



Transparency in Coverage

**Consumer Price Transparency Tools (CPTT)
External Frequently Asked Questions**

3/1/24

United
Healthcare

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Resources

External - these are publicly available and found on [uhc.com](#).

CMS Transparency in Coverage [Final Rule Fact Sheet](#)

[List](#) of the 500 items and services in the 2023 tool

[Tri Agency FAQ 49 - guidance from August 2021 extending enforcement date for MRF](#)

[Tri Agency FAQ 53 – April 2022](#)

[Tri Agency FAQs 55 – August 2022](#)

[Tri Agency FAQ 61 – September / December 2023](#)

[Transparency in Coverage Page on \[uhc.com\]\(#\)](#)

External Transparency in Coverage [FAQs](#)

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Transparency in Coverage Overview

What are the key elements of the Transparency Rule? [Update 4/11/21](#)

On November 12, 2020, the Departments of Health and Human Services, Labor and the Treasury finalized the Transparency in Coverage Rule that requires health insurers and group health plans to create a member-facing price comparison tool and post publicly available machine-readable files that include in-network negotiated payment rates and historical out-of-network charges for covered items and services, including prescription drugs. Data in machine-readable files must be updated monthly.

- **Consumer Price Transparency Tool:**

The Transparency in Coverage rule requires insurers and plans to create online consumer tools that include personalized information regarding members' cost-sharing responsibilities for covered items and services, including prescription drugs. The ruling stipulates a web based internet tool be made available to estimate personal cost-share liability for both medical and prescription drugs.

The tools must:

- Permit members to search based on billing code or description
- Allow members to compare costs across both in-network and out-of-network providers
- Inform members of any accumulated deductible or other out-of-pocket expenditures to date
- List any factors that impact the cost such as service location or drug dosage
- Provide cost estimates in paper format at the member's request

Beginning with plan years on or after January 1, 2023, the cost estimator tool must disclose information on 500 items, services and prescription drugs identified in the final rule. Starting with plan years on and after January 1, 2024, the tool must list all covered items and services including prescription drugs.

What is the effective date for compliance with the Rule? [Update 9/1/21](#)

Consumer Price Transparency Tool:

Effective for **plan years beginning on and after January 1, 2023**, insurers and plans must provide members with real-time benefit cost estimator tools that allow members and consumers to understand and compare their personalized out-of-pocket costs for covered in-network and out-of-network services. The price comparison tool must list 500 items, services, and prescriptions drugs identified in the final rule. The list is primarily for medical items and services for January 1, 2023.

Effective for **plan years beginning on and after January 1, 2024**, insurers and plans must provide members with real-time benefit cost estimator tools that provide costs for all covered

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medical items, services and drugs that allow members and consumers to understand and compare their personalized out-of-pocket costs for in-network and out-of-network services.

What is meant by all items and services? **Update 12/29/23**

Beginning on and after January 1, 2024, the disclosure requirement for the cost comparison tool expands to **all** covered items and services by the insurer or plan – for example: charges in connection with office visits, virtual care, medical tests, durable medical equipment, prescription drugs and more.

Code Type	Description
Current Procedural Terminology (CPT)	Comprehensive and standardized system set of medical codes used by physicians, allied health professionals, nonphysician practitioners, hospitals, outpatient facilities, and laboratories to describe the procedures and services they perform
Diagnosis-Related Group (DRG)	System which classifies inpatient hospital cases according to certain groups which are expected to have similar hospital resource use (cost)
Revenue	Set of standardized 4-digit numbers used in medical billing by facilities. Many revenue codes are 3 digits and a leading zero is implied – e.g., 0450, 0636, 0210
Healthcare Common Procedure Coding System (HCPCS) *includes DME	Comprehensive and standardized system that classifies similar products that are medical in nature into categories for the purpose of efficient claims processing
Vision within Medical Plan * includes materials (e.g., frame allowances are in scope for 1/1/2024)	Embedded within existing CPT and HCPCS codes
Dental within Medical Plan *Current Dental Terminology (CDT) codes	Embedded within HCPCS codes – e.g., D0120 - Routine dental checkup
Hearing within Medical Plan	Embedded within existing CPT and HCPCS codes

Does the rule apply to insurers and group health plans? **New 4/15/21**

Yes. The rule applies directly to health insurers and to group health plans. The health insurer is responsible for implementing the requirements for fully insured group health plans.

