Consolidated Appropriations Act Frequently Asked Questions

External

3/7/24

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United Healthcare

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Resources

External

Consolidated Appropriations Act document

CAA /NSA FAQs

Provider No Surprise FAQs

Transparency In Coverage FAQs

IDR Links

- IDR payment dispute page on cms.gov site
- List of certified entities
- Revised Certified IDR Entities Guidance and revised IDR Disputing Parties Guidance, which provide updates to conform with the recent Texas Medical Association, et al. v United States Department of Health and Human Services, et al. decision.
- Frequently asked questions about the Federal IDR process, IDR entity qualifications and the application process, and fees.
- Frequently asked questions for providers and facilities about the No Surprises Act rules, Independent Dispute Resolution, and exceptions to the new rules and requirements.
- Chart for Determining the Applicability for the Federal Independent Dispute Resolution (IDR) Process, which provides a high-level summary to assist in determining whether the Federal IDR process or a state law or All-Payer Model Agreement applies for determining out-of-network rates.

Gag Clause Resources New 2/27/23

- FAQ 57
- CMS's Gag Clause Website
- Attestation Website

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Consolidated Appropriations Recent Guidance

Interim Final Rule - Surprise Medical Billing - July 1 New 7/15/21

- 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.

Proposed Rule - July 10 Update 1/19/24

Air Ambulance Reporting

- Reporting requirements for health plans for air ambulance claims.
- Air ambulance carriers are required to file annual reports regarding their service history with HHS and Transportation departments on services.
- Services include the number of transports by payer mix, the number of claims denied by plans or issuers, and the reason for the denials.
- Added reporting requirements for Federal Employees Health Benefits program.
- Applies the reporting requirements for plans, issuers, FEHBP carriers and providers for two calendar years. Reports due 3/31/23 (for 2022 calendar year) and 3/30/24 (for 2023 calendar year).
- We're waiting for additional guidance on the timing, content and submission requirements for Air Ambulance reporting.
- Based on recent information from the tri-agencies, we’re not expecting to get any rule updates until Q3/Q4 2024. We’ll certainly provide an update via existing communication channels as soon as we have anything more to share.

HHS Enforcement

- Outlines the procedures HHS will use to enforce CAA provisions. HHS will defer to state enforcement to the state where it exists for insurers, providers, and air ambulance.

FAQ 49 - August 20 Update 11/15/22

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On August 20, 2021, the Departments of Health and Human Services, Labor, and the Treasury released FAQ 49 that addressed the implementation of several provisions of the Transparency in Coverage (TIC) Rule and the Consolidated Appropriations Act (CAA). The focus of the FAQ was to provide an overview of the delay in enforcement of some provisions and an extension of deadlines for others. Not all provisions are impacted.

Tri Agency FAQ 49 guidance stated plans and issuers should use good faith and reasonable interpretation to meet 1/1/22 dates for the following requirements:

- No Surprise Billing
- Independent Dispute Resolution
- ID Cards
- Directories
- Continuity of Care
- Gag clauses including attestation of compliance

Tri Agency FAQ 49 guidance stated that the following provisions are paused or delayed pending additional guidance:

- Advance Cost Estimates (Advanced EOB)

Interim Final Rule - October 7 Update 1/19/24

Independent Dispute Resolution (IDR) Arbitration Provisions

- Establishes the timeframes, processes, and requirements for using the Federal arbitration – or IDR – process for surprise medical bills from OON providers, facilities and air ambulances.
- Allows batching of claims for arbitration of "same or similar" items or services
- Health plans may submit separate QPAs for each type of item or service when similar items and services are batched
- Allows the arbitrator to choose different payment awards for each type.
- Requires the losing party to pay the arbitration fee and requires each party to pay an administrative fee to the Tri-Agencies of $115 beginning January 22, 2024.
    - Note: The fee had been $350 beginning 1/1/23 through August 2023, then changed to $50. It is now $115 beginning 1/22/24.
- Further guidance will establish an acceptable range of arbitration fees, to be updated annually.
- Arbitrators may impose a set fee for a single case within an IDR process and a separate, larger fee for batched IDR cases.

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Consolidated Appropriations Act 2021 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.

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- Advance Cost Estimate
- 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

Should an ASO customer request UnitedHealthcare to sign a contractual agreement that UHC will support providing support for CAA? New 11/15/22

UHC does not have to do that. According to the language our ASA covers UnitedHealthcare responsibility and therefore there is no requirement to sign other agreements for our clients.

Within the ASA, it states that the parties agree to comply with all applicable federal, state, and other laws and regulations in its performance under this Agreement.

Can UnitedHealthcare confirm the base ASO fee includes compliance with all applicable provisions of the Transparency in Coverage Final Rule and Consolidated Appropriations Act, 2021, and all associated deliverables (included but not limited to: machine readable files, RxDC reporting, ID card updates, etcetera)? Update 12/13/22

- Our fees cover what we currently understand via the law and published rules released to date.
- The government continues to publish and clarify the rules of compliance.
- UHC will do what we can to accommodate changes without impacting fees. That being said, we reserve the right to adjust fees if there are changes to compliance requirements that result in meaningful cost impact.
- Should a fee adjustment be necessary UHC commits to being transparent with our clients regarding such impact and the basis for fee increase.

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 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.

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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.

Will UnitedHealthcare be compliant with the CAA regulations? Update 9/16/22

Compliance with the laws and regulations applicable to our business is a fundamental commitment of UnitedHealth Group, and we intend to comply with the requirements of the new rules.

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

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.

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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.

CAA and UnitedHealthcare Approach

UnitedHealthcare is committed to providing customers with an important update on two new health care regulations that affect your business and ours: 1) the Consolidated Appropriations Act (CAA), including the No Surprises Act (NSA) and 2) the Transparency in Coverage rule. These groundbreaking regulations are designed to provide greater consumer protections for employees and their families. However, they place new and potentially costly accountabilities on plan sponsors for self-funded groups for actions in 2022 and beyond. UnitedHealthcare has mobilized to make it easier for self-funded plans to meet the compliance and timing requirements set forth in the new regulations.

Are there communication materials that cover a summary of what is in the Consolidated Appropriations Act including the No Surprises Act and the Transparency in Coverage rule? New 10/27/21

Yes. The *CAA, NSA, and Transparency in Coverage Guide* is a good source for that summary of the requirements.

Which CAA provisions had UnitedHealthcare worked to implement and support customers for 2022? Update 11/3/21

Some of the more significant requirements that UnitedHealthcare has worked on to support customers include:

- End to end handling of the independent dispute resolution (IDR) process for claims subject to the NSA.
- Calculation of Qualifying Payment Amount (QPA) and adjustments to member cost-sharing and information on explanations of benefits (EOB) and provider remittances in compliance with the NSA.
- Updates to members' health plan ID cards to include in-network and out-of-network deductible and out-of-pocket maximum as well as the phone number and URL for member support.

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- Enhancements to provider directories and implementation of a protocol to respond to member inquiries about our network of providers.
- Implementation and notification to members of new continuity of care rights.
- Facilitation of an external appeal/review process for members who dispute the resolution of a surprise bill; updates to EOBs and health statements to describe members' external appeal rights.
- Maintenance of network agreements compliant with the CAA prohibitions on gag clauses; preparation and deliver of language to support plan sponsor's attestation requirement.
- Significant new reporting requirements (government and customer)
- Support for Mental Health Parity NQTL audits initiated by DOL, HHS, or Treasury.

Are there fees that the federal government requires for independent dispute resolution (IDR)? Update 1/19/24

Yes. There is a $115 administration fee required from both the provider and the health plan once either party makes the decision to go to IDR following the negotiation period. The $115 fee was modified by CMS beginning 1/22/24

In addition, when the final offer is made and documentation provided to the arbiter, the arbiter fee is required to be paid. When UnitedHealthcare is managing the IDR we upfront the arbiter fee (not the $115 fee) and then do reconciliation with the customer later if the arbiter selected the provider's offer. As always, the plan sponsor is responsible for funding claim payments required based on the IDR entity's decision.

Under IDR who is charging the administrative fee? Update 1/19/24

The $115 fee is a charge by the government for administration of the IDR program. The money goes to the arbiter who has the responsibility to submit the fee to the federal government.

The $115 admin fee must be paid by the plan and by the provider immediately when either party submits the IDR request online to the government.

Will UnitedHealthcare process the administrative fee go through the claim account for ASOs? Update 11/27/23

Yes.

If a claim goes to arbitration, does the plan sponsor pay the arbiter? Will the plan sponsor get a refund if the provider does not win? Update 1/19/24

For UnitedHealthcare customers, if a claim goes to arbitration, both the plan and the provider are responsible for upfronting the arbiter fee. This must occur when the final offer and documentation is sent to the arbiter.

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UnitedHealthcare will front the arbiter fee for our customers and then reconcile with the customers once a decision is made. This is to ensure the fee is paid to the arbiter on time so a delay would not impact the decision.

As with the $115)administrative fee, any arbiter fees required would go through the claim account.

Remember, if the provider prevails, the plan sponsor pays both arbiter fees.

Do you know arbiter fee amount or range? Update 1/1/24

- IDR entity fee for single determinations — Range is $200 to $840
- IDR entity fees for batched determination — $268 to $1,173
- For batched fees exceeding 25 dispute line items, the agencies are looking at implementing a fixed range of $75-$250 for each increment of 25 dispute line items increment.

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Consolidated Appropriations Act 2023 Overview

What pre-deductible guidance was part of the Consolidated Appropriations Act of 2023 regarding qualified high deductible health plans? New 1/10/23

The Consolidated Appropriations Act of 2023 (CAA 2023) was passed by the House and Senate and signed by President Biden on Dec. 29, 2022. This legislation included a provision to allow a qualified high-deductible health plan (HDHP) to cover telehealth services, pre-deductible – for effective dates beginning in 2023 and 2024 – without jeopardizing health savings account (HSA) eligibility.

Will UHC support self-funded groups that want to add this for their 2023 or 2024 plan years? New 1/10/23

UnitedHealthcare will support self-funded groups with qualified HDHPs that decide to take advantage of the CAA 2023 guidance permitting qualified HDHP with HSAs to cover medical and behavioral telehealth services without the member requirement to reach the deductible first. For self-funded groups with UnitedHealthcare Virtual Visit program with national vendors, the Virtual Visit would also be covered.

Customers should contact their UnitedHealthcare representative.

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No Surprises Act Key Provisions

Does the No Surprises Act apply to retiree only plans, whether or not they are Medicare? New 10/26/21

The NSA does not apply to retiree-only plans if they have fewer than two participants who are current employees. For example:

- If a retiree plan (pre-65 or post 65) is offered to 2 or more active individuals in any manner, it is subject to CAA.
- If the plan is a closed offering to retirees only, the plan is NOT subject to CAA.

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

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- 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

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).

If the custom’s plan has zero OON coverage, does the No Surprises Act still apply to them? New 8/25/21

Yes, it applies for any covered services that are outlined in the No Surprises Act.

What are provider requirements under surprise billing? New 7/7/22

Refer to the provider FAQ put out by SME in April 2022.

Can you explain the new requirements and prohibitions of the No Surprises Act for providers? New 7/7/22

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Patients now have new billing protections when getting emergency care, certain non-emergency care from out-of-network providers during visits to certain in-network facilities, and air ambulance services from out-of-network providers.

New Surprise Billing Requirements and Prohibitions

- No balance billing for out-of-network emergency services
- No balance billing for non-emergency services by out-of-network providers during patient visits to certain in-network health care facilities, unless notice and consent requirements are met for certain items and services.
- Providers and health care facilities must publicly disclose patient protections against
- balance billing
- No balance billing for covered air ambulance services by out-of-network air
- ambulance providers
- In instances where balance billing is prohibited, cost sharing for insured patients is limited to in-network levels or amounts
- Providers must give a good faith estimate of expected charges to uninsured and self-pay patients at least 3 business days before a scheduled service, or upon request
- Plans and issuers and providers and facilities must ensure continuity of care when a provider's network status changes in certain circumstances
- Plans and issuers and providers and facilities must implement certain measures to improve the accuracy of provider directory information

What information must be included in the Notice and Consent form? New 7/7/22

The government provided information on the form to submit for Notice and Consent. This form may only be modified as outlined in the document.

