CAA and Transparency Rule

Provision Highlights Guide

This information is intended to provide general information on CAA and Transparency In Coverage rule and does not constitute medical, legal or tax advice nor does it constitute a binding obligation of UnitedHealthcare with respect to any matter discussed herein. Please note, in addition to federal law, states may have additional or differing requirements. Please contact your UnitedHealthcare account representative for additional details.

October 15, 2021

Consolidated Appropriations Act including the No Surprises Act Highlights

No Surprises Billing and Independent Dispute Resolution

- The Consolidated Appropriations Act (CAA) is a comprehensive set of regulations that included No Surprises Act (NSA) and CAA transparency provisions. The section on surprise billing legislation provided changes to one of the biggest issues consumers have – surprise medical bills from out-of-network (OON) providers.
- The surprise billing legislation establishes federal standards to protect patients from balance billing for defined items and services provided by specified doctors, hospitals and air ambulance carriers on an OON basis. The federal law applies to individual, small group, level funded and large group fully insured markets and self-insured (ASO) group plans, including grandfathered plans.
- The legislation sets patient cost-sharing at in-network levels and requires providers to work with insurers and self-funded health plans to negotiate remaining bills. When insurers/health plans and providers are unable to reach an agreement, an Independent Dispute Resolution (IDR) process, sometimes called arbitration, is established to determine the final reimbursement amount.
- The IDR entity will choose either the insurer/health plan or provider offered amount, commonly referred to as baseball arbitration. In making this decision, the IDR entity must consider the Qualifying Payment Amount (QPA), which is the par median rate under federal regulations, and may consider other factors such as the provider's market share, the provider's training and experience, and the severity of the patient's condition.
- The law does not apply if the member chooses to receive services from an OON provider.
- Beginning with plan and policy years on and after January 1, 2022, the No Surprises Act applies to three types of services provided by health care providers and facilities:
    1. OON emergency covered items and services
    2. Certain covered medical items and services performed by an OON provider at an in-network facility
    3. OON air ambulance items and services

On September 10, 2021, a proposed rule outlined reporting requirements for health plans for air ambulance claims. Reporting will be required by March 31, 2023 (for 2022) and March 30, 2024 (for 2023).

On July 13, 2021 and October 7, 2021, Interim Final Rules were released that provided additional detail on the NSA requirements including prohibitions on balance billing and the IDR process. Batching of claims for arbitration of same or similar items or services are allowed. Health plans may submit separate QPAs for each type of item or service when similar items and services are batched. The IFR, allows the arbitrator to choose different payment awards for each type.

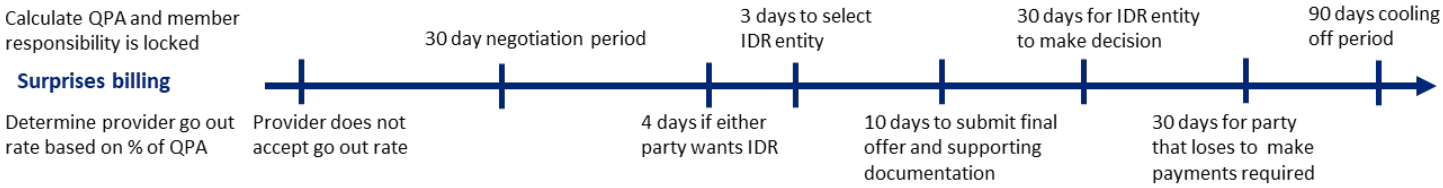
Providers and balance billing

The NSA is intended to limit what members will pay for OON services and protect them from balance billing. UMR will work with health plans interested in modifying their benefit plans since employees will no longer be impacted by balance bills for the situations covered under the No Surprises Act.

Under the new regulations, a provider may, in advance, secure the patient's consent to be balance billed. However, the provider would need to disclose information regarding the fact that they are out-of-network and the member would have to agree in writing. This variation to the rule would not apply in an emergency situation or for certain ancillary providers outlined in the provision.

Independent Dispute Resolution (IDR)

The NSA establishes an independent dispute resolution (IDR) process when the payer and provider disagree about payment for OON services covered e.g., OON emergency services, OON items and services at a network facility and OON air ambulance services. The process* includes:



- After a claim/payment denial, there is a 30-day open negotiation period for insurers, health plans or providers to resolve disputes over reimbursement for OON covered items/services.
- If an agreement cannot be reached during the negotiation period, either the insurer/health plan or the provider may initiate the IDR process during the 4-day period after negotiations end.
- The insurer/health plan and provider may jointly agree on a certified IDR entity. If they cannot agree within 3 days following initiation of the IDR process, the Tri-Agencies will select the certified IDR entity.
- Within 10 days of the certified IDR entity's selection, the insurer/health plan and provider will each submit an offer to the certified IDR entity for consideration.
- The certified IDR entity has 30 days from the date of selection to make a decision and to notify both the insurer/health plan and provider of the decision.
- An administration fee of $50 from both parties is required when the decision is made to go to IDR. A separate IDR entity fee is paid by each party when the final offer is submitted to the IDR entity. The party whose offer is chosen by the IDR entity will have their arbiter fee returned. Additional payments are due within 30 days after final decision.
- UMR is committed to providing value added services to our self-funded customers, including the services that relate to the new legal requirements imposed on health plans by the Consolidated Appropriations and the No Surprises Acts. UMR will provide end-to-end process for negotiating surprise medical bills with providers and administering the IDR process for health plans consistent with the No Surprises Act (NSA). These services include:
  - Intake of dispute and determination if dispute is eligible for IDR based on applicable law.
  - Engage provider in formal negotiation process. Monitor and administer the negotiation process in accordance with required timelines.
  - If negotiations fail and provider invokes formal arbitration in required time frame, then UMR:
    - Prepares and submits IDR the final offer and any additional information to the IDR entity.
    - Engages as needed to defend QPA/par median methodology and 'go out rate'.
    - Monitors and administers required timelines and compliance with IDR rules/guidelines.
    - If provider offer is accepted by IDR entity, handles payment of arbitration fee, and claim payment adjustment through customer's claim funding account.

Disclosure requirements for members

- Insurers and self-funded plans must publicly post notices related to surprise billing for OON items/services and include such notices on websites and member Explanation of Benefit (EOB) documents. UMR is prepared to provide disclosures as required under the No Surprises Act and will post a notice on umr.com. Customers may link to the posted notice if they wish.
- The Department of Labor (DOL) provided a model notice. The notice must include the following:
  - 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.

* In the IDR process timeline days are business days except for initial claim payment/denial while others are calendar days.

Self-funded health plan support and fees

UMR will support the following requirements of the CAA by the respective enforcement dates.

- Facilitate new continuity of care requirements for members during the term of the Agreement,
- Provide a price comparison tool
- Support new data requirements for ID cards,
- Maintain provider directories pursuant to updated requirements,
- Maintain network agreements compliant with the CAA prohibitions on gag clauses and provide language to support attestation requirement, and
- Provide reports on air ambulance claims and prescription drug benefits and health care costs.

In addition, as indicated in the earlier sections, the No Surprise Act under CAA requires plans to implement a process to administer IDR for plan years beginning on or after January 1, 2022.

This process requires plans to negotiate disputed claims and participate in an arbitration process for any claims that are challenged by out-of-network providers. UMR will administer the entire IDR process for self-funded health plans for a fee. Fixed and variable options may be available.

Fees to support CAA and No Surprises Act and IDR

- Administrative Services Agreements beginning with effective dates of January 1, 2022 will include the CAA fees.
- As always the health plan should discuss compliance requirements with their legal counsel.
- Any self-funded health plan that does not wish UMR to provide IDR services must let UMR know where we can direct IDR disputes related to their plan. A IDR fee and connectivity fee will be assessed for data and other support required.

Negotiation and Independent Dispute Resolution is complex, requires extensive data, and can be administratively burdensome.

UMR commits to do the following for our self-funded customers:

- Perform required reporting back to applicable agency.
- Work with the health plan's OON program.
- When IDR is initiated, support the customer by knowing the new laws and regulations and:
    - Assess provider billing behavior and provider negotiation history.
    - Determine optimal offer based on analysis and reporting on factors that may influence final decision.
- Analyze published decisions and refine strategy if needed.

Additional Consolidated Appropriations provisions – No Surprises Act (NSA)

UMR has made a significant investment in technology and resources to support our customers in complying with the additional NSA requirements under the CAA as follows:

INFORMATION ENHANCEMENTS FOR INSURANCE CARDS

Under the CAA, online and printed ID cards must consider federal, state and corporate standards and include:

- In-network and out-of-network deductibles applicable to the plan coverage.
- In-network and out-of-network out-of-pocket maximum limitations applicable to the plan coverage.
- Telephone numbers and the website address where members may obtain support and network facility and provider information.

UMR 2022 approach

UMR will have NSA compliant ID Cards with the new information available digitally by the plan effective date on or after January 1, 2022. There is no cost to customers for producing new electronic cards or standard card distribution as outlined in the service agreement (ASA). ID Cards will follow standard card distribution rules unless otherwise instructed by the customer. Health plans requesting a full issue of all ID Cards may have a fee assessed if there are no other plan changes on the ID Card.

- Members who call and request an ID Card will have one mailed to them.
- Most custom ID Cards can be accommodated, but some information may need to be adjusted. The account representative will reach out during Q4 2021 if any customization requests need to be adjusted.