A self-funded group health plan may contract with a third-party administrator to implement some or all requirements of the rule on behalf of the plan.

Can insurers support the compliance requirements for a group health plan? **New 4/8/21**

Yes. While the Transparency in Coverage Rule applies directly to group health plans, an issuer or third-party administrator (TPA) may support the compliance requirements for the group health plan.

Doesn't the rule violate HIPAA or other security or privacy rules? **New 4/8/21**

No. The Transparency Final Rule did not alter existing state and federal privacy or security requirements, including the requirements under the Health Insurance Portability and Accountability Act (HIPAA). The transparency final rule does not require the public disclosure of protected personal health information (PHI).

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How will the Transparency Rule be enforced? New 4/8/21

Insured plans — for the most part states have the primary enforcement authority. The Department of Health and Human Services (HHS) will enforce the rule if a state fails to do so.

ERISA plans — the Department of Labor (DOL) has primary enforcement authority over group health plans subject to ERISA.

Do the machine-readable files need to directly relate to the shoppable items and services in the price comparison tool? Update 12/6/22

No. There is no requirement in the rule that a crosswalk is required between the data displayed in the machine-readable files and the price comparison tool because the price comparison tool is member specific.

The machine-readable files are not intended to be utilized for the cost estimation tool as these files are from the perspective of the payer. The cost estimation tool is for the member and considers not only provider rates but also a member's plan benefits, eligibility and accumulators.

Isn't this just another example of why some advocate for a single-payer system? New 6/27/22

No. Providing access to actionable quality and cost information will help individuals seek affordable, quality care while driving down overall health care costs. In fact, providing health care prices to people, health care professionals and other stakeholders could reduce U.S. health care spending by more than \$100 billion over the next decade, according to a report by the Gary and Mary West Health Policy Center.

FAQ 65 HSS and Treasury

[FAQ 65](#) covers HHS and Treasury ACA guidance for health insurance plans and issuers that addresses how to comply with the cost-sharing disclosure requirements of the Transparency in Coverage Final Rules with regard to items and services with extremely low utilization.

Does UnitedHealthcare meet the requirements outlined in FAQ 65? New 3/1/24

UnitedHealthcare is compliant with the Transparency in Coverage Rule and FAQ 65, including the provisions related to Machine Readable Files (MRFs) and the Consumer Cost Transparency Tool (CPTT) provisions.

If utilization is low, what information is shared with the individual using the cost estimation tool? New 3/1/24

In situations where utilization is low based on review of relevant claims data the cost estimation tool and myuhc.com use disclaimer message including but not limited to:

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We did not have enough claim information to provide an estimate for the service from an out-of-network provider. Please contact the provider.	Display messaging on the OON estimate screen when we cannot generate an OON estimate so that the member will know they need to contact the provider for additional information regarding the cost for the service
We apologize for the inconvenience. We are unable to provide an estimate at this time. Please call the member phone number on your health plan ID card.	When a user searches for a service and no rates are returned due to the unavailability of cost data for that service, display informative messaging on the Cost Estimation Tool to inform members/advocates that we are unable to return an estimate. Display message to members when a network is not defined for the member and they select the option to obtain an in-network geo average cost. If there is no in-network geo average cost available for that service, the following message will be displayed

This messaging is also available to customer service advocates, to support the member should they call and look for assistance (e.g., review of relevant benefits.)

Customer Communication and Timing

How and when will updates on your compliance with the various requirements of the Transparency in Coverage rule be disseminated to clients? **Update 10/17/23**

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

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

Consumer Price Transparency Tools (CPTT)— Transparency Rule

The Consumer Price Transparency Tool began to go in to effect on and after January 1, 2023.

What must be included in the Consumer Price Transparency tool? **Update 10/2/23**

The tool must make available to participants, beneficiaries and enrollees or their authorized representative personalized out-of-pocket cost information as well as the underlying negotiated rates for all covered health care items and services including prescription drugs. The

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information must be available through an internet-based self-service tool and when the member request it, the information must be provided in writing.

