CASE NO. 85525; *Combined with* CASE NO. 85656

IN THE SUPREME COURT OF NEVADA

UNITED HEALTHCARE INSURANCE COMPANY; UNITED HEALTHCARE SERVICES, INC. D/B/A UNITEDHEALTHCARE; UMR, INC. D/B/A UNITED MEDICAL RESOURCES; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.; AND HEALTH PLAN OF NEVADA, INC.,

Appellants/Petitioners,

vs.

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C.; AND CRUM STEFANKO AND JONES, LTD., D/B/A RUBY CREST EMERGENCY MEDICINE.

Respondents/Real Parties in Interest.

Appeal from the Eighth Judicial District Court, Clark County
District Court Case No. A-19-792978
Hon. Nancy L. Allf, District Judge

APPENDIX OF EXHIBITS TO RESPONDENTS' ANSWERING BRIEF

VOLUME 4 OF 13

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CERTIFICATE OF SERVICE

I certify that I am an employee of BAILEY❖KENNEDY and that on the 28th day of August, 2023, service of the foregoing **Appendix of Exhibits to Respondents' Answering Brief – Volume 4 of 13** was made by electronic service through Nevada Supreme Court's electronic filing system and/or by depositing a true and correct copy in the U.S. Mail, first class postage prepaid, and addressed to the following at their last known address:

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Employee of BAILEY❖KENNEDY

EXHIBIT 18

EXHIBIT 18

Out-of-Network Billing Initiative
Media Statement/Talking Points/Q&As
Tuesday, June 3, 2014 (updated)

INITIATIVE OVERVIEW

UnitedHealthcare's individual members, member businesses and providers who agree to engage with us to provide in-network access to quality care have been harmed by physicians and other health care professionals who choose not to participate in our network and subsequently charge exorbitant and often ever-increasing fees. Typically, these providers fall into these categories:

1. Non-par emergency providers and facilities;
2. Non-par providers such as assistant surgeons, radiologists, anesthesiologists, pathologists and labs who treat patients at par facilities; and
3. Non-par providers who have received an authorization to provide services because of a member's lack of access to a par provider (these authorizations are known as "gap exceptions"); and
4. Physicians who refuse to participate in an insurer's network, and in many cases in no insurers' networks.

Because these providers have learned that insurers often want to protect their members from being balance billed – and in some states are required to "hold the member harmless," they often act with impunity. Although much progress has been made in the past 10 years to control claim payments to non-participating providers, there remain certain physicians and facilities that are far outside the bounds of reasonable billing. Initial HCE analysis reflects $300 million in payments over 500 percent of Medicare.

Methods of claim payment are governed by members' "Certificates of Coverage" (fully insured) and "Summary Plan Descriptions" (ASO or self-funded), which are largely regulated by state and federal laws. In many states, like New York, state regulations require that individuals be "held harmless" for out-of-network charges. So insurers end up paying billed charges – no matter how unreasonable – so a member will not be billed for the unpaid balance – or "balanced billed." However, unless providers are paid their full billed charges, they may – and can – bill members for the balances and regulatory and legal inquiries may result.

The lack of controls has led to an escalation in costs. Nevertheless, there are opportunities, under a variety of legal theories, to offer alternative payments and still protect the member.

MEDIA PLAN

Situation Analysis

- Stories around "surprise medical bills" continue to garner media coverage, including coverage of our own missteps in paying egregious bills.
- Extensive media coverage of our network changes over the past six months has sensitized the public – including the media – to any further initiatives we may undergo to increase quality and control costs.
- This program targets physician outliers and takes members out of the middle of out-of-network billing disputes in most cases – so should be seen as a positive development (i.e., combatting fraud, addressing inflated costs, etc.); however, medical societies, public officials and consumer advocates may try to frame this as another assault on choice.

Objectives

- Increase understanding of the problems around out-of-network billing and its impact on individuals and the overall health care system;
- Increase understanding of insurers' role in controlling charges that may defy common sense – and more significantly our role in addressing this issue for our members;

- Minimize reputational risk; and
- Balance the tone of stories; ensure that UnitedHealthcare's key messages are included and that UnitedHealthcare is positioned reasonably and fairly in coverage

Tactics

- Develop extensive messaging including media statement, general talking points, questions and answers and other materials to support our media and other outreach efforts.
- Craft pitch e-mails to select media outlets for interviews on:
  - Billing/pricing dynamics in the marketplace and its impact on members; and
  - UnitedHealthcare out-of-network billing practices initiative.
- Identify and prepare one or two key spokespersons to conduct proactive media outreach.
- Regularly review media coverage and other responses to initiative to determine additional communications needs (i.e., advertising, op-eds, further media engagement).