Provider requesting a claim reprocess as a non-surprise bill claim based on fact that they had received notice and consent from member, must submit us this Notice and Consent form as out lined in the documentation.

Form must be signed prior to the service.

Provider may not be one of providers/services outlined by guidance that Notice and Consent forms are not permitted.

https://www.cms.gov/files/document/standard-notice-consent-forms-nonparticipating-providers-emergency-facilities-regarding-consumer.pdf

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

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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.

What is UnitedHealthcare's approach for supporting the various CAA provisions for fully insured and level funded groups? New 8/25/21

UnitedHealthcare will meet all requirements under CAA.

How would a broker know if the All Saver groups opted in State / Federal rule? Will All Savers choose the best option (state or federal) for their customers? New 8/25/21

All Savers (level funded) will be handled in the same manner as fully insured business.

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Can a self-funded ERISA plan opt into a state law after the No Surprises Act takes effect? New 8/25/21

Yes -- if the state law permits. However, in most cases the federal law is preferable and only the federal law covers the air ambulance provision. The client should discuss their options with their counsel.

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 OON 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.

How does the No Surprise Act work when there is an auto claim involved? New 5/31/23

With Commercial and other coverage (for example: Medicare, or other commercial coverage) if UnitedHealthcare is not primary, then the claim is out of scope for NSA.

Specifically, automobile accidents claims are subject to NSA rules. When a claim involves an auto insurance carrier, the coverage is not the same as with coordination of benefits (COB) in the same way. However, it is sometimes called out as COB.

- **State with auto no-fault rules** – UnitedHealthcare typically deny first pass pending the auto insurance carrier payment determination.
- **State without auto no-fault rules** – UnitedHealthcare pays as NSA first pass.

In both the above circumstances (no-fault or without no-fault) if UnitedHealthcare receives an auto insurance carrier payment determination:

- UnitedHealthcare reduces our payment by the amount the auto -carrier already paid. We do not overpay.
- UnitedHealthcare will apply NSA protections and assigning QPA as the allowable.

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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.

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.

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

The law applies to medical bills related to:

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

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

How are emergency services handled? Update 3/22

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

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

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

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

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

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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.
- 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

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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

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).

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– 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.

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

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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

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

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

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

Can ancillary providers balance bill? New 3/22

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

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

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

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

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

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

Which providers are considered ancillary? New 3/22

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

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INN facility to provide the services. OON providers of ancillary services at INN facilities may not balance bill.

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

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

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

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

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

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

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

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

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

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

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

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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.

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

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

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

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

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

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

If states have 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.

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Does UnitedHealthcare has anyone participating in the WEDI discussions relating to the NSA? New 5/18/22

Yes, UnitedHealthcare has staff members who are a part of the WEDI Task Force.

No Surprises Service Rate Calculations

How will UHC price NSA applicable claims? New 4/7/22

Member OON cost-sharing amount based on the "Recognized Amount:"

- Reimbursement defined by applicable state law methodology.
- "Qualifying Payment Amount" if no state law.
- Payment amount in state All-Payer Model Agreement.

Providers cannot bill members for any amounts beyond their cost share.

While the NSA limits what out of network providers can bill members it does not limit what out-of-network providers can pursue in terms of reimbursement from the plan. UnitedHealthcare will continue to assess fair and reasonable payment for out-of-network providers and may potentially adjust our approach over time.

If self-funded client has employees in multiple states--- is the rate adjusted to the applicable residing state, service state or employer situs? Would it be more advantageous for them just opt out of state no surprises regulations and go with Federal for their entire organization? New 8/25/21

The par median rate is based on the geographic region where the OON services are provided. The plan sponsor is responsible for deciding whether to opt-in to a state balance billing law where permitted or to follow the federal No Surprises Act.

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.

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.

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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 the no surprises billing regulations change the relationship and billing for OON Anesthesiologist services? New 8/25/21

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OON anesthesiologists who perform services in a surprise bill situation will have their claims paid according to the NSA rules and they cannot balance bill the member.

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 is QPA calculated for self-funded groups? New 8/29/22

AS it pertains to self-funded plans, the NSA requires, among other things, that the member cost-share for certain items and services covered under the plan be calculated based on the lesser of the providers billed charges or the NSA qualifying payment amount (QPA). With respect to the calculation of the QPA, the customer elects to use and adopts the QPA calculated by UnitedHealthcare based on UnitedHealthcare's self-funded business. All QPA amounts under the NSA will be calculated based on an insurance market across all self-insured group health plans administered by UnitedHealthcare as permitted under NSA.

UnitedHealthcare fully meets requirements under the NSA for calculation of the QPA including market calculations.

What is UnitedHealthcare's approach to determine reimbursement rates for OON providers? New 8/25/21

UnitedHealthcare will determine reimbursement rates for OON providers consistent with the No Surprises Act and any applicable state balance billing laws.

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.

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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.

If a self-funded group is a non-ERISA public sector group plan, meaning they are required to follow state laws in most cases, would they need to use the state pricing methodology? New 8/25/21

Yes, if the state has pricing methodology for OON billing that applies to non-ERISA public sector group plans. Otherwise, they would follow the federal pricing methodology.

Downcoding Guidance

What was the requirement in the Surprise Billing Final Rule regarding downcoding disclosure requirements? New 12/7/22

The Surprise Billing Final Rule released August 26th includes a new requirement for payers to include certain disclosures about down coded QPAs in the response to the provider's OON claim.

- The payer must disclose whether the QPA was down coded and what the QPA would have been absent the down code.
- The notice requirements are effective October 25th.

What id Surprise Medical Billing down coding? Updated 12/8/22

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Down coding means the alteration by a plan or issuer of a service code to another service code, or the alteration, addition, or removal by a plan or issuer of a modifier, if the changed code or modifier is associated with a lower qualifying payment amount than the service code or modifier billed by the provider, facility, or provider of air ambulance services.

The new guidance requires UHC to provider the Qualified Payment Amount (QPA) to the provider for the code(s) or modifier(s) provider originally submitted on his/her claim.

The information required goes out with the PRA.

No Surprises Consumer and Provider Disclosures

Will there be changes to the surprise billing disclosure notice and EOB message in 2023? New 12/7/22

UnitedHealthcare is transitioning to using the Federal Model Notice language in 2023. The language we are using now together with the updates we are making to the Ombudsman section of member EOBs fully meet requirements. However, based on some feedback from states during 2023 filings, we've decided to make a language change. The notice posted to uhc.com has already been updated with the Federal Model Notice language as of 12/2/22 (https://www.uhc.com/legal/federal-surprise-billing-notice) and we are looking to update EOBs as soon as possible.

What disclosures to members are required under the 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 is in place to prevent the provider from sending the member to collections? New 8/25/21

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CAA requires the provider and the insurer or plan to provide a notice to individuals of their rights under the federal law and any applicable state laws. If a member is balanced billed in error and sent to collections, the member can file a complaint citing the provider's noncompliance with the law

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.

Will UnitedHealthcare be accommodating individuals who are visually impaired with the new CAA requirements? New 8/25/21

We are committed to ensuring that our website and mobile applications are accessible to individuals with disabilities. If you need assistance using our website or mobile application, or assistance with a PDF, we can help you. Please call us toll-free at 1-844-386-7491.

NSA Negotiation to IDR Requirements

What are the requirements to open negotiation under NSA? New 10/22/21

Upon the provider's receipt of an initial payment or notice of denial of payment from the plan/issuer for NSA surprise medical bill items/services, either party may initiate an open negotiation period within 30 business days beginning on the date the provider/facility receives the initial payment or notice of denial of payment.

- The initiating party must provide a written notice to the other party of its intent to negotiate. The open negotiation notice must include information to identify the

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items/services subject to negotiation, including the DOS, service code, initial payment amount or notice of denial of payment, an offer for the OON rate, and contact information of the party sending the open negotiation notice.

- The Tri-agencies are issuing a standard notice that the parties must use to satisfy the open negotiation notice requirement.
- The open negotiation notice may be sent electronically if (a) the party sending the open negotiation notice has a good faith belief that the electronic method is readily accessible to the other party, and (b) the notice is provided in paper form free of charge upon request.

How long is the negotiation period? New 10/22/21

The open negotiation period may continue for up to 30 business days, beginning on the date that the initiating party sends the open negotiation notice.

If the open negotiation notice is not properly provided and no reasonable measures have been taken to ensure actual notice has been provided, the Tri-agencies may determine that the open negotiation period has not begun.

In this situation, any subsequent payment determination from a certified IDR entity may be unenforceable.

Is the negotiation period required before going to IDR? Update 10/22/21

If the parties cannot agree on an OON rate, they **must** exhaust the 30-business day open negotiation period before initiating the IDR process.

At that point, either party may initiate the IDR process during the 4-business period beginning on the 31st business day after the start of the open negotiation period. The initiation date of the IDR process will be the submission date of the Notice of IDR Initiation, specified upon receipt date of the Notice. The Tri-agency will acknowledge/confirm the initiation date with both parties.

How does the notice to initiate IDR occur? New 10/22/21

The initiating party, either the provider or insurer/health plan must submit a Notice of IDR Initiation to both of the following:

1. The other party - electronically or paper. To send electronically there must a be a good faith belief that the electronic method is readily accessible to the other party.
2. The Tri-agencies through the Federal IDR portal. The Notice is required on the same day it was sent to the other party.

What must be in the IDR notice? New 10/22/21

1. Information sufficient to identify the qualified IDR items/services (and whether the items are designated as batched). For example, the DOS and location of the items/services, the

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type of qualified IDR items/services (e.g., emergency, post-stabilization, professional, hospital-based services), service and place of service codes, amount of cost-sharing allowed, initial payment amount
2. Names and contact information of the parties involved, including email addresses, phone numbers, and mailing address
3. State where the items/services were furnished
4. Commencement date of the open negotiation period
5. The preferred certified IDR entity
6. Attestation that the items/services are qualified IDR items/services within the scope of the IDR process
7. QPA and information about QPA

general information describing the IDR process, next steps, and timeline. There is a form that must be used to satisfy this requirement.

Member Disclosure Notice

Will there be changes to the surprise billing disclosure notice and EOB message in 2023? New 12/7/22

UnitedHealthcare has transitioned to using the Federal Model Notice language in 2023. UnitedHealthcare is updating EOBs with the federal notice.

Where may the customer or member get a copy of the disclosure notice? New January 1/7/22

The balance bill (surprise bill) disclosure notice is posted publicly on uhc.com with other member notices. https://www.uhc.com/legal/federal-surprise-billing-notice

The language may not be customized. This disclosure notice will only appear with EOB when the claim is processed using federal surprise billing rules. It contains information required in the federal model notice.

What protection is required in the disclosure notice for members? New 11/2/21

The following information will be distributed with every EOB for a surprise bill claim. It will also be posted on uhc.com and other main public websites.

How you're protected from surprise medical bills under the No Surprises Act.

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Sometimes where and from whom you get health care is out of your control. Like when you need emergency care, or an out-of-network provider is involved in your care without your choice. When this happens, the No Surprises Act may apply, and when it does, you won't have to pay more than your copay, coinsurance, or deductible.

What is a surprise bill? New 11/2/21

A: When you receive health care services, you may owe copayment, coinsurance or deductible. If an out-of-network provider is involved in your care, you may owe these costs and face additional costs—or even the entire bill.

This is in part because out-of-network providers sometimes bill you for more than your health plan determines it and you (through your copayment, coinsurance or deductible) should pay. This bill is called a surprise bill or a balance bill. Network providers don't do this. Out-of-network providers sometimes do.