The member must call customer services using the number on their ID card to request the estimate in writing.

The cost estimation tool is a starting point for members to begin their shopping experience, providing consumers with real-time information on providers in the network and quality and cost estimates. The cost estimation tool includes disclaimers clearly stating it is an estimate and has certain limitations that should be considered before deciding to receive an item or service. The disclaimers also encourage members to contact the provider directly to get a more accurate estimate.

Access the Transparency in Coverage Rule on the Centers for Medicare and Medicaid Services (CMS) website for more information ([Health Plan Price Transparency | CMS](#)).

What is the timing for the tool to have available services? Update 9/1/22

Starting with plan years beginning on or after January 1, 2023, insurers and plans must make the tool available for 500 shoppable items, services and drugs identified in the rule. For the first year, most of these required services are medical.

All covered items, services, and drugs will be required to be included in the consumer price transparency tools for plan years that begin on or after January 1, 2024.

What is meant by all items and services? Update 12/29/23

Beginning on and after January 1, 2024, the disclosure requirement for the cost comparison tool expands to **all** covered items and services by the insurer or plan — for example: charges in connection with office visits, virtual care, medical tests, durable medical equipment, prescription drugs and more.

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Revenue	Set of standardized 4-digit numbers used in medical billing by facilities. Many revenue codes are 3 digits and a leading zero is implied — e.g., 0450, 0636, 0210
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What is UnitedHealthcare approach to Consumer Price Transparency Tool (CPTT) enhancements being made and when is the enhanced tool available? Update 12/29/23

The CPTT tool for the 500 items and services outlined by the Tri-Agencies was released for members on Jan. 1, 2023. On Jan. 1, 2024, the cost estimation tools include all covered items and services.

- For those UnitedHealthcare entities that use myuhc.com, members will have the myuhc.com experience.
- For those UnitedHealthcare entities that do not use myuhc.com, UnitedHealthcare has created a cost estimation tool experience. The tool will be integrated with the portals used by those members. For example: UMR, Sierra.

What is available for members to use the CPTT and Cost Estimation tool? Update 12/29/23

UnitedHealthcare implemented the provision on 1/1/2023 for the 500 shoppable services and on 1/1/24 for all covered items and services.

1. For customers who use myuhc.com – their access has not changed. Members are able to search for cost estimates as they were previously.
2. For customers who do not have access to myuhc.com – a cost estimation tool is available to those members as stand-alone or embedded links to their portal experiences (e.g., umr.com)
3. Customer advocate teams also have access to the cost estimation tool to facilitate written cost estimates for members should they call and request

What resource is available to share with customers and members on UnitedHealthcare's approach to cost estimations? Update 12/29/23

A member flyer is available for clients and members regarding the cost estimation tool.

Are there some new or different features for 2024? Update 10/2/23

- Yes, including but not limited to:
- DME code for purchase or rentals – e.g., wheelchairs
- Dental, Vision and Hearing embedded into medical plan
- Additional disclaimers

Will UnitedHealthcare provide members with a written cost share estimate? Update 12/29/23

Yes, if the member calls customer service and requests the cost share estimate in writing.

If the member has digital paperless preferences on file, the estimate is emailed. If not, a physical letter is sent.

Note: The member may print the cost share estimate directly from the cost estimate tool or myuhc.com. It is only when the member wants the estimate in writing with logo and branding applied would they need to call customer service.

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How does the member access the cost estimation tool? **Update 12/29/23**

The members who use myuhc.com today, would continue to access the application in the same manner (e.g., HealthSafe ID or Single Sign-on from their portal).

For those members who don't use myuhc.com today but have access to a cost estimation tool they enter their "Big 5".

Note: the "Big 5" represents their first name, last name, DOB, group and member number.

What enhancements and additional detail is UnitedHealthcare planning for the Consumer Price Transparency Tool required? **Update 12/29/23**

The Transparency in Coverage rule requires insurers and plans to create online consumer tools that include personalized information regarding members' cost-sharing responsibilities for covered items and services, including prescription drugs.

There are two approaches for CPTT that address the 1/1/23 500 shoppable services and the 1/1/24 all covered items and services regulatory requirements.