CONTINUITY OF CARE

By plan renewal date on or after January 1, 2022, certain patients have an opportunity to request to continue care from a provider or facility when they are no longer in the plan's network of providers. Continuity of care ends the earlier of 90 days after the request or the date on which the patient is no longer undergoing continuing care.

UMR 2022 approach

- The rule applies to network status change (except fraud), terminations, or plan changes that would result in a loss of benefits from a provider.

DIRECTORIES

Insurers and self-funded health plans are required to provide up-to-date provider directories on a public facing website beginning with plan and policy years on or after January 1, 2022. The CAA requires insurers and health plans to have a process to verify provider geographic information and a member response process to respond to member requests related to a provider's network status. The print directory must include a notification that the directory was accurate on the date of publication and that the member should consult the database for the most current information.

UMR 2022 approach

- UnitedHealthcare/UMR will manage provider network requirements for their contracted providers.
- Customers will manage requirements for their customer specific network contracts.
- Leased networks will manage provider network requirements for their contracted providers.

EXTERNAL APPEALS

Group health plans and insurers must provide an external review process to determine whether the plan's determination on whether the service is subject to the No Surprises Act is accurate.

UMR Approach

UMR has both a formal external review process in place today which will expand to include surprise bill.

ADVANCE COST ESTIMATE (ADVANCE EOB) – Delayed pending additional guidance

Under the Advance EOB provisions of the CAA, providers are required to confirm coverage and send a notice to the patient's insurer/health plan of the estimated costs associated with any services scheduled three or more days in advance.

Upon receipt of such notification from a provider or facility, insurers/health plans are required to send an Advance EOB to the member through mail or electronic means.

UMR approach

In FAQ 49, the Tri-Agencies delayed implementation of the Advance EOB requirements pending additional rulemaking. UMR continues to advocate for changes to the Advance EOB rules that will be more beneficial for health plans, members and providers.

CAA COST COMPARISON TOOL – Moved to coincide with consumer price transparency tool requirements in the Transparency in Coverage (TIC) rules effective 2023

The CAA originally required insurers and group health plans to offer price comparison information to members via telephone and via a web-based cost-transparency tool starting on January 1, 2022. The tool must allow enrollees to compare costs across participating providers in a specific geographic region for specific item or service. In addition, the tool must show the cost-share that the member would be responsible for paying under the plan based on item or service and by provider.

In FAQ 49 issued by the Tri-Agencies this requirement was moved to 2023 to align with similar Consumer Price Transparency tool requirements under the federal Transparency in Coverage (TIC) rule, which are required beginning in 2023 and 2024.

UMR approach

UMR has long supported actionable price and quality transparency for consumers. UMR already offers price and quality of care information on medical care services. UMR plans to expand our existing tools meet the TIC and CAA customer price transparency tool requirements in 2023 and 2024.

Additional Consolidated Appropriations provisions – Transparency

UMR has also made a significant investment in technology and resources to support our customers in complying with the Transparency requirements under the CAA as follows:

GAG RULE

Under the CAA gag clause prohibition requirements, group health plan contracts or agreements will not be permitted with the provider, network or association of providers, TPAs or other service providers if they:

- Restrict enrollees, plan sponsors or providers from access to cost or quality data.
- Prevent plan enrollees from electronically accessing deidentified claims or encounter information including:
  - Financial information such as allowed amount or claims-related financial obligations included in the provider contract.
  - Provider information including name and clinical designations.
  - Service codes or other data elements in claim or encounter transactions.

Group health plans and insurers must annually attest to their compliance with this requirement.

UMR 2022 approach

- Maintain network agreements compliant with the CAA prohibitions on gag clauses and provide language to support Plan Sponsor's attestation requirement.
- UMR has reviewed and removed gag clauses as required and will attest that this is complete.
- UMR has prepared a statement for self-funded clients to include in their attestation. The Department of Labor will issue guidance on the process for insurers and self-funded plans to submit the attestation.

MENTAL HEALTH PARITY AND NON QUANTITATIVE TREATMENT LIMITATION (NQTL)

The CAA allows the Departments of Health and Human Services (HHS), Labor (DOL) and the Treasury, sometimes referred to as the Tri-Agencies, to conduct audits of plans and require the plans to produce nonquantitative treatment limitation (NQTL) analysis for purpose of demonstrating compliance with The Mental Health Parity and Addition Equity Act (MHPAEA).