What is an out-of-network provider? New 11/2/21

An out-of-network provider is one that has not signed a contract with your health plan. Out-of-network providers service rates are likely higher and may not count toward your deductible or out-of-pocket limit. That's why it's best to visit network providers whenever possible. Find them anytime at your online member website, or mobile app>.

When am I now protected from surprise bills? New 11/2/21

You're protected from surprise bills when you receive:

- Out-of-network emergency services, including air ambulance (but not ground ambulance)
- Out-of-network non-emergency, ancillary services* provided at in-network facility
- Non-emergency, non-ancillary services provided at in-network facility, and the provider did not get your prior consent in the way the No Surprises act requires.

And, for the above services, your health plan must ensure your cost-share (in other words, your coinsurance, copay, deductible):

- Be the same as it would have been if the service was provided in-network.
- Be based on what your plan would pay an in-network provider.
- Count toward your in-network deductible.
- Count toward your out-of-pocket maximum

*Ancillary services include services related to emergency medicine, anesthesiology, pathology, radiology and neonatology; certain diagnostic services (including radiology and laboratory services); items and services provided by other specialty practitioners; and items and services provided by an out-of-network provider if there is no in-network provider that can provide that service.

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Remember: Out-of-network providers may not ask you to give up your protections against surprise billing, and you are never required to do so.

If I get a surprise bill in one of these situations, what should I do? New 11/2/21

In these situations, you are only responsible to pay your copay, coinsurance, or deductible that would have been charged if you had seen a provider in your plan's network. That means, you should not get—and, if you get, you do not need to pay—a balance or a surprise bill from an out-of-network provider.

What if I choose to see an out-of-network provider or visit an out-of-network facility outside of these situations? New 11/2/21

Choosing to visit an out-of-network provider or facility under different circumstances means you may face paying the entire bill, because providers are generally not prohibited by law from sending you a surprise bill. That's why it's so important to stay in your network whenever possible.

What if I have questions? New 11/2/21

We're here for you. If you have questions about a provider's network status or you believe you've been wrongly billed, please contact the No Surprises Help Desk: 1-800-985-3059

Visit www.cms.gov/nosurprises for more information about your rights under federal law.

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Provider Requirements

What are the requirements for providers for no surprise rules? Update 4/7/22

The Consolidated Appropriations Act of 2021 established several new requirements to protect consumers from surprise medical bills. These requirements are collectively referred to as “No Surprises” rules. These requirements generally apply to items and services provided to consumers enrolled in group health plans, group or individual health insurance coverage, and Federal Employees Health Benefits plans. The agencies released frequently asked questions from providers and facilities regarding No Surprises rules, independent dispute resolution, and exceptions to the new rules and requirements which are posted to the following No Surprise provider FAQ document. https://www.cms.gov/files/document/faq-providers-no-surprises-rules-april-2022.pdf

Independent Dispute Resolution

For now ,the CMS portal is closed to batch and certain IDR submissions. Awaiting final ruling on new process, QPR calculations, IDR administrative and IDR entity fees. ***11/27/23***

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)? Update 3/3/22

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.

For a list of approved IDR entities go to the CMS.gov site.

Who can request an Independent Dispute Resolution (IDR)? New 3/22/21

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.

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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.

Under the No Surprises Act, even though the "member" won't be hit with a surprise balance bill, could the plan be required to pay more? New 8/25/21

The plan reimbursement rate with be negotiated with the OON provider and if an agreement is not reached it may be decided by Independent Dispute Resolution.

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

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

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

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- The acuity of the patient.
- The teaching status, case mix, and scope of services of the facility.
- Demonstrations of good faith efforts by the provider or facility to participate in the insurer or plan network.

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

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

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

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

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

   HHS or parties select IDR entity.

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

What is the 90-day cooling off period? New 10/8/21

There is a suspension period (cooling off period) for consideration of similar claims if the end of the 30-business day negotiation period for those claims falls within a 90-calendar day period following the initial IDR decision date. The suspension period applies to claims for the same or similar item or service submitted by the same provider for payment by the same plan (i.e., batched items and services).

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

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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.

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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

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Customers should be making decisions now if they would like UnitedHealthcare to handle this for them.

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.

Tri-Agencies Order IDR Entities to Hold Payment Determination

Why is there a hold on payment determinations by the IDR entities? New 2/15/23

Effective Feb. 10, 2023, the Tri-Agencies (Department of Labor (DOL), Health and Human Services (HHS), and the Treasury) instructed certified independent dispute resolution (IDR) entities to hold all payment determinations under the No Surprises Act until further guidance is issued and to recall any payment determinations issued after February 6, 2023.

The hold resulted from an order issued by the U.S. District Court for the Eastern District of Texas in the following lawsuit: Texas Medical Association, et al. v. United States Department of Health and Human Services, Case No. 6:22-cv-372 (TMA II). The order vacated certain portions of rules governing the Federal IDR process and other provisions applicable to air ambulance disputes.

As a result, certified IDR entities will not issue new payment determinations until receiving further guidance from the Tri-Agencies. The Tri-Agencies are currently reviewing the court's decision and evaluating current IDR processes, guidance, templates, and systems for updates that will be necessary to comply with the court's order. Then updated guidance will provide specific directions to certified IDR entities for resuming the issuance of payment determinations that are consistent with the court's order.

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Certified IDR entities may continue working through other parts of the IDR process, including eligibility determinations, as they wait for additional direction from the Departments.

What additional guidance was released regarding the hold on payment determinations? New 3/7/23

Further updates recent guidance for certified Independent Dispute Resolution (IDR) entities to resume processing payment determinations on February 27 for disputes involving items or services furnished before October 25, 2022. Certified IDR entities will continue to hold issuance of payment determinations involving items or services furnished on or after October 25, 2022 until the Departments issue further guidance. This change in policy is required to allow the Departments to review and modify guidance in order to comply with recent opinions and orders by the U.S. District Court for the Eastern District of Texas.

Certified IDR entities may continue working through other parts of the IDR process, including eligibility determinations, as they wait for additional direction from the Departments.

Is there any impact that customers will see based on the payment determination hold? New 2/15/23

While this hold on payment determinations is in place, customers may see less activity in their bank accounts until guidance is issued and the IDR payment determination process resumes. Customers could still be seeing charges coming through from 2022 activity and for Jan. 2023 at some point.

IDR Process

Is the IDR portal open and when do IDRs begin to be processed through the system? New 4/25/22

Yes, Centers for Medicare & Medicaid Services opened the Federal Independent Dispute Resolution (IDR) process for providers (including air ambulance providers), facilities, and health plans and issuers to resolve payment disputes for certain out-of-network charges. The IDR portal opened on April 15, 2022. The parties who intend to file a dispute have 15 business days to enter information in the IDR portal. The process and form to complete may be found on the IDR payment dispute page on cms.gov site.

How can a provider or an insurer or group plan start a dispute? Update 1/19/24

Centers for Medicare & Medicaid Services opened the Federal Independent Dispute Resolution (IDR) process for providers, facilities, and health plans and issuers to resolve payment disputes for certain out-of-network charges.

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After the end of a 30-business day open negotiation period where all parties failed to reach an out-of-network payment agreement, the parties may use the online portal to initiate the Federal IDR process. The dispute must be initiated within 4 business days to initiate a dispute via the portal. To begin a dispute, an initiating party will need provide certain information and complete the online form including:

- Information to identify the qualified IDR items/services
- Dates and location of items/services
- The items/services type such as emergency or post-stabilization services
- Codes the service and place-of-service
- Attestation that items/services are in scope for the Federal IDR process
- The preferred certified IDR entity from the list of certified entities.
- Requires the losing party to pay the arbitration fee and requires each party to pay an administrative fee to the Tri-Agencies of $115 beginning January 22, 2024.

Can the provider/facility and insurer/group health plan continue negotiation during the IDR? New 1/19/24

Yes. Even after starting the federal IDR process, disputing parties can continue to negotiate until the IDR entity makes a determination. If the parties reach an agreement on the out-of-network payment rate, within 3 days of the agreement, they are required to email the certified IDR entity and the agencies at FederalIDRQuestions@cms.hhs.gov and attach the following:

1. The agreed-upon out-of-network rate for the qualified IDR item, batched determinations, or service (that is, the total payment amount, including both participant, beneficiary, or enrollee cost sharing and the total plan or coverage payment, including amounts already paid);
2. How parties agree to pay certified IDR entity fee (if parties choose not to evenly split the fee)
3. Authorized signatures from both the initiating and the non-initiating party.

What happens if either of the disputing parties cannot meet the IDR deadlines? New 4/25/22

If the disputing parties experience extenuating circumstances during the IDR process that prohibit them from complying with deadlines to submit information, they may email the Departments (at FederalIDRQuestions@cms.hhs.gov) to receive a Request for Extension Due to Extenuating Circumstances form and instructions for next steps.

Are there more resources on IDR? New 4/25/22

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To learn more about the Independent Dispute Resolution process, including to read guidance materials, FAQs, and model notices, visit www.cms.gov/nosurprises

Additional Resources:

- Revised Certified IDR Entities Guidance and revised IDR Disputing Parties Guidance, which provide updates to conform with the recent Texas Medical Association, et al. v United States Department of Health and Human Services, et al. decision..
- Frequently asked questions about the Federal IDR process, IDR entity qualifications and the application process, and fees.
- Frequently asked questions for providers and facilities about the No Surprises Act rules, Independent Dispute Resolution, and exceptions to the new rules and requirements.
- Chart for Determining the Applicability for the Federal Independent Dispute Resolution (IDR) Process, which provides a high-level summary to assist in determining whether the Federal IDR process or a state law or All-Payer Model Agreement applies for determining out-of-network rates.

IDR Reporting

Is IDR Reporting available for UnitedHealthcare self-funded groups? New 6/26/22

Yes. Customer reporting is available for self-funded (ASO) Key Accounts, National Accounts, and Public Sector customers that use Employer eServices® (EeS). Customers can now access and download the IDR report from their customer reporting page.

eServices reporting does not apply to fully insured customers, UMR or All Savers®/Level Funded groups.

IDR Requirements

Has the government issued a final rule on surprise billing and arbitration? New 11/12/21

Yes. October 7, 2021 the Departments of Health and Human Services, Labor, and the Treasury (the Tri-Agencies) and the Office of Personnel Management posted an Interim Final Rule (IFR) — Requirements Related to Surprise Billing —which outlined how a number of requirements under the No Surprises Act are to be implemented. The IFR establishes the process to determine a final reimbursement rate for out-of-network bills if a health care provider and health plan cannot reach agreement. The requirements are effective for plan and policy years beginning on and after 1/1/22.

The IFR also requires providers and facilities to provide a good faith estimate of treatment costs to an uninsured or self-pay individual and establishes a dispute resolution process when an uninsured/self-pay individual is billed an amount in excess of the good faith estimate.

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What are the key requirements in the surprise billing IFR? New 11/12/21

- Establishes the timeframes, processes, and requirements for using the federal independent dispute resolution (IDR) process that applies for surprise medical bills from out-of-network providers, facilities and air ambulance carriers.
- Requires the health care provider and health plan to submit an offer for consideration by the IDR entity.
- Instructs the arbiter/IDR entity to consider the Qualifying Payment Amount (QPA) – defined as the health plan's median contracted rate for the billed item or service – as the appropriate reimbursement amount in most cases.
- Allows the arbiter/IDR entity to consider certain information such as the patient's medical condition that is submitted by either party supporting a higher or lower reimbursement amount if the information is credible
- Requires the arbiter/IDR entity to select the offer closest to the QPA unless the additional information clearly demonstrates that the value of the item or service is materially different from the QPA.
- Establishes IDR process timelines for submitting offers and decisions by the arbiter/IDR entity.