1. **myuhc.com:** Existing cost estimation within myuhc.com is unchanged and will retain existing care paths, in addition to providing cost estimates for all covered items and services effective 1/1/24. To receive the cost estimate in writing with the UHC logo/brand the member must call Customer Service.
2. **Cost Estimation Tool:** A stand-alone cost estimation tool for all covered items and services effective 1/1/24. Care paths will not be available. This applies to members and portals that currently do not use myuhc.com for cost estimation. The cost estimation tool supports customer advocates generating the members request to receive the information in writing.

Note: The member may print the cost share estimate directly from the cost estimate tool or myuhc.com. It is only when the member wants the estimate in writing with logo and branding applied would they need to call customer service.

What are the search capabilities in the Consumer Price Transparency tool? **Update 12/7/22**

Members must be able to search for covered items and services by:

- Billing code or descriptive term (e.g., rapid flu test),
- Provider/pharmacy name, and
- Other factors relevant to determine cost sharing (e.g., facility name, service location)

The consumer can adjust their search or prioritize the results based on geographic proximity of providers and the estimated cost share liability for the item/services/drug if there are multiple results.

Note: myuhc.com will continue to provide cost estimates for existing care paths, otherwise referred to as episodes of care.

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What are care paths on myuhc.com and why are they not on the cost estimation tool?

Update 10/2/23

A care path is a complete episode of care, across multiple healthcare encounters. For example, a knee replacement care path includes surgery for knee replacement in addition to pre-/post-op visits, imaging, and physical therapy.

This gives members a more complete view of their expected costs and does not change from what UHC does currently – how the results are displayed effective 1/1/2023 does change and displays not the listing of services but displays for the member’s cost estimates for the service searched.

This gives members a more complete view of their expected cost for the service searched and does not change from what UHC does currently.

The cost estimation tool does not support care paths. .

Why is there no provider listed for an out-of-network estimate on the cost estimation tool or myuhc.com? **Update 10/2/23**

When the estimate is calculated for a particular provider, it compares the estimate to Geographic 25th, 50th and 75th percentiles. That is how it determines whether to generate above or below average cost verbiage

- Only UHC claims are used in the pull to derive average costs.
- UMR uses the UHN networks for much of their claims/business – the only claims that are actually not represented are leased networks and domestic contract providers. The amount of claims from the leased networks and domestic providers is most likely statistically insignificant to change the average cost to the member.
- **Reminder:** The provider search is not a provider directory

Why am I not able to receive a cost estimate and being directed to call customer service?

Update 12/29/23

The member may receive the error message when the members benefit, and eligibility information is not available. “We apologize for the inconvenience. We are unable to locate benefit or provider information to complete this request. Please call the member phone number on your health ID card.”

Examples include but are not limited to when the member has a capitated or delegated arrangement, when another vendor provides the service, or when manual special processing instructions apply.

What is a capitated or delegated arrangement and why is the member not able to receive a cost estimate? **New 12/7/22**

The amount is based on what the provider charges for the service. UHG does not have the negotiated rate in our system for that provider's contract.

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What are manual special processing instructions? New 12/7/22

The members benefit details are not always available in our systems. Customer service advocates supply benefit details to the member in these isolated circumstances.

How do I perform a new search when the existing code or service is still displayed? Update 12/29/23

Select the “X” in the search box to remove the existing code and begin a new search. If the cost estimate page results are displayed, simply select the “back to member search” to select a different code or service. Additional prompts allow the member to begin a brand new search without logging out of the tool.

What if I can't find a service? Update 12/29/23

To ensure a service is found the member must search using the billing code or service names. Keyword searches provide a list of potential results for the member to choose from.

What happens if no results are returned? Update 12/29/23

Please refresh the browser. All browsers other than Internet Explorer are supported. If the error persists, please contact your customer service advocate.

Note: if a member does not have benefits coverage (e.g., out-of-network or a particular service) a no results found message, or a similar message would display to the member.

What happens when the Search button is greyed out? New 12/29/23

Click on the Doctor, specialist or facility section and two hyperlinks will show. Select In-Network Estimate or Out-of-Network Estimate.

What does the plan summary information represent? Update 12/29/23

The plan summary reflects the individual deductible and out-of-pocket (OOP) maximum. Where applicable the family plan summary is also displayed.