Under the CAA health plans and insurers must:

- Perform and document comparative analyses of the design and application of NQTLs within mental health/substance use disorder (MH/SUD) and medical/surgical (M/S) benefits.
- NQTL documentation typically includes a side by side analysis of M/S and MH/SUD NQTL, which could include prior authorization, concurrent review, retrospective review, network adequacy, credentialing, etc.
- NQTLs applied to MH/SUD benefits must be comparable to and applied no more stringently than those NQTLs applied to M/S benefits.
- Federal or state regulators may request this documentation.
- Self-funded customers should meet with their legal counsel to review MHPAEA requirements and documentation specific to their plan designs.
- This reporting requirement does not impact the Quantitative Treatment Limit testing (i.e., cost-sharing, day or treatment limits).

UMR 2022 approach

This CAA provision went into effect in Q1 2021.

Upon request, UMR will provide standard NQTL documentation to assist customers with their analysis.

UMR will assist customers who receive notice from the federal agency advising that they will be conducting a Regulatory MHPAEA Audit on their plan. We will help the customer respond to questions, gather information, and help the customer finalize their NQTL audit response.

BROKER AND SERVICE PROVIDER COMPENSATION DISCLOSURE REQUIREMENTS

Brokers or service providers that receive compensation in connection with services provided to a group health plan must reveal that information to the group health plan prior to finalizing the agreement. Direct and indirect compensation information must be disclosed prior to purchase and no later than 60 days after a change.

UMR 2022 approach

Brokers/consultants may need to work with UMR to get data they need for reporting. Information is available in our proposal. The customer fiduciary should review this information.

PHARMACY BENEFITS AND COST REPORTING (paused pending further rulemaking)

In FAQ 49, the Tri-Agencies delayed implementation of the Pharmacy Benefits and Health Care Cost Reporting requirements pending additional rulemaking. The CAA requires reporting of specific prescription drug spending and certain medical cost data annually to the Tri-Agencies, including:

- Claims paid for the top 50 brand prescriptions most frequently dispensed
- Annual amount spent by top 50 most costly prescription drugs by total plan/coverage spend
- Amount spent for the top 50 prescription drugs with the greatest prior year plan spend
- Total health care spend
- Premiums and rebates

UMR 2022 approach

Even though implementation is delayed, UMR is continuing to determine how to collect and report the information above.

Transparency Rule provision highlights

TRANSPARENCY IN COVERAGE

NETWORK AND OUT-OF-NETWORK MACHINE-READABLE FILES

For plan and policy years beginning on and after January 1, 2022, insurers and group health plans are required to create and publish machine-readable files on a public site and update them monthly. There are three required machine readable files. These include:

1. In-network negotiated rates for all items and services.
2. Allowed amounts for out-of-network items, services, and prescription drugs.
3. Negotiated rates and historical prices for in-network prescription drugs. (Delayed pending rulemaking.)

In FAQ 49, the Tri-Agencies delayed enforcement of the machine readable file requirements from January 1, 2022 to July 1, 2022, and also delayed implementation of the prescription drug machine-readable file pending additional rulemaking.

UMR 2022 approach

- Create and publish the files for medical plans (by product and by plan). Pharmacy file is delayed pending rulemaking. When additional guidance is received regarding inclusion of pharmacy information in the machine readable files, UMR plans to include integrated/carve-in (OptumRx) pharmacy.
- Create files at the plan level for all customers that have a standard product. Information/data will be published to a public website at the plan level.
- UMR will not support creation or acceptance of raw data for file creation or publication.

PRICE TRANSPARENCY TOOLS FOR MEMBERS

Under the Transparency in Coverage regulations, insurers and plans must provide members with real-time benefit cost estimator tools that allow members to understand and compare their personalized out-of-pocket costs for covered network and out-of-network services.

- In 2023 the tools must list 500 items, services and prescriptions drugs identified in the final rule.
- In 2024 the tools must provide costs for all covered medical items, services and drugs and allow members and consumers to understand and compare their personalized out-of-pocket costs for network and out-of-network services.

As indicated above, in FAQ 49 the Tri-Agencies aligned the implementation date for the CAA price comparison tool requirement with the 2023 and 2024 TIC implementation dates.

UMR approach

- Tools will be available to all members including those of our self-funded clients.

Interim Final Rule - Independent Dispute Resolution (IDR) Arbitration Provisions – October 7, 2022

- Establishes timeframes, processes, and requirements for (IDR) process
- Guidance for arbiters on what to consider in making decisions including QPA
- Allows batching of claims for arbitration of “same or similar items or services”
- Requires the losing party to pay arbitration fee and each party pays administrative fee to the Tri-Agencies of $50. Fees must be paid prior to submitting final amount and supporting documentation
- Further guidance will establish an acceptable range of arbitration fees, to be updated annually. Arbiters may impose set fee for a single case within an IDR process and a separate, larger fee for batched IDR cases

Consolidated Appropriations Act FAQs

Transparency in Coverage FAQs