What are the key timeline requirements? Updated 1/19/24

- A "good faith" negotiation period between parties for 30 business days before initiation of IDR can occur
- Initiation of IDR by either party four business days after the end of the negotiation period. At this time a $115 fee is due from the insurer/health plan and the provider to cover the government costs associated with the IDR program. Prior to Jan. 22, 2024 the fee had been both $350 and $50.
- Joint selection of a certified arbiter/IDR entity within three business days after initiation of IDR
- In cases where a joint selection is not achieved, the Department of Health and Human Services will select the IDR entity.
- Ten business days after selection of the arbiter/IDR entity, both parties submit payment offers and any additional information for consideration. At this time the insurer/health plan and provider also pay the arbiter/IDR entity fee. Final reconciliation of fees is determined based on the final decision.
- Within 30 business days of the submission of the dispute to IDR, the arbiter/IDR entity issues a binding written determination selecting one of the parties' offers as the payment amount and includes the underlying rationale for the decision.
- Thirty business days after the arbiter/IDR entity's decision, final payment is made to the provider or plan depending on the decision.
- The IDR entity fee paid by the party whose offer was accepted is returned by the arbiter/IDR entity.

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OON providers have 12 months to submit claims, and 180 days to appeal. Is arbitration overriding the contracts? New 1/25/24

Arbitration overrides the contract.

What are the IDR fees and who pays them? Update 1/19/24

Under the IDR requirements, each party must pay the administrative assessment of $115 to the agencies. In addition, both parties pay an arbiter/IDR entity fee when they submit their offer. The IDR entity fee paid by the party whose offer was accepted is returned by the arbiter/IDR entity.

How much may an arbiter/IDR entity charge for their services? New 11/12/21

Each arbiter/IDR entity will be permitted to establish fees within a range determined through guidance that will be forthcoming. The arbiter/IDR entity may charge a set fee for consideration of a single claim and a fee for batched claims. The fees may be adjusted annually.

Who is qualified to be an arbiter/IDR entity, what will the government use to assess their expertise? New 11/12/21

The IFR requires an arbiter/IDR entity to demonstrate expertise in areas such as coding and billing, maintain accreditation from a from a nationally recognized and relevant accreditation organization, and be re-certified every five years.

IFR also established a process to petition the agencies for the denial or revocation of a certification of an arbiter/IDR entity.

Arbiter/IDR entities are required to submit monthly reports to the Tri-Agencies on their activities, including the size of the provider practices and facilities initiating the IDR process, the offers submitted by each party, and whether the offer selected by the arbiter/IDR entity was submitted by the health plan or the provider.

Requirements for uninsured or self-pay individuals

What are the protections for individuals who are uninsured or pay claim themselves? New 11/12/21

A provider or facility must provide a good faith estimate of expected treatment costs to uninsured or self-pay individuals. The estimate must include the costs for primary and ancillary services as well as items or services that may be provided by other providers or facilities.

- Establishes a separate arbitration process for uninsured or self-pay individuals who are billed an amount substantially in excess of the good faith estimate.

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- Allows individuals to use the process if they initiate a claim within 120 days of receiving the bill.
- Defines substantially in excess as an amount that is at least $400 more than the total amount of expected charges listed on the good faith estimate.
- Caps the administrative fee for using the SDR at $25 in 2022.

IDR Fees for Administration and Arbiters

Does UnitedHealthcare pay the fees for fully insured plans? New 3/3/22

Yes. UnitedHealthcare pays administrative fee and the arbiter entity fees if there is one.

Does UnitedHealthcare pay the fees for minimum premium plans? New 3/3/22

Yes.

Does the self-funded employer pay the fees for self-funded plans? Update 1/19/24

Yes. The self-funded health plan would pay the $115 administrative fee when due. UnitedHealthcare will upfront the arbiter IDR entity fees and then once the final decision on IDR is made reconcile and charge the health plans bank account. Reports will be available showing any fees.

Under IDR who is charging the $115 (was $50 and $350 in 2022 in 2023) administrative fee? Update 1/19/24

The $115 fee is a charge by the government for administration of the IDR program. The money goes to the arbiter who has the responsibility to submit the fee to the federal government.

The $115 admin fee must be paid by the plan and by the provider immediately when either party submits the IDR request online to the government.

Does the $115 fee go through the claim account? Update 1/19/24

Yes.

If a claim goes to arbitration, does the plan sponsor pay the arbiter? Will the plan sponsor get a refund if the provider does not win? Update 1/19/24

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For UnitedHealthcare customers, if a claim goes to arbitration, both the plan and the provider are responsible for upfronting the arbiter fee. This must occur when the final offer and documentation is sent to the arbiter.

UnitedHealthcare will front the arbiter fee for our customers and then reconcile with the customers once a decision is made. This is to ensure the fee is paid to the arbiter on time so a delay would not impact the decision.

As with the $115 administrative fee, any arbiter fees required would go through the claim account.

Remember, if the provider prevails, the plan sponsor pays both arbiter fees.

Do you know IDR entity (arbiter) fee amount or range? Update 1/19/24

According to the Interim Final Rule on Oct. 7, 2022, the Tri-agencies are recommending a target
According to the guidance in December 2023, beginning 1/22/24, the Tri-agencies are recommending a target o

- IDR entity fee for single determinations — Range is $200 to $840
- IDR entity fees for batched determination — $268 to $1,173.

There are arbiters that charge less and some that charge more. The IDR entity would need to request permission to charge more than the range.

Remember, the arbiter fee is to be paid to directly to the arbiter for a particular IDR.

Air Ambulance

Is there a potential delay in CAA Air Ambulance reporting? Update 11/27/23 for Air Ambulance reporting.

On Feb. 23, 2023, CMS announced their website for air ambulance reporting and noted on the new website, a clarification that despite the proposed rule's suggestion that reporting would be due 3/31/23, in fact air ambulance reporting won't be due until the final rule is published.

Based on recent information from the tri-agencies, we're not expecting to get any rule updates until late 2023 or early 2024.

We'll provide an update via existing communication channels as soon as we have anything more to share.

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

No.

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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.

What is the approach if air ambulance not covered on the plan or coverage criteria not met? New 8/29/22

If air ambulance is not covered on the plan, or if the criteria for coverage for non-emergency air ambulance is not met, then we would deny the claim. The provider may still have requirement to provide notice and consent for these services, but from the plan perspective, we would simply deny the claim and it becomes and adverse benefit determination and would not be tagged as an NSA claim and the member would be liable for the charges for the not covered services.

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.

What is the approach if air ambulance is covered on the plan and coverage criteria is met or waived? New 8/29/22

If air ambulance is a covered benefit on the plan and the criteria for coverage of non-emergency air ambulance is met (or if the plan chooses to waive the criteria by way of a benefit exception), then the claim would be in-scope under the No Surprise Act (NSA).

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Once the Air Ambulance claim is in scope for NSA, the rules require the Air Ambulance provider to only hold the member liable for their cost share as calculated based on QPA. The provider then has rights to negotiate and arbitrate within the guidelines of the IDR process. In this instance, the Notice and Consent obtained is irrelevant.

Air ambulance folks charge very high amounts for their services and have raised their rates significantly in many areas this year. Will self-funded plans be required to pay a higher rate if they don't pay these high costs today? New 8/25/21

OON air ambulance providers are subject to NSA rules. If the plan and OON air ambulance provider are unable to agree on a reimbursement rate, the payment amount may be submitted to Independent Dispute Resolution.

Is there any protection from balance bills from non-contracted ground ambulance? New 8/25/21

No. Ground ambulance was not part of the federal No Surprises Act guidance.

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

Can plans have both an INN and OON dollar limit for air ambulance? New 8/29/22

Yes. As long as the dollar limits are the same, there can be one on INN and one for OON.

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.

Air Ambulance Reporting

What is the status of air ambulance reporting? New 3/7/24

The air ambulance reporting has been postponed several times.

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The No Surprises Act Air Ambulance Reporting provisions is a two-year requirement currently applying to reference year 2024 (report due in 2025) and reference year 2025 (report due in 2026).

Based on preliminary indications of the air ambulance reporting requirements, UnitedHealthcare plans to report on behalf of all customers (fully insured. ASO, level funded, on all platforms). Once the final rule is released, we will determine if any additional data would be needed from the customer.

The government agencies have indicated that the final rules will be published in the Fall.

What information was in the proposed rule that came out September 10 that included information on reporting for air ambulance? Update 3/15/23

The rule made clear that the No Surprise Act bans surprise bills for individuals using out-of-network air ambulance services. Beginning with plan years on and after 1/1/22, the amount a person would pay for emergency air ambulance services as outlined in NSA would be limited.

In the proposed rule, the air ambulance providers have certain reporting requirements. In addition, insures and self-funded plans will be required to report certain claims data for the services.

Applies the reporting requirements for plans, issuers, FEHBP carriers and providers for two calendar years.

We're waiting for additional guidance on the timing, content and submission requirements for Air Ambulance reporting. While proposed rules did indicate a 3/31/23 first report date, guidance is not expected until later in 2023. At that time, we expect to learn the report date.

Based on recent information from the tri-agencies, we're not expecting to get any rule updates until August. We'll certainly provide an update via existing communication channels as soon as we have anything more to share.

Will UHC handle reporting requirements for Air Ambulance Reporting on behalf of its ASO/TPA customers? Update 1/27/23

We will be better able to respond to this question once the Interim Final Rule (IFR) addressing air ambulance reporting is released sometime in 2022. The first reports aren't due until **March of 2023** for the 2022 plan year.

We're waiting for additional guidance on the timing, content and submission requirements for Air Ambulance reporting. While proposed rules did indicate a 3/31/23 first report date, as we've not received the necessary information, we do think the previous date will get pushed out by the tri-agencies.

Based on recent information from the tri-agencies, we're not expecting to get any rule updates until August. We'll certainly provide an update via existing communication channels as soon as we have anything more to share.

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When are the first Air Ambulance Reports due? Update 3/15/23

We are continuing to wait for guidance.
Based on recent information from the tri-agencies, we're not expecting to get any rule updates until at least August. We'll certainly provide an update via existing communication channels as soon as we have anything more to share.

What reporting will UHC provide related to Air Ambulance? New 5/18/22

Air Ambulance reports are due March 2023. UnitedHealthcare plans to support these reporting requirements.
We're waiting for additional guidance on the timing, content and submission requirements for Air Ambulance reporting. While proposed rules did indicate a 3/31/23 first report date, as we've not received the necessary information, we do think the previous date will get pushed out by the tri-agencies.
Based on recent information from the tri-agencies, we're not expecting to get any rule updates until August. We'll certainly provide an update via existing communication channels as soon as we have anything more to share.

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ID Cards

Does the law require any changes to ID cards? Update 11/27/23

Yes, 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.

Will UnitedHealthcare still include copay with the Deductible and oops if the customer wants them on the card? New 11/10/21

Yes, those fields are not impacted and will continue to appear on the cards.

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 required new ID cards to be issued? Update 8/2/23

- **Grandfathered plans** – required the new ID card
- **Retiree plans** – did not require the new ID card
- **Collectively bargained plans** – required the new ID card
- **COBRA** – Member uses the card they had when they were an active employee.

Retiree plans are out of scope, but what if a plan has actives and retirees in the same plan — would everyone in that plan get the deductible and OOP added to their ID cards? New 11/10/21

Yes. Everyone in that plan would get the Deductible and OOP added to their ID cards.

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Are retiree plans exempt from the mandate for ID cards and is the guidance applicable to pre-65 or post-65 plans? Update 11/8/21

There is no distinction between guidance for pre- or post-65 plans. Retiree-only plans with fewer than 2 active employees are exempt from the CAA ID card requirement.

Retiree plans can be opted out of the process of showing deductibles or OOP max limits by entering zeros in the ID Card design.

Although retiree plan only cards will not get the updated Ded/OOPM information added, if the customer would like to add Ded/OOPM to the retiree plan cards is there a special approval process to get it added or do we just notify the IS? New 11/10/21

Retiree plans are not required to include Ded/OOPM. However, UnitedHealthcare will accommodate those requests to include the values. Customers should discuss with their account team.

Will members new or current who get new ID cards receive any communication with the ID card when it is mailed? New 11/1/21

Anyone receiving a printed ID card will get an insert with the abbreviations and a remark code noting ID card changes were due to regulation changes.