Are the cost estimation tools available to prospective members? New 12/7/22

No. Only active members have access to the cost estimation tool or myuhc.com depending on their experience. Active members must authenticate (have valid log-in credentials) to access the tools and receive a cost share estimate.

How would Surest members receive a cost estimate? Update 12/29/23

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Surest members have their own cost estimation tool. For more information specific to receiving a Surest cost estimate, go to the Surest Connect to Market page under Alerts and Talking Points:

<https://view.surest.com/viewer/6442daef37fc537cb67394d4?iid=6565ffeb266b422e83c5aae9>

What is the source of truth for in-network (INN) and out-of-network (OON) cost estimates? New 12/29/23

INN providers - contracted rates are accessed from provider source systems

OON providers – allowed amounts are based within claims source systems and a geographical service area based on the member search radius is applied.

Reminder: The members plan benefits, eligibility and accumulators are applied when the cost estimate is returned.

Does UnitedHealthcare support carve – out rate, benefits, notices and disclaimers in their cost estimation tools? Update 12/29/23

UnitedHealthcare intends to be compliant with the Transparency in Coverage rule and Consumer Cost Transparency Tool (CPTT) provision for 1/1/2024 all codes and services implementation. Where UnitedHealthcare has access to the rate, benefit, and provider information within our source systems would the information be available to the member when retrieving a cost estimate.

What is the definition of carve – out for the purposes of the cost estimation tool by UnitedHealthcare? Update 12/29/23

Carve-out means that the client has a direct contract with someone else to provide a service (e.g., physical therapy or behavioral then NO those rates are not included in the UHC tool and the member would need to go to the website of the entity that manages those benefits. An exception to that might be Optum rates where they have provided that data to us for usage in the tool. For any clients that have a direct contract with an outside entity (e.g., vendor, network, etc.) UnitedHealthcare does not house those rates and the client's members are directed to contact them or the provider directly for an estimate.

Is the member able to print the cost share estimate? Update 12/29/23

Yes, the member can print the cost estimate directly from the screen. The printout would look exactly like the screen with the disclaimers added. If the member would like a written estimate with logo and branded letterhead, they must call customer service and request cost estimate letter be mailed to them.

What are the benefits of the Consumer Price Transparency tools? Update 9/1/22

Today's consumers have more of a vested interest in understanding the cost of care and have more options, making it important for consumers to understand the cost of services and their share of the cost before they have the service.

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According to the federal agencies, the transparency in coverage requirements may provide the following consumer benefits:

- Enables consumers to evaluate health care options and to make cost-conscious decisions.
- Strengthens the support consumers receive from stakeholders that help protect and engage consumers.
- Reduces potential surprises in relation to individual members' out-of-pocket costs for health care services.
- Creates a competition that may narrow price dispersion for the same items and services in the same health care markets.
- Potentially lowers overall health care costs.

UnitedHealthcare provides these types of transparency tools to members to support the member optimizing their benefits and help the member to access lower cost, more affordable health care services.

Are clients able to host the myuhc.com link on their own websites? Update 12/29/23

No. Members have to register/log-on for personalized cost estimates.

Are 3rd party leased networks that UMR supports in scope for the Consumer Price Transparency Tool (CPTT)? Update 12/29/23

Yes. Where UMR provides these services and UnitedHealthcare has access to the information, cost estimates are available.

Is the Puerto Rico leased network in scope for CPTT? Update 9/1/22

Yes.

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Scope for CPTT - What's included or not

Who is in scope for compliance with the Rule? Update 9/1/22

The Transparency in Coverage Rule applies to health insurers in the individual and group markets and to group health plans. Exchange plans, grandfathered, Transitional Relief plans (sometimes called “grandmother” coverage) plans, and short-term limited benefit plans are also included. Excepted benefit plans are NOT included.

What is a grandfathered plan or a Transitional Relief plan? Update 12/29/23

Grandfathered plans are those that were in place prior to the March 23, 2010, enactment of the Affordable Care Act (ACA). Grandfathered plans are exempt from many ACA requirements provided no significant changes are made to the plan design. A health plan must disclose whether it considers itself a grandfathered plan.