Proactive Media Outreach

- *The New York Times*, Reed Abelson and Roni Rabin
- *Crain's New York Business*, Barbara Benson
- Newsday, Ridgely Ochs
- New York Daily News, Melissa Klein

Timeline (tentative)

- TBD – Letters drop to physicians and members
- TBD – PR team reaches out to targeted media outlets
- On-going – Monitor media and other key stakeholder response to determine further communications actions (i.e., broader proactive outreach, enhanced messaging, etc.)
- TBD – Tailor plans and materials for additional states

MEDIA STATEMENT

Excessive – often egregious – billing practices by medical professionals who do not participate in insurers' networks are a significant concern. UnitedHealthcare continues to look for opportunities to positively impact the quality and cost of care our members receive. Reforming how we work with non-network physicians will provide our members greater protection from "surprise bills" while addressing excessive – and often egregious – billing practices by some medical professionals. We will continue to engage and collaborate with members, employers and interested physicians to ensure access to affordable, quality care.

TALKING POINTS

Overall

- UnitedHealthcare is committed to collaborating with physicians, employers, public officials and others to help reform our health care system. The overall goal is to ensure that individuals have access to affordable quality care by eliminating waste, fraud and abuse; ensuring adherence to evidence-based medical care; and providing individuals with information to make the best care decisions, among others.
- Some out-of-network physicians may bill excessive – or egregious – charges sometimes more than 500 percent of Medicare rates or 90 percent of Fair Health rates for care because they know that insurers are required to hold members harmless are a significant part of the affordability problem.
- We want to thank the more than 750,000 physicians and other health care providers who work with us to ensure members have in-network access to care.
  - We believe health care provider networks encourage better health care outcomes for patients by focusing on their specific needs.

- Our intent is to work with physicians to further assist in keeping members healthy, preventing sickness and reducing unnecessary services and trips to the emergency room.
- Our focused networks support UnitedHealthcare's efforts to work collaboratively with care providers to provide quality, affordable health care coverage for our members.

About Initiative

- Many are shocked by "surprise billing" stories – suggesting physicians' demands for payments defy "common sense." Insurers, consumer advocates, public officials and others have introduced ways to address excessive – and more significantly egregious – out-of-network bills – and ways to hold members harmless.
  - There is no silver bullet to addressing this on-going – and escalating – issue.
- This out-of-network payment initiative takes our members out of the middle, as physicians will need to work with us to resolve any payment issues.
- UnitedHealthcare is reviewing all claims from non-participating providers, but currently only ones deemed excessive – or worse, egregious, will be part of this process.
  - Some physicians in the New York area have been billing in excess of 90-percent of Fair Health or greater than 500-percent of "usual and customary rates" set by the Centers for Medicare and Medicaid Services (CMS).
  - Physicians may contact us to discuss payments, providing justification with documentation to support the billed amount.
  - Physicians will be notified that they can no longer balance bill members – and we are requesting that members notify us if physicians try.
- UnitedHealthcare has modified the "explanation of benefits" that members receive following an office visit or procedure.
  - Members who received care from non-network providers will be alerted that they are not responsible for payment beyond what UnitedHealthcare has reimbursed those physicians.
  - If providers send any follow-up bills to the members, members should call the number of the back of their ID cards.

DATA

- Initial number of providers – 100
- Geographic location – New York City, Long Island, Hudson Valley
- Specialties – cardiology, oncology, dermatology, anesthesiology [PLEASE ADD OTHERS IF NEEDED]
- Impacted number of members – [ADD]

QUESTIONS AND ANSWERS

General

Why is UnitedHealthcare undertaking this initiative?

Excessive – often egregious – billing practices by medical professionals who do not participate in insurers' networks are a significant concern in addressing the quality and affordability of care. Member concerns about out-of-network bills – often deemed surprises – continue to increase. Also in reviewing out-of-network claims, we have identified physicians who continually bill significantly over Medicare and Fair Health rates. The most egregious are billing in excess of 500 percent of Medicare and 90-percent of Fair Health with no justification for those charges. For example, [ADD].

Reforming how we work with non-network physicians will provide our members greater protection from "surprise bills" while addressing excessive – and often egregious – billing practices by some medical professionals. We will continue to engage and collaborate with members, employers and interested physicians to ensure access to affordable, quality care.

What is UnitedHealthcare doing?
UnitedHealthcare is reviewing all claims from non-participating providers. Only ones deemed excessive – or worse, egregious, will be part of this broader review process initially. UnitedHealthcare will review information on the submitted bill and available medical records against the amount billed and determine based on Medicare rates or Fair Health rates, depending on the plan – forward what would be deemed as reasonable reimbursement. Physicians may contact us to discuss payments, providing justification with documentation to support the billed amount. Out-of-network physicians also are being notified that they can no longer balance bill members – and we are requesting that members notify us if physicians try.