Is the Health Plan ID on the ID Card? New 12/8/21

The Health Plan ID was removed from all card fronts with the exception of the Rx Only card, on which it's labeled "Issuer ID". However, the health plan ID is still encoded within the bar code on the back of the card.

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

Does the Rx logo move for all PBMs to the top of the card? Update 11/10/21

Yes

Will every ID card need to be replaced with the new format or will maintenance ID cards and online cards suffice? Update 8/2/23

Cards have been 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

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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.

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.

Does the deductible and OOP need to be on the front of the ID Card, or can it be on the back? Update 11/8/21

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.

UnitedHealthcare will put the deductible and OOP maximum on the front. UMR is putting the information on the back of the card.

Are there any changes to the administrative fees as a result of the ID card changes? Update 8/2/23

No.

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).

For customers that have carve out pharmacy logos on the ID card, where will the carve out pharmacy logos appear? Update 11/10/21

Carve out and Optum RX pharmacy will now be on the top middle section of the ID Card.

Out of Network Programs

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

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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.

How do the out-of-network (OON) programs work with the No Surprises Bill? New 6/18/21

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.

Does R&C, MNRP, 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, MNRP, OCM (non emergent) and Naviguard (non emergent) will not be triggered in NSA situations so will not have to follow the NSA.

Is Naviguard available for UMR clients? New 8/25/21

At the moment, Naviguard is not available for UMR clients. Your Strategic Account Executive will be glad to discuss Naviguard with you once that solution available for UMR clients

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-

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funded groups and to date only six states have a self-funded opt in program in place. Additional 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

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- Outlier Cost Management (OCM) Non-Emergent
- 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-

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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.

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.

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.

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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.

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- Scheduled nonelective surgery including post-operative care.
- Course of treatment for pregnancy.
- Terminally ill patients.

What is the scope for CAA Continuity of Care requirements? New 3/21/23

For Commercial Fully Insured Groups:

- Provide the Employer Group/Client (not the member) with guidance in their termination / cancellation letters.
- Include a model notice/communication that the Group is responsible for informing its membership of their options.

	In-Scope [for Fully Insured Group requirements]	Out-of-Scope [for Fully Insured Group requirements]
General Scope	Commercial **Fully Insured (FI) Group Health Plan (GHP)**	Self-Insured / ASO Clients Individual Exchange Federal Employee Health Benefits Medicare, Medicaid, Medicare Supplements Excepted Benefits Short-Term Limited Duration Insurance

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.

Are PPO plans covered under the CAA continuity of care provision? New 9/26/22

CAA covers commercial plans so PPO plans would be included in COC provisions.

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.

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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.

Can you summarize the Continuity of Care requirements for termination? New 10/6/22

For Commercial Fully Insured Groups:

- Provide the employer group (not the member) with guidance in their termination / cancellation letters.
- Include a model notice communication informing the group that they are responsible for making the membership aware of their options.

This impacts all terminations or cancellations (so member is held harmless) including:

- Voluntary cancellation/termination
- Termination due to non-payment of premiums
- Termination due to non-compliance w/ eligibility/participation requirements

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

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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

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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.

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

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

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

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

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

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

The network rate applies.

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

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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

Advance Cost Estimate implementation dates are moved pending additional guidance.

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 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;

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- Other information the plan or coverage determines appropriate.

Who is required to provide an Advance Cost Estimate, sometimes called advanced EOB? Update 11/15/22

Advance Cost Estimate implementation dates are moved pending additional guidance.

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.

Once the Advanced EOB provision is implemented, healthcare plans will be required to provide advanced EOBs to plan participants after receiving notice of scheduled service from the provider or facility.

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
- 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

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- 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.

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.

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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**.

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

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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 included external review to respond to disputes for adverse actions.

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

Yes.

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

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

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

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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.

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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 812/1/23

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 moved under the Transparency in Cover Rule for Consumer Price Transparency Tools (CPTT) on and after January 1, 2023. Refer to the Transparency in Coverage CPTT FAQs.

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Provider and Member 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? Update 2/16/22

Commercial Employer and Individual (E&I) plans 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? Update 2/16/22

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, i.e., email address and/or URL

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, i.e., email address and/or URL

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 5 times a 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 may 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.

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How will directory accuracy and updates be handled? Update 2/16/22

UnitedHealthcare will ask providers to verify their data through My Practice Profile (MPP) attestations, roster submissions, and CAQH data every 90 days. If a provider's data cannot be verified within a reasonable time after the last verification date, the provider may 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.

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.

Will a member who relied on incorrect information received be liable only for in-network cost-sharing amounts? Update 9/20/22

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.

Provider directory provisions under the CAA state that if the online database incorrectly lists an out-of-network provider as in-network and a participant or beneficiary obtains items or services

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from that provider, the plan must limit cost sharing to the in-network amount and credit those amounts toward the in-network deductible or out-of-pocket maximum.

Claims are processed according to the network status of the provider in our system. If that status is incorrect, we investigate to ensure we have the correct status.

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 information is provided to members who ask if a specific provider(s) are in network? New 3/3/22

A confirmation communication will be sent to member with information as follows:

Thank you for contacting us. Below is the information you recently asked for regarding a provider's network status.

This provider [is/is not] in your network:

Provider name:

Provider address:

Provider phone number:

The information above is valid as of <date Member called>; however, the provider's network status can change at any time. Please check with your provider at the time you schedule a service to confirm they are in your network. If you receive service from an out-of-network provider, your costs may be higher. Please refer to your plan documents to confirm benefit coverage.

Visit <Portal url> to sign in or register your online account to locate providers in your network and verify benefit coverage. Have your member ID and email address ready if you need to register your account.

Please call the toll-free Customer Service number on the back of your member ID card.

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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? Update 2/16/22

If a provider's data cannot be verified within a reasonable time after the last verification date, the provider may 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? Update 2/16/22

No, the provider will only be suppressed from the directories in scope for the CAA, which are the Commercial Employer and Individual and Exchange directories.

Will the un-verified provider be terminated? New 3/22/21

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

What if a states directory requirement differs from the CAA directory requirement? New 3/22/21

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 5/10/21

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.

State Regulations for directories

What is the NY disclosure requirement on member provider status calls? New 1/6/23

NY state passed a NY Records retention regulation on 12/7/2022 which requires that an issuer must retain any recordings of telephone request for network status information and a copy of its written response to the insured in the insured's file for six years in accordance with section 243.2 (b)(8). Final Adoption of Sixty-Third Amendment to Insurance Regulation No. 62 (11 NYCRR 52)

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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.

What is a self-funded group requirement under CAA for reporting to states regarding the state's All Payer Claim Database (APCD)? New 4/7/22

CAA provision required the Department of Labor (DOL) to develop uniform standards that states could use for voluntary reporting by self-funded groups to state APCDs. As part of the process of developing standards there was an advisory committee that met and made recommendations to DOL. UnitedHealthcare provided comments but unsure if our recommendations will be included in the updated guidance on standards. The DOL has not yet announced updates to the standards.

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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.

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Gag Rule

What was the change in the FAQ 49 that came out on August 20? Update 6/16/23

Plans and issuers must annually submit to the Departments an attestation that the plan or issuer is complying with the gag clause prohibition. This is referred to as the Gag Clause Prohibition Compliance Attestation (GCPCA).

- The first attestation is due no later than December 31, 2023, covering the period beginning December 27, 2020 (the date the law was enacted) or the effective date of the applicable group health plan or health insurance coverage (if later) through the date of the attestation.
- Subsequent annual attestations, which cover the period since the last preceding attestation, are due on December 31, each year thereafter.
- Plans and issuers are subject to enforcement action and possible financial penalties from the Departments if they fail to meet the December 31 attestation deadline.

UnitedHealthcare has already handled removal of gag clauses.

What are the requirements for insurers and health plans under the Gag Rule? Update 4/20/23

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. The group that owns the relationships must review their agreements with the above and attest annually with CMS directly.

Is there an effective date for removal of Gag Clauses? Update 6/1/23

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The first attestation is due no later than December 31, 2023, covering the period beginning December 27, 2020 (the date the law was enacted) or the effective date of the applicable group health plan or health insurance coverage (if later) through the date of the attestation.

Subsequent annual attestations, which cover the period since the last preceding attestation, are due on December 31, each year thereafter.

What is the scope of the Gag Clause requirements? New 2/27/23

Scope of Plans Subject to the Requirements

The gag clause prohibitions and attestation requirements apply broadly to all health insurance issuers offering fully insured or self-funded coverage in the group and individual markets, including grandfather and grandmother (transitional relief) plans, student health plans, individual coverage offered through an association, ERISA plans, non-Federal governmental plans, and church plans subject to the Code. However, plans and issuers otherwise attesting do not need to attest about coverage that is solely an excepted benefit.

The following entities are not required to attest:

- Plans or issuers offering only excepted benefits
- Issuers offering only short-term, limited duration insurance (STLDI)
- Medicare, Medicaid, CHIP or Basic Health Program plans
- TRICARE
- the Indian Health Service program

The Departments will not take enforcement action against plans that consist solely of health reimbursement arrangements or other account-based group health plans.

How will UnitedHealthcare handle leased networks? New 4/20/23

Leased networks (e.g., Harvard Pilgrim), UnitedHealthcare will need to get the *confirmation of compliance* from the party leasing the network.

Will UHC attest for UHC and benefit administered by outside carriers? New 7/18/23

No. UHC neither attests nor provides a confirmation of compliance for benefits not administered by UnitedHealthcare

How are external customer arrangements handled? Update 6/16/2023

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Customers/plan sponsors with special arrangements such as CSP/GSP and carve outs (including OptumRx Direct) need to work directly with those third parties for attestation. For OptumRx Direct check with your Optum SAE.

Customers may check with their OptumRx Account Team representative.

Do any provider contracts that UnitedHealthcare is a party to contain a claim prohibiting disclosure of pricing terms ("gag clause") which will be prohibited under the No Surprises Act? Update 6/16/23

UnitedHealthcare provider contracts are in compliance. In 2022, UnitedHealthcare reviewed our provider contracts to determine if they meet the required regulation and revised them as necessary to meet the requirements under the law.

UnitedHealthcare has an annual review process to ensure compliance.

For our fully Insured business, UnitedHealthcare will provide attestation to HHS (Health and Human Services) portal by December 2023 and annually thereafter.

For self-funded and Level funded will provide a *confirmation of compliance* to our customers in Q3, which the self-funded customer may use to attest on the HHS portal.

Who is responsible for mixed funding cases? Update 4/20/23

UnitedHealthcare will submit the attestation for the fully insured business. The customer will need to make their own attestation for the self-funded group.

UMR and Surest will follow the UnitedHealthcare approach.

What statement will we provide for our self-funded customers regarding UnitedHealthcare's compliance with the gag clause? Update 6/15/203

UnitedHealthcare will provide the account teams with a ***confirmation of compliance*** during Q3 that the self-funded customer can use when they attest. The confirmation of compliance will also be sent out through the Broker Connect, Customer Connect and National Account Client Connection in early September.

UnitedHealthcare confirmation of compliance to self-funded group health plans will assist self-funded customers in making necessary attestations.

If the self-funded group has other networks or contractual arrangements with Third parties, they will need to gather information from them to complete the attestation.

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 5/10/21

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UnitedHealthcare and UMR still require nondisclosure agreements (NDA). The Consolidated Appropriations Act (CAA) impacts agreements we enter into 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.

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

Has UnitedHealthcare evaluated existing contracts? Updated 4/20/23

Yes, UnitedHealthcare has evaluated and ensures that our existing contracts don’t contain gag clauses. 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 a ***confirmation of compliance*** to self-funded group health plans to assist them in making necessary attestations.

Is there a penalty if the customer fails to attest? Update 5/16/23

Plans and issuers may be subject to enforcement if they fail to meet the Dec. 31 attestation deadline. UnitedHealthcare has no additional information about enforcement action.

