the TPA UnitedHealthcare will provide the information to the self-insured customer to assist them in making necessary attestations. If the self-funded group has other networks that are not administered through UnitedHealthcare, the group will need to gather that information to complete the attestation.



**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 includes 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.

**Is UnitedHealthcare prepared to report compliance with the gag rule that requires that group health plans cannot enter into a services agreement that directly or indirectly restricts the group health plan from disclosing provider-specific costs, quality of care information, or electronically accessing de-identified claims data? New 6/5/21**

Yes. As with other federal and state laws, UnitedHealthcare intends to comply with the new requirements and keeping customers informed on UnitedHealthcare's approach and options for self-funded customers.

## **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.

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**With the new broker compensation transparency requirements, what will UnitedHealthcare/Optum Rx or the brokers /consultants reveal regarding their direct and indirect compensation to the employer group? Does UnitedHealthcare play a role? **New 6/21/21****

It is the broker/ consultant's responsibility to report all direct and indirect compensation to the employer. UnitedHealthcare is creating a vehicle for the broker / consultant to pull down and report any actual or contingent compensation that could be paid for placing business with UnitedHealthcare.

**What types of compensation are required to be reported so an employer can see how the broker / consultant is or may be compensated? **New 6/21/21****

The following are the various types of direct and indirect compensation that may need to be disclosed:

- Base commission / fee
- Service fees for assistance in selecting, placing, and administering coverage under a consulting agreement with the plan
- Transaction compensation (e.g., per claim, per visit, per prescription, per person etc.)
- Retention and new sales bonus
- Contingent compensation - such as for growth target, volume target, or other specified goals
- Overrides - such as General Agent fees
- Non-Cash compensation - such as meals, entertainment, gifts, or trips

**Will UnitedHealthcare provide compensation numbers to the brokers? **New 7/19/21****

UnitedHealthcare will provide the broker with information on where to access compensation information they have with UnitedHealthcare.

## **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

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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.

### **Are brokers required to disclose any compensation from PBMs? New 8/3/21**

Does this answer your question? The requirements for service providers to disclose direct and indirect compensation to the plan sponsor would apply to Rx vendors such as PBMs.

### **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).

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### 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.

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## 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 change became effective with the release of FAQ 49? [New 8/24/21](#)**

Pharmacy Benefit and Cost Reporting implementation dates are moved pending additional guidance.

**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? [Update 8/24/21](#)**

Based on the Tri Agency FAQ 49, the first few dates originally scheduled for the report are cancelled (Dec. 27, 2021 and June 1, 2022). Plans are encouraged to prepare to meet the Pharmacy Benefits and Cost Reporting by December 27, 2022. 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.

Additional rulemaking is expected in 2022.

**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](#)**

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- 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.

### **For the Pharmacy Benefit and Cost Reporting provision, will UnitedHealthcare accept responsibility for doing this reporting for its self-funded as well as fully insured customers? New 7/26/21**

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Currently, the CAA has remained silent on specific reporting details, such as data element definitions, calculations, templates, sample reports, or other submission requirements. It has been noted that additional rules will be published; however, a date has not been provided.

As UnitedHealthcare continues to monitor updates from the federal agencies, we will continue to assess how best to support our self-funded plans.

UnitedHealthcare is committed to partnering with our customers to provide support. As UnitedHealthcare monitors updates from the federal agencies, we are evaluating capabilities to document the details of our approach in order to best support our customers' needs. Customers can expect timely and relevant information regarding potential administrative costs as more details become available.

### **What process will UnitedHealthcare use to reporting prescription drug cost information to the federal government and if you will do this for self-funded groups? New 6/21/21**

UnitedHealthcare is evaluating our process to report plan specific prescription drug spending and medical cost data annually to the Departments of Health and Human Services, Labor, and the Treasury. To date the CAA has remained silent on specific reporting details, such as data element definitions, calculations, templates, sample reports, or other submission requirements. It has been noted that additional rules will be published; however, a date has not been provided.

UnitedHealthcare is committed to partnering with our customers to provide support. As UnitedHealthcare monitors updates from the federal agencies, we are evaluating capabilities to document the details of our approach in order to best support our customers' needs. Customers can expect timely and relevant information regarding potential administrative costs as more details become available.

### **What is meant by "plan?" Is the plan or insurance company responsible for reporting? New 6/4/21**

The insurer is responsible for reporting based on the legal entity (e.g., UnitedHealthcare of Illinois).

Self-funded health plans would be responsible for reporting for their plans.