Transitional Relief plans became effective after the ACA enactment and do not comply with certain ACA provisions. Federal regulators have allowed these plans to renew under a non-enforcement policy on an annual basis if the plan is otherwise permitted by state law.

What health plans are not covered under the Transparency Rule? Update 9/1/22

The following plans are not covered under the rule as defined by the government:

- Excepted benefits (e.g., standalone vision, dental, and hearing plans)
- Retiree only plans
- Flexible Spending Accounts (FSA), Health Reimbursement Accounts (HRA) and Health Savings Accounts (HSA)
- Medicare
- Medicaid

When dental or vision are integrated with the medical plan, would they be included in the consumer cost transparency requirement? Update 4/12/23

Yes. These apply once all items and services are included beginning 1/1/24.

While the rule does not apply to excepted benefits such as standalone dental or vision coverage, if those benefits are integrated with the medical plan, they would be subject to the rule.

Are non-ERISA self-funded plans included in the Transparency Rule requirements? New 4/8/21

Yes, subject to potential government immunities, non-ERISA self-funded plans are impacted and must meet the requirements for both machine-readable files and price comparison tool. Clients should always discuss the issue with their legal counsel.

Are UnitedHealthcare Global Solutions business travel plans in scope? Update 5/5/22

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No. Business travel plans are not included in the Transparency Rule requirements.

What are treatment limits? Updated 12/29/23

Treatment limits are covered benefits within the member plan. Treatment limits are defined as for the plan year or lifetime. Treatment limits are a regulatory requirement and must be displayed on a cost estimate to the member, where applicable.

Example of a treatment limit: The member has a chiropractic benefit for 10 sessions for the plan year. The cost estimate tool, at the time the member searches for a covered chiropractic service would provide a disclaimer “You have used x sessions of your total 10 for the plan year.”

What is the difference between rental vs. purchase on my cost estimate? Updated 12/29/23

Durable medical equipment (DME) refers to services such as wheelchairs, canes or other medical devices or services. DME cost estimates may be based on a rental, rent to own or outright purchase price. The cost estimate displayed to the member takes into account this information when a DME code or services is searched.

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Price Comparison Tool –Consolidated Appropriations Act Requirement

Based on Tri Agency FAQ 49 that was released in August 2021, the CAA member price tool has now been removed as duplicative and is included in the Transparency in Coverage Consumer Price Transparency Tool provision beginning on and after January 1, 2023, and 2024.

UnitedHealthcare Current Support for Price Comparison

How will you use price transparency as an opportunity to improve the consumer experience? **New 6/1/21**

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

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

How does UnitedHealthcare's approach to cost estimation work? **Update 9/1/22**

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

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

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

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

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

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UnitedHealthcare will use our expertise and experience as we develop the price transparency tools required under the Transparency in Coverage Rule in 2023 and 2024.

How does UnitedHealthcare provide telephonic support for members? New 6/21/21

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

This support does not require a dedicated team to provide the tool and assist with its use since all UnitedHealthcare service teams provide support for transparency tools available via our member website, myuhc.com, and mobile tools.

How does a member search for cost estimate for services? Update 9/2/22

According to the regulations, the self-service tool must allow users to search for cost-sharing information for a covered item or service by inputting the name of a specific in network provider in conjunction with a billing code or descriptive term, as well as other relevant factors like location of service, facility name, or dosage.

The final rules require refining and reordering search results only for in-network providers, as the Departments are of the view that doing so for out-of-network providers would be too burdensome at this stage.

The Departments expect that in order for beneficiaries, participants, and enrollees to search for out-of-network providers, they would have to input, at minimum, the billing code or name of an item or service and the geographical location of the provider.

How can a member change their search for a cost estimate, e.g., a different provider, different radius? Update 4/12/23

A member can refine or begin a new search using the back buttons within the cost estimation tool or myuhc.com

How does a member access the cost estimation tool? Update 12/29/23

A member accesses myuhc.com for find care and costs (FCC) the same way they did prior to the Transparency in Coverage regulation.

A member accesses the cost estimation tool by entering their Big 5 key information. For example: first name, last name, DOB, member group number from the member's health ID Card.

Does UnitedHealthcare charge for using the CPTT? Update 9/2/22

No. Refer to your existing administrative agreement. There are no additional costs included for this tool.