Who is responsible for external customer arrangements? Update 6/16/2023

Customer/plans with special arrangements such as CSP/GSPs and carveouts including OptumRx Direct are responsible for submitting their own attestation.

If the self-funded group has other networks or TPA arrangements, they will need to gather information from them to complete their attestation.

For OptumRx Direct check with your Optum SAE.

Customers may also check with their OptumRx Account Team representative.

Does the Gag clause provision apply to pharmacy providers? Does it apply to OptumRx? New 5/16/21

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

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Is there an impact to the ancillary lines of business for the Gag clauses (dental, vision, hearing)? Update 5/16/23

For excepted benefits, the prohibition on gag clauses applies.

Excepted benefits are in not 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.

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 the pediatric dental/vision EHB (Essential Health Benefits) plans.

Resources

CMS Gag Clause Compliance

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Broker and Service Provider Compensation

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.

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? Update 10/27/21

It is the broker/ consultant's responsibility to report all direct and indirect compensation to the employer. UnitedHealthcare is creating a guide to instruct the broker / consultant where they may locate report any actual or contingent compensation that could be paid for placing business with UnitedHealthcare.

This UnitedHealthcare CAA Broker Compensation Guide provides instruction to help brokers and consultants or other service providers locate direct or indirect compensation information to input into the report they must provide to the plan sponsor before they sign their contract. UnitedHealthcare does not create the report itself.

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? Update 10/27/21

UnitedHealthcare will provide the broker with the UnitedHealthcare CAA Broker Compensation Guide that outlines where the broker/consultant may access compensation information they have with UnitedHealthcare.

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Group Health Plans

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

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

Brokerage and consulting services subject to the new rules include:

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

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

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.

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- If compensation is paid to service provider, the service provider's affiliate, or the service provider's subcontractor on a transaction basis (such as commissions or finder's fees), a description of any such arrangement and identification of the payers and recipients of such compensation (including the status of a payer or recipient as an affiliate or a subcontractor).
- A description of any compensation that the service provider (or an affiliate or subcontractor) expects to receive in connection with termination of the contract or arrangement, and how any prepaid amounts will be calculated and refunded upon such termination.
- A description of how any direct or indirect compensation will be received by the service provider (or an affiliate or subcontractor).

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

- Direct Compensation is compensation directly from a covered plan.

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

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

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

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

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

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

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

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

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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.

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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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Pharmacy Benefits and Costs Reporting

Important message. Update 2/21/24

The original date for the RxDC RFI tool to be open to collect data needed for submission to CMS was Feb. 1, 2024. Due to a technical issue and the release of CMS new CMS RxDC Reporting instructions, UHC moved the opening of the RFI to Feb. 21. The deadline to complete the RFI has been extended to April 10. We apologize for the inconvenience.

For UMR and Surest groups getting a survey rather than using the RFI tool, a new survey has been mailed beginning on Feb. 15 and 16. Please use this second mailing because of the CMS changes.

- ***Surest employers have until April 10 to complete the survey.***
- ***UMR employers must complete the survey by March 31.***

The new CMS instructions resulted in changes to the data needed for the employer/employee monthly calculation and certain integrated/carve out data. The RxDC worksheets have been updated.

Status of Rx Reporting Update

Update 3/7/24

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

1. UnitedHealthcare will update the collection of data to do the submission for clients based on the CMS Instructions released Feb. 2, 2024.
2. UnitedHealthcare submits Pharmacy Benefits & Costs Reporting data to CMS by the deadline June 1 deadline, each year for the prior reference year.
3. UnitedHealthcare submits the RxDC report to CMS for NA, KA, PS and Surest® ASO customers by June 1 each year. There are two options available for self-funded groups:
    - Standard approach (all ASO, Level Funded and fully insured): UnitedHealthcare will submit all data and appropriate narrative for plans administered by UnitedHealthcare and OptumRx carve in (integrated).
        i. Customers will be requested do complete an RFI on the employer/broker portal beginning Feb. 21. Deadline for completion is April 10.
        ii. Surest employers that receive a survey have a deadline of April 10 to complete the survey.
        iii. UMR customers will receive a survey beginning on Feb. 15 and 16, which must be completed by the March 31 deadline.

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iv. Customers that do not provide UHC information that is not in a UHC system by the deadline will need to submit that data themselves.

- Alternative approach (ASO only): the customer may request their data from UnitedHealthcare by March 31 and submit the data and appropriate narrative or engage a third party to submit the data for them.

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

4. UMR and certain Surest employers will do an email survey rather than RFI.

5. Fully insured: UnitedHealthcare is responsible for submission of required data for all fully insured groups. UnitedHealthcare will be collecting information not in our systems via a Request for Information (RFI). If that information is not provided by April 10, then the fully insured employer must submit the missing information to CMS by June 1.

6. Self-funded (ASO): Employers must provide the information requested by UHC in the RFI on the employer portal. Employers may use the Pharmacy Benefits and Costs Reporting Guide as a resource. The guide is posted uhc.com in the reform section under CAA Pharmacy Benefits and Costs Reporting.

7. UnitedHealthcare does not provide copies of RxDC reports submitted to CMS.

8. All data files submitted is in aggregate as defined by CMS.

9. UnitedHealthcare submits the appropriate narrative for each data file submitted.

10. Each data file submission requires a corresponding P2.

11. UnitedHealthcare produces the P2 using information from the 5500 filing and UHC systems.

    - UHC reconciles the Group Health Plan Name based on the Plan Sponsor name in the 5500; where feasible.
    - Group Health Plan Number requires a unique plan identification number.
    - UHC uses the EIN from our system as the unique plan identification number.
    - For companies that use multiple EINs, UHC will use the primary EIN as noted in our UHC systems.

12. UHC is unable to incorporate external data or make changes to data if there are discrepancies. If there are data mismatches, UHC will reconcile with CMS directly.

13. For ASO groups that chose to submit the data themselves, UnitedHealthcare provided the required data to customers by mid-May of the reporting year. In 2024, data will be provided by May 15 to 19 and communicated to those customers submitting their own data.

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Collecting data via RxDC RFI/survey to report June 1

What does the self-funded customer be required to submit if they do not complete or only partially complete the request for information in the RFI tool or survey? Update 11/30/23

If UnitedHealthcare did not receive an RFI/survey or if we received an incomplete survey, UHC will submit:

- the P2 and D1 with the information we have available,
- a complete D2 for coverage administered by UnitedHealthcare
- a complete D3-D8 for integrated pharmacy

The customer or delegate would be responsible for submitting data to CMS, not provided to us in the UHC survey

If the customer has requested that UHC not submit the D1 or any other combination of D1 through D8 files, an ad hoc is required by 3/31/24. UHC will not submit data for these customers.

For more information refer to the UnitedHealthcare approach to RxDC in the Pharmacy Benefits and Costs Guide.

CMS instructions for submitting data are on the CMS site.

What communications do customers get if they do not complete the RxDC request for information or survey? Update 11/28/23

UnitedHealthcare sends communications through the Connect electronic newsletter to employers, brokers and consultants regarding collection of data needed for UnitedHealthcare to submit data to CMS for the RxDC reporting requirement. It's important to be signed up for the Connect to get RxDC and other important regulatory information.

This communication explains to customers and brokers/consultants that any information not provided via the RFI in the employer/broker portal, would need to be submitted to CMS by them. We only submit data for coverage administered by UnitedHealthcare that we have in our system.

The customer accepts the risk for data elements not provided to UnitedHealthcare. In addition, the customer or another reporting entity will need to submit RxDC data and narrative to CMS by June 1, 2024.

CMS instructions for submitting data are on the CMS site.

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What confirmation may I provide to a customer that only partially completed the survey but some information is missing? Update 11/30/23

Inform the customer that UnitedHealthcare is scheduled to submit the data to CMS for the files and narrative for data we have in our system. UnitedHealthcare submits

- P2 and D1 information on file or what the customer provided in the RFI/survey.
- Corresponding files and narrative for D2 and D3 to D8 for carve in pharmacy.

For any data that was not provided to us via the RFI/survey, including if the customer left the D1 RFI/ survey information blank or entered a zero, they will need to submit that data to CMS by the June 1 deadline.

UnitedHealthcare is aware that CMS may publish changes to the documented RxDC instructions. If this occurs, UnitedHealthcare, UMR and Surest will evaluate any new instructions and communicate any change to the strategy.

For more information refer to the UnitedHealthcare approach to RxDC in the Pharmacy Benefits and Costs Guide.

CMS instructions for submitting data are on the CMS site.

What is UnitedHealthcare's approach to supporting RxDC reporting for June 1? Update 11/30/23

Under the Consolidated Appropriations Act (CAA), health insurers offering group or individual health coverage and self-funded (ASO) group health plans are required to report data annually regarding prescription drugs and health care spending to the Departments of Health and Human Services, Labor, and Treasury (Tri-Agencies). This information must be submitted to CMS by June 1, 2024, for 2023 data, through a web portal set up by the Centers for Medicare & Medicaid Services (CMS).

The UnitedHealthcare approach for customers:

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

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

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

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What is UnitedHealthcare standard approach? Update 2/1/24

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

For customers with OptumRx integrated PBM, UnitedHealthcare will also submit the D3-D8* files.

For customers that use any other PBM, including OptumRx Direct, the customer will need to work with that PBM to submit the D3-D8 files.

There is no fee for customers that use the standard approach.

Annually, UnitedHealthcare will collect data from each customer to complete the RxDC. To obtain the data, UnitedHealthcare requests all customers to complete an RFI /survey to collect the necessary data elements by the March/April deadline.

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

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

What is expected for customers wanting to use the Alternative approach (ASO customers only)? Update 11/30/23

ASO customers that plan to submit all data must contact their UnitedHealthcare representative prior to March 31 to request their data. A fee may apply.

It is important for the customer selecting this approach that they submit all the data. UnitedHealthcare will provide them with the data we have in our system, but they will need to do the entire reporting themselves for the data the employer requested.

UnitedHealthcare does not include the data for customers reporting their own data in the submission we submit.

Note: If you request all the data files, you do not need to complete the RFI. However, for partial data requests, the employer will need to complete the RFI (or survey for UMR or certain Surest employers) since UnitedHealthcare will be submitting data for the employer as well.

Will there be an option to have employers opt out of UHC reporting certain data, such as the D1, on their behalf? Update 3/7/24

Yes. Customers must contact their UnitedHealthcare representative **NO LATER THAN MARCH 31**, 2024.

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Can fully insured and Level Funded used the alternate approach to submit data themselves? Updated 11/30/23

Fully insured groups cannot submit the data themselves. UnitedHealthcare will submit on behalf of these customers. However, UnitedHealthcare is request certain data be submitted via the RFI/survey from fully insured and Level Funded customers to support the submission.

If the customer has an EIN that is changing, what should they do? New 11/27/23

UnitedHealthcare submits the data to CMS using the EIN in our system. If the customer has changed the EIN for any reason, they should contact their UnitedHealthcare representative, and the EIN can be updated through the normal process. The system will be updated, but not for the 2024 submission.

Rx Reporting Overview of Regulation

Does UnitedHealthcare sign a contractual agreement regarding UnitedHealthcare's support for submitting the CAA Pharmacy Benefits and Costs data? Update 11/30/23

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

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

Refer to the CMS instructions, Section 11.9, Compliance with Laws and Regulations.

Where can customers find more information about Pharmacy Benefits and Costs reporting also referred to as RxDC? New 10/4/22

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

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

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

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

When did the CAA reporting for pharmacy benefits and costs begin? Update 11/30/23

The first report was required by Dec. 27, 2022, and then by June 1 each year thereafter.

What is the deadline for submitting the report? Update 11/30/23

The deadline is every June 1, subsequent to the reference year. The reference year is the calendar year immediately preceding the calendar year in which the RxDC report is due. The RxDC report for the 2023 reference year, which is due in 2024, should contain information based on what happened in calendar year 2023.