### **How does UnitedHealthcare define plan-year? Does plan year equal current plan year for 2021 or upcoming year? New 6/4/21**

The first reports are due by December 27, 2021. The plan year is the term of the plan benefits. We anticipate additional guidance.

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**Does number of enrollees include all enrollees even if they were not enrolled entire plan year? Update 6/4/21**

Yes.

**Does state equal sitused state or states where plan is offered? New 6/4/21**

Pharmacy reporting is based on situs state.

**What if a member's plan is sitused in one state but services are rendered in another (snowbirds, students), would they report both states? New 6/4/21**

Reporting would only be based on situs state.

**Would a mailed or 90-day script be considered 1 script or 3 scripts? New 6/4/21**

A 90-day script would be 1 script.

**What does Total Spend equate to? Does it mean net paid? New 6/4/21**

Total Spend is not defined in the Consolidated Appropriations Act.

**How are Type of Costs reported for hospital (inpatient, outpatient, ASC), provider and clinical services? New 6/4/21**

The terms were not defined in the Consolidated Appropriations Act.

**How are Wellness services defined? New 6/4/21**

The term is not defined in the Consolidated Appropriations Act.

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## Mental Health Parity NQTL Reporting

**Given the new requirements for health plans to conduct comparative analyses of the nonquantitative treatment limitations (NQTLs) used for medical and surgical benefits as compared to mental health and substance use disorder benefits, will you be offering services to support this? New 6/5/21**

Under the Mental Health Parity and Addiction Equity Act (MHPAEA), if a plan covers both medical/surgical benefits and mental health/substance-related and addictive disorder benefits, MHPAEA requires parity between medical/surgical and mental health/substance use disorder benefits with respect to the financial, quantitative and non-quantitative treatment limitations.

**Fully Insured** — UnitedHealthcare standard fully insured plan designs and processes are designed to be parity-compliant.

**Self-funded** — Customers with self-funded plans are legally responsible for compliance with the mental health parity requirements, including testing. Upon request and to address MHPAEA and the 2021 CAA, UnitedHealthcare can provide a Mental Health Parity NQTL Standards document that details UnitedHealthcare and Optum compliant standard 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.
- A self-funded customer will need to conduct plan review to ensure that their elections are reflected accurately and confirm that each response aligns with their plan documents.
- We recommend that customers visit with its legal counsel to review MHPAEA and CAA requirements and documentation specific to its plan designs.
- If a customer would like assistance with testing Financial/Quantitative Treatment Limits (QTL), testing can be provided by OptumInsight for a fee. The Strategic Client Executive/Strategic Account Executive can assist with this request. If a customer has engaged a third-party consultant or actuarial firm to conduct its QTL testing, UnitedHealthcare can provide certain data.

**Can you describe how UnitedHealthcare may support a self-funded customer? New 7/21/21**

For our self-funded clients, we provide the following support:

1. We will assist ASO clients in meeting CAA NQTL documentation requirements.

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2. Specifically, we will assist by providing our FI Standard NQTL documentation, depending on variables on the particular ASO — for example does the customer have medical necessity or prior authorization or does the customer have carve in or carve out pharmacy.
3. Remember, the legal responsibility for Mental Health Parity and CAA NQTL Reporting compliance has and remains with the self-funded client. We encourage self-funded clients to work with outside legal counsel of their choice.
4. Should an ASO client receive a DOL audit request, they should let UHC know *immediately* so that we can partner with them in supplying timely the requesting info to the regulator.
5. We can support Quantitative Treatment Limit (QTL) testing and analysis by offering on a fee-for-service basis support from by OptumInsight.
6. Our standard plan designs, as illustrated by the FI Standard NQTL documentation, comply with parity requirements.

### **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

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- 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**

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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.

### **Under the ASA is the customer responsible for compliance with law with respect to their plan design? New 5/12/21**

UnitedHealthcare's role is limited to claim payment, which is a narrow fiduciary role, and not compliance with law. UnitedHealthcare is not the plan administrator, which carries with it a broad fiduciary role.

### **How does the Act differ or add to MHPAEA requirements? Update 4/26/21**

- 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.

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- 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 inquiries 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 than 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)

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- 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**

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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.)

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## Custom Networks

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## 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

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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 1<sup>st</sup> 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 need 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 15<sup>th</sup>, 2021.

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

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**Once we are notified, will systems be updated to reflect the choices 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 President's 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.**

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## Extend Health Coverage Tax Credits

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