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Logistics and Process for CPTT

Will you incorporate external data (e.g., PBM, specialty network, etc.) into the platform?

Updated 3/1/24

As of 1/1/24, all items and services are part of the cost estimation tool.

UnitedHealthcare will have a price transparency tool available for all UnitedHealthcare platforms, pricing structures, and plan designs for individuals and their authorized representatives consistent with the requirements beginning on and after 1/1/23.

Does UnitedHealthcare support a mobile cost estimate tool experience? Update 12/29/23

Yes. UnitedHealthcare complies with the Transparency in Coverage rule to provide a web-based internet tool for cost share estimates. Members may download the myuhc mobile app to receive estimates on some services.

Do you have screen shots of the before and after? New 9/2/22

Screen shots are not available.

Disclosure Requirement

What information must be provided to the members in the health plan? New 4/8/21

Beginning with plan years on and after 1/1/2023, issuers and self-funded plans are required to provide members with the following information.

- An estimate of cost share responsibility: The member's cost share for an item or service covered under the plan.
- Accumulated amounts: Any accrued deductible or out of pocket payment amount including the items and services that accrued under the plan.
- Negotiated rates: Based on network provider payments for items and services.
- Out-of-network allowed amount: max a plan would pay and out-of-network provider for a covered item or service.
- Content list of items and services: for bundled services a list of each covered item and service plus the costs for bundled services.
- Notice of prerequisites to coverage: health plans must inform the member if an item or service is subject to medical management requirements including prior authorization, concurrent review, step therapy.

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- Disclosure notice that the tool is providing an estimate and that actual costs may vary.

What is required in the disclosure notice? New 4/8/21

The issuer and the self-funded health plan must provide the following disclosures in plain language:

- Information disclosing that out-of-network providers may balance bill the individual member for the difference between what the provider billed and the member's cost share amount (copayment, deductible or coinsurance) if and when balance billing is permitted under state or federal law.
- A statement that the actual charge may be different from the estimate.
- A statement that the cost share estimate is not a guarantee of coverage.
- Information on whether the copay counts toward the deductible and the out-of-pocket max.

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Network and Negotiation Strategies

How will insights on market pricing affect provider contract negotiation strategies? **New 6/1/21**

UnitedHealthcare shares national contracting guidelines with the local health plan contracting staff who may tailor these recommendations to reflect the local environment. As they prepare their negotiating strategy, the local contracting staff considers our national guidelines, the competitive situation in the local marketplace and our internally developed pricing tools in order to develop a fair reimbursement rate designed specifically for the local market. The bottom line is that our contracting process is fact-based and capitalizes on both our national strengths and our local market knowledge and expertise to satisfy our customers' needs. Our contracting efforts are designed to:

- Increase customer access by maintaining a variety and generous choice of physicians, other providers, and facilities
- Establish positive and supportive relationships with physicians to promote the delivery of quality health care to all of our customers
- Reimburse physicians only for those services actually rendered and only for services that are medically appropriate
- Achieve the most favorable price through fixed, negotiated rates

What are the implications of transparency requirements for value-based care arrangements (compared to fee-for-service)? **New 4/12/23**

UnitedHealthcare is evaluating how value-based care arrangements will be disclosed as required by the transparency requirements. Transparency requirements under the CAA do not make special provision for value-based care arrangements vs. fee-for-service.

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UnitedHealthcare Approach

Will UnitedHealthcare support the transparency rule requirements? Update 9/1/21

UnitedHealth Group is committed to compliance with the laws and regulations applicable to our business and intends to comply with the requirements of the rules.

UnitedHealth Group has long supported actionable price and quality transparency for consumers and currently offers transparency tools to a significant portion of our business.

UnitedHealthcare provides support for machine-readable rate files and price transparency tools are available for all UnitedHealthcare platforms, pricing structures, and plan designs for individuals and their authorized representatives at the appropriate time.

Does UnitedHealthcare meet the requirements outlined in FAQ 65? New 3/1/24

UnitedHealthcare is compliant with the Transparency in Coverage Rule and FAQ 65, including the provisions related to Machine Readable Files (MRFs) and the Consumer Cost Transparency Tool (CPTT) provisions.

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