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

Does the Pharmacy Benefits and Costs Reporting have a Safe Harbor? Update 11/30/23

The Safe Harbor is no longer in effect.

How is the reporting organized? Is there a required standard of reporting? Update 11/30/23

Data is reported by reference year.

- The data that will be reported June 1, 2024, will be for the 2023 reference year.

This information must be aggregated at the state/market level, rather than separately for each plan.

- The guidance provides uniform standards and data definitions, including standards for identifying prescription drugs regardless of the dosage strength, package size, or mode of delivery.
- These uniform standards for submitting data are designed to allow the Tri-agencies and OPM to conduct meaningful data analysis and identify prescription drug trends.

What are the reporting benefits and cost requirements? Update 11/30/23

Section 204 of Division BB, Title II (Section 204) of the Consolidated Appropriations Act, 2021 requires group health plans (plans) and health insurance issuers (issuers) offering group or individual health insurance coverage to submit information about prescription drugs and health care spending

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to the Department of Health and Human Services (HHS), the Department of Labor (DOL), and the Department of the Treasury (the Tri-Agencies/Departments).

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

CMS instructions for submitting data are on the CMS site.

Where must the insurer or health plan submit the pharmacy coverage and cost report? Update 11/28/23

The Centers for Medicare & Medicaid Services (CMS) within HHS is collecting Section 204 data submissions on behalf of the Departments of Health and Human Services, Labor, the Treasury (the Departments) and the Director of the Office of Personnel Management (OPM).

Self-funded customers wishing to do their own submission should speak with their UnitedHealthcare account team.

What do the reports require for reporting of medical services costs and spend? Update 11/30/23

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. For more details around Hospital and Medical spend (excluding spend under a PBM) go to CMS instructions, Section 7.
- **Spending by prescription drugs** by health plan coverage and member. For more details around spend under a PBM go to CMS Instructions, Section 8.4.

CMS instructions for submitting data are on the CMS site.

What is considered "wellness" under the Rx Reporting requirement? Update 7/20/22

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

- If a wellness service is billed on a claim, include it in the "Other medical costs and services" spending category in data file D2 Spending by Category.
- If a wellness service is not billed on a claim or is not a covered service under a plan or policy, do not include it anywhere in the RxDC report.

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Go to CMS instructions, Section 7.2.

How do the reports require insurers and health plans to report premium costs? Update 11/30/23

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

1. **Average monthly premium:**
    - Paid by employers on behalf of members/enrollees; and
    - Paid by members/enrollees.
2. **Premiums impacted by rebates, fees, and any remuneration** paid by a drug manufacturer to the plan or coverage or administrators or service providers, including:
    - Amounts paid for each therapeutic class of drug, and
    - Amounts paid for each of the 25 drugs that yielded the highest amount of rebates and other remuneration.
3. **Any reduction in premiums and OOP costs** associated with rebates, fees, or other remuneration.

Refer to CMS instructions, Section 6.1, for definitions of “Average monthly premium”, Earned Premium”, and “Premium equivalents”.

What should be included in the average monthly premium paid (AMPP) calculation? New 12/1/23

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

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

What should NOT BE INCLUDED in the average monthly premium paid (AMPP) calculation? New 11/27/23

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

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

What should be included as part of the 2023 reference year for the June 1, 2024 submission? **New 11/30/23**

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

- **Example 1:** employer policy with UnitedHealthcare from 7/1/2022 to 6/30/2023 and Other Medical Carrier from 7/1/2023 to 6/30/2024.
    - Only report the AMPP associated with UHC in the reference year 2023: 1/1/2023 to 6/30/2023.
    - Note: 7/1/2022 to 12/31/2022 as is 1/1/2024 to 6/30/24 is excluded for the 2024 report.
- **Example 2:** employer policy with UnitedHealthcare from 7/1/2022 to 6/30/2023 and renewed with UHC 7/1/2023 to 6/30/2024.
    - Report the AMPP associated with UHC in the reference year 2023: 1/1/2023 to 12/31/2023.

What is being reported regarding prescription drug rebates, fees and other remuneration paid by drug manufacturer? **Update 11/28/23**

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

Reporting includes the following in the total fee:

- Renumeration received by and on behalf of entities providing pharmacy benefit management services regardless of the source (e.g., pharmaceutical manufacturer, wholesaler, retail pharmacy or vendor).
- Discounts, chargebacks or rebates.
- Cash discounts, free goods contingent on purchase agreement.
- Up-front payments, coupons, goods in kind.

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

Refer to CMS instructions, Section 9.

What is a reference year? Update 11/30/23

The reference year is the calendar year of the data that is in the Pharmacy Benefits and Costs report. For example, the Pharmacy Benefits and Costs report for 2023 reference year means the information in the report is based on what happened in 2023. This report will be submitted to CMS by June 1, 2024.

Refer to CMS instructions, Section 1.2.

How are the reports submitted for non-calendar year plans? Update 12/1/23

Both calendar plans (Jan. 1 to Dec. 31) and non-calendar plans are required to submit a full year of data related for the reference year.

For calendar years the reports would be Jan 1 through Dec. 31 of the year reported.

However, for non-calendar year plans the reports would be populated with the applicable dates. Therefore, partial years would appear in separate rows per the CMS instructions.

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

Does cost sharing assistance a drug manufacturer provides to a member have to be included in the reporting? New 3/15/22

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

What is total annual spending based on? Update 11/30/23

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

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

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

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

If a business is acquired during the year by another business, who is responsible for the reporting? New 3/15/22

The acquiring entity.

How does data have to be organized for reporting? New 3/15/22

Data is submitted separately by market -

- Insured individual, small group, large group.
- Self-funded small group, large group
- Student health insurance
- Federal Employees Health Benefits

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

The insurer or group health plan reports separately for each state in which the insurer or plan does business. The report includes all plans and policies in the state during the reference year.

- Insured group business is reported for the state where the contract is issued (except for association coverage).
- Self-funded group business is reported for the state where the plan sponsor has its principal place of business.
- Individual insurance market business sold through an association is reported for the state of the certificate of coverage.
- Health coverage provided through a group trust or MEWA is reported for the state where the employer or association has its principal place of business or the state where the association

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is incorporated (for associations with no principal place of business).

Can different entities report data for a group health plan? Update 11/27/23

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

What count of members (enrollees, beneficiaries) is required? Update 11/28/23

The number of plan participants covered on 12/31 of the reference year.

What is the reporting requirement that is changing for member monthly premium or employer monthly premium? Update 3/7/24

While earlier guidance required the data at the member level, the updated CMS guidance in Q1 simplified the calculation.

Member monthly premium paid

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

Employer monthly premium paid

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

What does the member premium include? Update 3/7/24

Include:

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

Exclude:

- Premium or premium equivalents paid by employers or other plan sponsors on behalf of members. These amounts should be included in the next question totals.

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- If none of the members pay a premium, enter zero ($0).

What does the employer premium include? Update 3/7/24

Include:

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

Exclude:

- Premium or premium equivalents paid by members.

Does the aggregation state equal the situs state or states where the plan is offered? Update11/30/23

For self-funded plans, the aggregation state is the state where the plan has its principal place of business. For fully insured plans, the aggregation state is the state where the policy was issued.

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

What if a member's plan is situsedin one state but services are rendered in another (snowbirds, students), would they report both states? Update 11/30/23

For self-funded plans, the aggregation state is the state where the plan has its principal place of business. For fully insured plans, the aggregation state is the state where the policy was issued.

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

Would a mailed or 90-day script be considered one script or three scripts? New 6/4/21

A 90-day script would be one script.

How should employers calculate the total monthly premium paid by members and paid by employers? New 2/21/24

An example is shown below. If the employer was only with UHC for part of a year, the amounts paid by members and employers would only show for those months and a zero for other months. However, the amount would still be divided by 12 based on the 2024 CMS instructions.

Average Month Calculation -- Example: Full Calendar Year

Total Premium (or premium equivalents)

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Month	Paid by Members	Paid by Employers[1] (on behalf of members)	Paid by Plan (Total)
January	$ 5,675	$ 13,243	**$ 18,918**
February	$ 6,426	$ 14,994	**$ 21,420**
March	$ 6,426	$ 14,994	**$ 21,420**
April	$ 6,784	$ 15,829	**$ 22,614**
May	$ 6,784	$ 15,829	**$ 22,614**
June	$ 6,784	$ 15,829	**$ 22,614**
July	$ 7,497	$ 17,494	**$ 24,991**
August	$ 7,497	$ 17,494	**$ 24,991**
September	$ 7,497	$ 17,494	**$ 24,991**
October	$ 6,932	$ 16,174	**$ 23,106**
November	$ 6,932	$ 16,174	**$ 23,106**
December	$ 6,932	$ 16,174	**$ 23,106**
Total	**$ 82,167**	**$ 191,724**	**$ 273,892**
	Total A	***Total B***	
Average Monthly Premium Paid:	**$ 6,847.29**	**$ 15,977.00**	**$ 22,824.29**

In this example:

- Employer has a medical policy with UHC for full calendar year.
- Coverage period - 1/1/23 – 12/31/23.
- Calendar period – 1/1/23 – 12/31/23
- Employer paid portion is 70% of the total plan premium (or premium equivalents) paid.
- Divide by 12 even if the coverage was not in effect for the entire 12 months of the reference year.

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

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

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

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

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

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- Based on Reference Year 2023 instructions
- For RFIs containing multiple policies **all** policies should be included in the calculation.

Scope of the RxDC Reporting

To whom does the reporting of pharmacy benefits and costs apply? New 3/15/22

The reporting requirement applies to:

- Health insurance issuers offering group coverage
- Health insurance issuers offering individual market coverage, including:
  - Exchanges
  - Student health plans
  - Plans sold exclusively outside of the Exchanges
  - Individual coverage issued through an association
- Fully insured and self-funded group health plans, including:
  - Employer and union sponsored group plans
  - Non-federal governmental plans, such as plans sponsored by state and local government
  - Church plans that are subject to the Internal Revenue Code
  - FEHB plans

The reporting requirement does NOT apply to account-based plans, such as health reimbursement arrangements, excepted benefits including but not limited to short-term limited-duration plans, hospital or other fixed indemnity insurance, disease-specific insurance, or non-commercial plans such as Medicare Advantage and Prescription Drug plans, Medicaid managed care plans, state children's health insurance program plans and Basic Health Program plans.

What is a retiree only plan? Update 11/1/22

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

Does the Pharmacy Benefits and Costs reporting apply to retiree only plans? Update 11/4/22

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Retiree plans are in scope if they have more than more than one active employee. Most retiree only plans do not have any active employees and are out of scope. However, UnitedHealthcare will include all customer data in the policy (including retiree) in the Pharmacy Benefits and Costs data submission.

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

Does pharmacy benefits and costs include COBRA membership-count? Update 12/1/23

We do not include COBRA in the counts.

Are Health Saving Accounts and HRA are out of scope? New 11/15/22

Information on payments from a health savings account and health reimbursement account would be out of scope for the RxDC report.

Is EAP (Employee Assistance Program) in or out of scope for RxDC reporting? Update 11/30/23

EAP is out of scope for the RxDC report.

Does cost sharing assistance a drug manufacturer provides to a member have to be included in the reporting? New 3/15/22

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

Does number of enrollees include all members/enrollees even if they were not enrolled entire plan year? Update 3/15/22

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

Are customer networks included in the data submitted? New 11/15/22

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

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UnitedHealthcare Approach to Rx Reporting

What is UnitedHealthcare's approach to supporting RxDC reporting in 2024? Update 2/14/24

After the first two RxDC submissions in December of 2022 and June of 2023, employers asked for an easier process to submit required information to UnitedHealthcare. To respond to this feedback, we have worked to simplify the data collection process through the RFI which will be housed in the Employer portal.

UnitedHealthcare plans to submit the RxDC data for all fully insured, ASO and level funded employers administered by UnitedHealthcare (or its affiliates), UMR and Surest.

