No Surprises Act

What you need to know

The No Surprises Act (NSA) is federal legislation aimed at protecting health plan members from surprise medical bills from out-of-network (OON) providers and facilitating payment dispute resolutions among providers and insurers/health plans.

The Act applies to covered OON benefits for certain emergency situations, air ambulance and when an OON provider is providing services at a network facility. The Act also includes other provisions, including health plan ID card changes, advance cost estimates, directory updates and more.

Passed in late 2020 as part of the Consolidated Appropriations Act (CAA), the new law applies to commercial fully insured and self-insured plans beginning in 2022.

Surprise billing impacts nearly all Americans

1 in 5 insured adults
have had an unexpected bill from OON provider[1]

2/3rds of Americans
are worried about affording unexpected medical bills[1]

70% of OON bills
are a result of "choice" situations that the No Surprises Act won't fix[2]

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The Act's key provisions may require action for employers

A number of provisions may require employers to review their plan's administration and consider the experience they want to deliver to their employees.

1 Protects members from balance billing from OON providers

Establishes standards to protect members from "surprise" or balance billing for defined items and services provided by specified doctors, hospitals and air ambulance carriers on an OON basis.

Applies to covered medical bills related to:

- OON emergency services at a hospital/freestanding facility
- Items and services provided by certain OON health care providers at a network facility
- OON air ambulance items and services

2 New OON member and provider claims follow different path

Members are responsible only for their cost-share based on recognized amount (e.g., par median*). The member cost-share will not change regardless of the final payment to the provider.

The provider and insurer/health plan must try to negotiate the reimbursement rate or submit to independent dispute resolution (IDR).

*Unless state surprise billing law applies.

3 Creates independent dispute resolution

Creates a process to settle insurer/health plan disputes with providers related to reimbursement for covered OON emergency and air ambulance services, and for certain covered OON items and services provided at a network facility.

The law sets timetables for resolving disputes and holds the member harmless. The "losing" party pays all IDR entity expenses.

4 Requires enhancements for health plan ID cards

Online and printed health plan ID cards must display all deductibles and cost-share maximum out-of-pocket limits along with a telephone number and website address to obtain support and network facility and provider information.

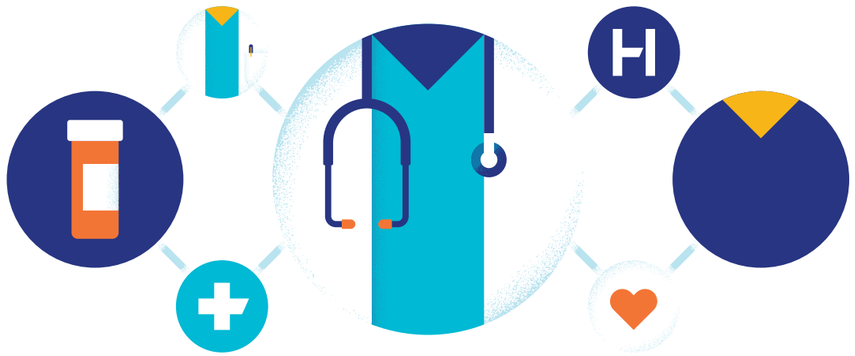
5 Requires publicly available directories

Requires publication of up-to-date provider directories on a public-facing website, with provider and facility information verified and updated as needed every 90 days. The law also requires establishment of a process to confirm whether a provider is in network when members specifically call to verify a provider's status.

Take advantage of UnitedHealthcare's experience in responding to this legislation

Managing OON benefits and an IDR process can be complex and time consuming. There are many things to consider, such as who has the data and expertise needed and can resolve OON claims in a timely manner. UnitedHealthcare is best positioned to help you do this by:

- Offering a turnkey approach and resources for managing OON benefits and IDR processes
- Understanding the legislation and what is needed to comply with federal and state requirements
- Evaluating network negotiation history, analyzing claims, providing member advocacy, and preparing for and managing dispute resolution administration
- Using our experience and track record administering similar programs in 34 states that have enacted no surprise or balance bill laws



See back for more on UnitedHealthcare solutions that can help you respond to this new legislation