Doesn't UnitedHealthcare already do this?
UnitedHealthcare has several initiatives to address out-of-network billing and this is another to address the most excessive – often egregious – outliers.

Who will be affected?
UnitedHealthcare will review all claims from out-of-network physicians and other health care providers who are providing care to UnitedHealthcare and Oxford Health Plan employer-sponsored plan members.

Are other health insurers undertaking like initiatives?
UnitedHealthcare is not the only insurer that is being impacted by this issue so other insurers are engaged in their own initiatives while also collaborating with state health associations and others to address the issue.

What is the cap?
UnitedHealthcare is reviewing all out-of-network physicians and other health care providers; however will only engage with ones that exceed a certain percentage of Medicare rates or Fair Health. [DO WE WANT TO PROVIDE GUIDELINES AS WORRY ABOUT "RACE TO BAR" ON BOTH SIDES]

Will UnitedHealthcare save as much money as it will have to expend in managing the process and negotiating with what it perceives as outliers?
This is not about saving money in the short-term but about addressing issues that impact affordability for the long term – and protecting our members from billing surprises. Excessive – often egregious billing – for out-of-network services has a significant impact on health care affordability. When physicians bill for services that are 400-, 500-percent or more of Medicare rates and upwards of 90-percent of Fair Health rates, there is a problem that needs to be talked about and addressed.

Is this initiative designed to force physicians to join networks?
Physicians may opt not to join insurers' networks or select insurers' networks for a number of reasons . However, it does not mean that these physicians do not have a responsibility to their patients and the employers that pay for these services to bill reasonably for services –not 400-, 500-percent or more of Medicare rates and upwards of 90-percent of Fair Health rates without justification.

You mention that your networks help address the cost and quality of care. While we understand the cost piece, how do your networks help address quality?
At UnitedHealthcare, we are continuing to work to build focused networks of health care providers with whom we can collaborate more closely to have the most positive impact in our members. These networks will help us to better coordinate care and increase member satisfaction, while providing continued, comprehensive access to a robust health care delivery network.

We have no way of knowing the quality of care our members are receiving when they seek care through out-of-network providers.

So dollars saved on out-of-network spend will then go to reward in-network physicians?
Certainly any savings from excessive – or egregious – billing can be used toward rewarding our in-network physicians for helping us provide quality, affordable care to our members. It also can provide us additional

resources to develop new technologies, tools and programs to address the quality and affordability issues that face our nation's health care system.

Is this initiative designed to force patients to seek in-network care?
No. Employers pay a premium to enable their employees to be able to access out-of-network care – but members need to be aware of what "going out of network" entails and how much they may have to pay on top of their co-insurances and deductibles for that care.

UnitedHealthcare does have one of the largest networks in the country – and in the New York metropolitan area – with world-class hospitals and world-renowned specialists. If a member has been referred to an out-of-network provider but wants to see if there is one in-network who can address their health needs, he can call the number on the back of his card for assistance – or go to www.uhc.com or www.oxhp.com for our online provider directories.

Will this protect consumers from all out-of-network bills?
No. [NEED GREATER CLARIFICATION]

Are there exceptions where UnitedHealthcare will just pay the billed charges (i.e., gap exceptions)?
Yes. The most common scenario is where we do not have a provider in the geographic area to provide needed care to a member. In that case, we would allow the member to see the provider and pay accordingly.

How do you think the medical societies will respond?
While we cannot speak for the medical societies, excessive – and often egregious – billing and any unethical practices by any physicians are not good for consumers, other physicians and the health care system as a whole.

UnitedHealthcare has implemented a number of programs to address surprise and egregious billing, and other related issues associated with out-of-network utilization. How does this one fit into your need to reign in out-of-network utilization and costs?
We believe a more vigilant process around out-of-network payments; continued consumer education; and on-going collaboration with interested third-parties will continue to advance our efforts to address this significant issue.

Why does this not apply to Medicare or Medicaid members?
Federal and state programs, like Medicare Advantage and Medicaid plans, do not offer out-of-network coverage, except in very distinct cases where physicians would accept Medicare or Medicaid rates without balance billing the member.

"Hold Members Harmless"

What does UnitedHealthcare mean by "hold harmless"? How will it hold members harmless?
[WAITING FOR CLARIFICATION FROM NORTHEAST LEGAL]

Why do all states not adapt legislation that does not allow for physicians to balance bill members?
Each state addresses the issue over out-of-network coverage and billing differently. UnitedHealthcare works within state regulations and requirements to help protect members.