The 2024 submission is due June 1, 2024, and includes any employer that was active with UnitedHealthcare during the 2023 reference year. Therefore, for employers using the RFI or Surest employers who receive a survey, information must be submitted to UnitedHealthcare anytime on or before April 10, 2024. For UMR customers, the survey will need to be completed by March 31.

What's new for employers using UHC to submit the RxDC data this year? Update 2/14/24

Employers or brokers who completed a survey for UnitedHealthcare for the June 2023 RxDC submission, will notice a few changes. As mentioned, UnitedHealthcare does not store some of the required CMS data in the UnitedHealthcare system, so this information is necessary to confirm that missing data from the employer.

To that end

1. UnitedHealthcare designed a new RFI tool to simplify and streamline gathering required information to complete the submission of data to CMS.
2. UnitedHealthcare has made the RFI tool available within the employer/broker portal
3. Because the tool is built into the employer and broker portals either the employer or the broker can complete the RFI.
4. in direct response to feedback we have received, the RFI tool allows information to be partially completed and saved. The RFI can be reopened to add or change information any time prior to when the RFI tool closes on April 10, 2024.
5. the employer or broker can check on their status real time and they may download and print the responses submitted via the RFI tool.

As a reminder, for the 2024 submission, all UMR and a small number of Surest customers may use a survey rather than the RFI tool.

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What do RxDC reports require for reporting of pharmacy costs? Update 11/30/23

Plans and issuers in the group and individual markets are required to submit certain information on prescription drug and other health care spending to the departments annually, including:

- General information identifying the insurer or plan
- Enrollment and premium information, including average monthly premiums paid by employees and the employer
- Total health care spending, broken down by type of cost (hospital care; primary care; specialty care; prescription drugs; and other medical costs, including wellness services) by members/enrollees and employer or issuer
- Prescription drug spending by members/enrollees versus employers and issuer
- The 50 most frequently dispensed brand prescription drugs
- The 50 costliest prescription drugs by total annual spending
- The 50 prescription drugs with the greatest increase in plan or coverage expenditures from the previous year
- Prescription drug rebates, fees, and other remuneration paid by drug manufacturers to the plan or issuer in each therapeutic class of drugs, as well as for each of the 25 drugs that yielded the highest amount of rebates
- The impact of prescription drug rebates, fees, and other remuneration paid by prescription drug manufacturers on premiums and out-of-pocket costs.

How does the report get submitted and who submits the report? Update 11/30/23

The report must be submitted to The Centers for Medicare & Medicaid Services (CMS) on behalf of the Departments of Health and Human Services, Labor, the Treasury (the Tri-Agencies or Departments) and the Director of the Office of Personnel Management (OPM).

UnitedHealthcare's standard approach is to submit the data for UnitedHealthcare fully insured, level funded and self-funded employers including UMR, Surest, FEHBP and Railroad.

Carve out business must be reported by the PBM or carrier that has the business.

Refer to the **UHC Approach to CAA Pharmacy Benefits and Costs Reporting Guide** for more detail.

To support this initiative, UnitedHealthcare will be collecting data that is not in our system from each customer annually to complete the RxDC reporting. Data will be collected through an RFI tool on the

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employer/broker portal. For 2024, Surest employers that are not integrated in a UnitedHealthcare system and UMR will use a survey in place of the RFI.

Even customers that submitted data in the prior year will be required to provide the information because information may change.

Self-funded customers wishing to do their own submission should speak with their UnitedHealthcare account team.

What are ASO UnitedHealthcare legal entities EINs? Update 11/28/23

Legal Entity	EIN
UMR, Inc.	39-1995276
United HealthCare Services, Inc.	41-1289245
OptumRx, Inc.	33-0441200
HealthSCOPE Benefits, Inc	71-0847266

How will UnitedHealthcare handle how the premium splits between the employer and employee are reported, since that information is not in UnitedHealthcare's system? Update 11/30/23

This is based on the RFI/survey data received from the employer.

Employers who do not complete and attest to an RFI/survey will be required to submit the data requested in the RFI directly to CMS.

In what format will UnitedHealthcare provide the data to CMS? Update 12/1/23

Excel.

If a customer provided data to us to do the complete submission for the prior reference years, do they need to provide information again this year? Update 11/27/23

Yes. Data may change from year to year so we will collect it each year.

How will UnitedHealthcare request the data they do not have in their system? Update 2/21/24

UnitedHealthcare changed the approach for employers or brokers/consultants to submit information that will support UHC submission of pharmacy benefits and costs reporting data by the June 1, 2024, deadline.

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- To do this, UHC will request employers to complete a Request for Information (RFI)/Survey by April 10, 2024, deadline. The RFI /survey will be available on Feb. 21, 2024.
- The RFI tool is embedded in the employer portal and can be accessed after the employer or their delegate signs in with their secure passcode.
- For 2024, UMR and certain Surest employers not yet integrated into the UnitedHealthcare USP platform, will be requested to submit a survey. The survey will go out by Feb. 2 and the deadline for completion is March 31.

In order to complete the RFI, employers or their delegates will need access to the employer portal.

Customers, brokers and consultants will need access to our Connect newsletters to stay informed of the process.

For customers with direct or carve out OptumRx, will UnitedHealthcare or Optum submit the report? Update 12/1/23

Work with the OptumRx account team to determine who will be submitting the pharmacy data to CMS.

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? Update 2/14/24

Yes. The standard approach is for UnitedHealthcare to submit the data for customer business with UnitedHealthcare only, including integrated pharmacy. UnitedHealthcare will collect the data through an RFI tool on the employer/broker portal.

Note: For 2024 UMR and certain Surest employers that have not migrated to a UnitedHealthcare system will receive a survey to complete. The survey will go out beginning on Feb. 15 and 16 and be required to be completed by the March deadline identified on the survey.

Optum Direct (carve out) or other PBMs must do their own submission or provide the customers with the data so the customer submits it.

Where does UnitedHealthcare access the group health plan name that goes in the P2 date? Update 5/28/23

UnitedHealthcare asks for this information in the RFI or survey.

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If a customer wishes to streamline the P2 health plan number to accommodate their vendors, can UnitedHealthcare accept a custom group health plan number from the customer and use in in our P2 submission rather than use the EIN? Update 11/28/23

No. UnitedHealthcare is unable to accept any customization of data. If there is any discrepancy, UnitedHealthcare will work with CMS to clarify on behalf of our customers.

UnitedHealthcare anticipates clarification from CMS with each subsequent submission of future data submissions and will revisit and refine our approach as needed.

What should a customer do if they have questions on how to calculate D1? Update 5/22/23

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

Is the plan or insurance company responsible for reporting? Update 11/30/23

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. UnitedHealthcare will support self-funded plans and include the aggregated data when UnitedHealthcare submits the reports.

When there is data that is not captured by UnitedHealthcare, the fully insured and self-funded employers will have to submit that data on their own.

Self-funded employers may choose to do the reporting themselves and should discuss this with their UnitedHealthcare representative. We anticipate a limited number of customers may choose to do this.

If a customer has carve-out pharmacy even with OptumRx should the ASO customer speak with that vendor? New 8/11/22

Yes.

How does UnitedHealthcare plan to collect data? Update 2/21/24

Most employers will be required to complete several questions in an RFI tool on the customer/broker portal. Customers who do not complete and attest to an RFI will be required to submit the data requested in the RFI directly to CMS.

- UnitedHealthcare collects the data using a request for information (RFI) tool in the employer/broker portal.
- The RFI tool is open on Feb. 21, 2024, and must be updated by April 10, 2024.

A survey will be used to collect the necessary data for Surest employers (who have not integrated into UHC system) and for UMR.

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- The survey will be sent to the employers the week of February 16, 2024, and it must be updated by March 31, 2024.

When UnitedHealthcare submits D2 is the D2 file aggregated? Update 11/28/23

Yes.

Did UnitedHealthcare's contract language change? Update 12/1/23

- OptumRx Direct (carve out) issued a contract amendment.
- UnitedHealthcare ASA agreements have been adapted to cover the CAA provisions.
- Fully insured has no plans to make changes to COCs at this time, there is existing language in the COC that covers regulations.

What are the CMS reporting instructions for how data must be reporting? Update 5/18/23

CMS Reporting Instructions are online for our customers to use if they are doing reporting.

UnitedHealthcare is following these instructions for when we are doing reporting or shared reporting with our customers.

How does UnitedHealthcare define plan-year? Update 11/28/23

The plan year is the date the plan started, and the plan ended. For example, 1/1 through 12/31 or 7/1 through 6/30.

Is cancelled/terminated customer's data included in the reports? Update 11/28/23

The report will include data from the time the customer was active with UnitedHealthcare with in the reference year.

Resources for Reporting

- Pharmacy benefits and costs ASO guide
- CMS Reporting Instructions for 2024 (2023 reference year)
- CMS Training Resource Library
- CMS RxDC FAQS
- CMS RxDC Home page

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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.
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.

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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
    - Maximum out of pocket
    - Excludes lifetime and annual dollar limits

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Examples of Quantitative Treatment limits include:

- Visit limits
- Day limits
- Treatment and Episode limits

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

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

    - Medical management standards limiting or excluding benefits based ON medical necessity/appropriateness e.g. prior auth, concurrent review, retrospective review
    - Experimental/investigational exclusions
    - Formulary design
    - Standards for admission to participate in a network, including reimbursement rates
    - Step therapy requirements
    - Methods for determining UCR or R&C charges

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

Who is responsible for MHPAEA compliance? New 3/22

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

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

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

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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.

- 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

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demonstrate parity. The intent of this document is to provide self-funded customers a suggested framework to respond to regulator inquires if received.

- Any non-standard or custom plan deviations by self-funded customers are not considered in the MHP NQTL Standards Documentation. Plan specific information is included in the Administrative Service Agreement or Summary Plan Description.

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

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

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

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

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

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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

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the specific service to evaluate whether the service is considered Experimental or Investigational or Unproven. The plan SPD or COC defines “Experimental or Investigational Service(s)” and “Unproven Service(s)”. The definitions apply equally to both M/S and MH/SUD benefits.

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

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

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

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

Although UnitedHealthcare does not consider the fraud, waste, and abuse program to be an NQTL, since the program does not limit the scope or duration of treatment, UnitedHealthcare’s standard program for fraud, waste and abuse applies to both M/S and MH/SUD plans as outlined below.

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

Payment Analytics

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

Reimbursement Policies

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

Fraud, Waste and Abuse Investigations

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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

Content coming

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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 8/2/23

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 allowed 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 allowed 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 permitted 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 permitted 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. The plan year must have had a regular enrollment period that was on or before January 31, 2020; 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).
- **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 needed to be made by December 31, 2021.

How did UHC administer the options available? Update 8/2/23

- Amounts that were unused in 2020 may be carried over to 2021 and amounts that are unused in 2021 may be carried over into 2022: UHC allowed all unused amounts remaining in the 2020 (or 2021) plan year for carryover, regardless of how it was applied. Unused amounts from any plan year prior to 2020 were not be included. Any other request will require internal BAR review

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- Health and dependent care FSA grace periods for plan years ending in 2020 and/or 2021 could have been extended until 12 months after the end of the plan year: UHC extended the Grace Period for the customer.
- Plan participants who ceased participation in the plan during 2020 and/or 2021 (terminated participants) could 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 were permitted to make prospective changes to their health and/or dependent care FSAs during 2021 (without regard to change in status): Those choices were managed through the standard eligibility process.

Were plan documents required to be updated to allow for these changes? Update 8/2/23

Yes. Amendments need to be adopted by the last day of the year after the plan year in which the amendment is effective.

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

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

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

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

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

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

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

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

This is a mandatory change for fully insured and self-funded ERISA plans that will allow members to continue to submit expenses incurred in 2019 or 2020 through the end of the Outbreak Period. This applies to HRA/HIA and health FSA's. This applies to all plans with runout in effect on or after March 1, 2020. If the end of the pandemic is declared **by the president**, the

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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.

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