United Healthcare

Consolidated Appropriations Act and Transparency Rule: Key Health Provisions

CAA No Surprises Act	Overview	Date	UnitedHealthcare approach	Employer impact	Member impact
Surprise Medical Billing	Protects members from surprise medical bills for covered services related to 1) OON emergency at a hospital or facility; 2) items and services provided by certain OON providers at a network facility; 3) OON air ambulance.	Effective for plan years on and after 1/1/22	Provides end-to-end support for this process, including calculations for member-recognized amounts and provider initial payments.	Impacted when reimbursement goes up; member cost-share doesn't change. UnitedHealthcare will manage the process through IDR.	Once recognized amount is determined, member cost-share is fixed.
Independent Dispute Resolution (IDR)	Calls for a neutral third party to settle reimbursement disputes between parties. Party that loses IDR pays the other party's IDR expenses. Requires extensive knowledge of law, data, reporting, analysis, reporting and brief preparation.		Manages the entire process from negotiating reimbursement through IDR/arbitration.	UnitedHealthcare will manage the process on behalf of the employer through IDR. Plan is responsible for the $50 administrative fee and arbiter fee. UnitedHealthcare will pay $50 from ASO bank account and upfront the IDR entity fee and adjust on resolution.	No balance bill or change in member cost-share regardless of final provider reimbursement.
Plan ID Cards	Requires inclusion of network and OON deductible/OOP maximum on health plan ID cards. Requires phone numbers and the website address where members may obtain support and network facility and provider information.		Provides compliant health plan ID cards electronically on portal upon renewal.	Health plan card capacity, customization. Confirm if card production is based on standard process.	More detailed information on health plan ID card to assist member.
Patient Protections: Advance Cost Estimate (ACE) **External Appeals**	Providers must ask members if they have coverage when scheduling appointments and send estimated service/cost notice to insurer/health plan. Then insurer/plan sends an Advance Cost Estimate (ACE) to member with estimated member responsibility. Insurer/plan required to offer external review for surprise bill member disputes.	ACE pending rulemaking Appeals effective plan years on and after 1/1/22	Additional rulemaking required. Updating EOBs and existing external appeals process.	When effective, UnitedHealthcare handles ACE for employer. If group uses its own appeals vendor, group will need to update.	Upon launch date, member receives cost estimate and member expense information prior to service (paper or email notification).
Provider Directories	Insurer/health plan must have process to verify provider information, respond to member inquiries on provider status. Requires verification process and written/electronic member response.	Effective for plan years on and after 1/1/22	Update provider directories, verify provider data, and pay claims as INN in certain situations when directory is out of date. Include CSP and GSP where we have data and pay claims.	Employer works with UnitedHealthcare for custom networks managed. ASO client networks not managed by UnitedHealthcare must follow guidance separately.	Timely, accurate information. Member protected if status is communicated in error.
CAA Transparency	**Overview**	**Date**	**UnitedHealthcare approach**	**Employer impact**	**Member impact**
Removal of Gag Clauses	Health care contracts shall not prohibit electronic access of provider information, access to de-identified claims and encounter information or sharing information with others. Consistent with HIPAA and GINA requirements. Plans are asked to use good faith and reasonable interpretation to meet 1/1/22 date. Anticipate additional guidance on actual date and where to submit attestation.	Attestation required likely by end of Dec. 2022	Maintain network agreements compliant with the CAA prohibitions on gag clauses and provide language to support plan sponsor's attestation requirement.	Review any nondisclosure or language preventing sharing of data as required.	Member HIPAA and PHI will continue to be protected.
Broker Compensation Disclosure	Direct and indirect compensation information must be disclosed to employer group prior to purchase.	12/27/21	Provides compensation disclosure guide to where compensation is found.	Employer fiduciary reviews compensation; supports broker disclosure.	Member can review compensation.
Reporting Pharmacy Benefits and Rx Costs	Requires insurers/health plans to annually report information on prescription drug benefits and costs to the Tri-Agencies. Report due by 12/27/22.	12/27/22	UnitedHealthcare prepares data for reports. Report will include fully insured and self-funded data.	Employer works with UnitedHealthcare if the ASO wishes to submit data themselves.	No direct impact.
Mental Health Parity	Insurer/plan must develop and disclose to state and federal regulatory agencies information on Non Quantitative Treatment Limits (NQTL) upon request. Insurer creates report for fully insured plans.	2/10/21	Provide support related to Mental Health Parity NQTL audits initiated by DOL, HHS or Treasury.	ASO plans legally responsible for compliance, NQTL analysis and documentation. UnitedHealthcare provides assistance for regular requests. Remediate if not meeting NQTL standards.	Member is notified if plan doesn't meet NQTL requirements.
Transparency in Coverage Rule	**Overview**	**Date**	**UnitedHealthcare approach**	**Employer impact**	**Member impact**
Machine-readable Files (MRF)	Requires insurers/health plans to create and post three separate MRFs, including detailed pricing date regarding 1) network negotiated rates for all items and services; 2) allowed amounts for OON items, services and prescription drugs; 3) negotiated rates and historical prices for network prescription drugs (delayed).	INN/OON MRF plan years on/after 7/1/22	Create and publish files on publicly accessible website. Pharmacy MRF deferred pending rulemaking.	No fee—UnitedHealthcare creates/publishes monthly MRF on its public site for employer to put on its site. Includes customer CSP and GSP networks.	Minimal impact. Member price transparency tools are scheduled for 1/23 and 1/24.
Member Tools	Price Transparency tool—personalized, real-time, cost-share estimates for covered services and items, including pharmacy for 500 designated items/services in 2023 and all items/services in 2024. CAA cost transparency tool requirement now aligns with Transparency in Coverage timeline.	Plan years 1/23 and 1/24	Developing new tool to meet 2023 and 2024 requirements.	ASO would establish own tools if not using UnitedHealthcare tools. Attestation required.	New price transparency tool scheduled for 1/23 and 1/24.

[1] All data sourced by Kaiser Family Foundation, Data Note: Public Worries About And Experience With Surprise Medical Bills, 2/28/2020.

[2] Based on UHC commercial claims data 2020-2021.

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