What if a physician still sends a member to collections for the balance of the unpaid bill?
[WAITING FOR CLARIFICATION FROM NORTHEAST LEGAL]

Are there any scenarios in which an individual will be responsible for additional payments to the provider? If yes, how will he/she know to pay that bill?
[NEED EXAMPLES]

If a member has out-of-network benefits and is only on the hook for co-insurance and deductibles – and not the balance of the bill, won't this encourage more individuals to go out of network?
We do not believe so as the vast majority of our members see the broader benefit of seeking care in network. However for those who still choose to go out of network, our efforts will ensure that their co-insurance is based on a percent of reasonable charges. For example, members will have to pay more for 20 percent of a $50,000 bill than 20 percent of a $10,000 bill.

What can members do to protect themselves from egregious out-of-network charges?
There are a number of things members can do to protect themselves from excessive – or even egregious – out-of-network bills. [PULL APPROVED LANGUAGE FROM 2012 NEW YORK CAMPAIGN]

- Stay with contracted physicians.
- Know before you go.
- Ask to see only in-network providers.
- Get it in writing.

UnitedHealthcare offers many plan designs that have out-of-network benefits but seem to be discouraging members from using these. Why?
We want to provide our members with the flexibility to access the health care system to best address their care needs. However, members need to understand how their benefits work; how best to maximize those benefits; and the impact of the choices they make on the cost of their care.

New York-Specific

Is New York the only state you are targeting? If no, what other states will you be introducing this initiative in?
This initiative currently only applies to New York-sitused members, meaning those who have plans that were sold in New York.

Why New York first?
UnitedHealthcare has been focused on addressing the issues around excessive – often egregious – billing in the New York metropolitan area for several years – most especially New York State.

Did the New York State Department of Financial Services approve this initiative? CMS?
No.

Can you provide some examples of what UnitedHealthcare would deem excessive and egregious bills in New York?
[VINCE TO PROVIDE]

Will UnitedHealthcare be reporting these physicians to the New York State Department of Financial Services and the Department of Insurance?
Initially, no. However, we will begin to report physicians who continue to show patterns of excessive – and most significantly egregious – billing to these two departments, particularly in cases of suspected fraud, as required.

How does this affect the recently passed legislation in New York regarding the expansion of out-of-network coverage?
It doesn't. The legislation requires health insurers to provide benefit plans with out-of-network options, which does not take effect until 2015. What the legislation did not address was the amount out-of-network physicians can charge for their services – some of which are beyond egregious.

EXHIBIT 19

EXHIBIT 19

Out-of-Network Billing Review and Payment Process –
Media Statement/Talking Points/Q&As
(with examples for Florida, New Jersey, New York, Texas)
Monday, September 8, 2014 (updated)

(Note: Still working on Arizona. The following states are part of Phase 3 and 4 roll-outs through mid-October – California, Illinois, Missouri, Pennsylvania, Virginia and Wisconsin. Examples are being collected now.)

MEDIA STATEMENT

Out-of-network billing by some providers is out of control, with some charging 60 to 95 times more than Medicare rates and 10 or more times greater than [STATE] averages. To address this significant price gouging by these providers, we are stepping up our work to lower members' out-of-pocket costs in the face of excessive – often egregious – bills and shield them from threats of balance billing.

TALKING POINTS

Overall

- A small number of providers in [STATE] are treating their medical licenses as license to price gouge, and we are stepping in to protect our members from excessive out-of-pocket costs and balance billing.
- Some providers may submit excessive – often egregious – bills in excess of what is outlined in members' "Certificates of Coverage" for out-of-network care because they know that in some situations insurers are required to "hold members harmless." These include receiving services in the emergency room or needing exceptions, referred to as gap exceptions, to see particular physicians.
- Even worse, under current law, these providers don't even have to disclose their outrageous fees to members or how much members will have to pay above their insurance reimbursement.
- This lack of transparency and disclosure – and members lack of understanding about their out-of-network benefits – may lead to "surprise bills," which often exceed amounts that members would reasonably be expecting to pay.
- Insurers, consumer advocates, public officials and others have introduced ways to address excessive – and more significantly egregious – out-of-network bills – and ways to hold members harmless – but there is no one "perfect solution."
- We are determined to provide our members greater protection from "surprise bills" while addressing excessive – and often egregious – billing by some medical providers – and hopefully slow "rate creep" among out-of-network providers in certain specialties.
- We will continue to engage and collaborate with members, employers and interested providers to ensure access to affordable, quality care.

About Out-of-Network Billing Review and Payment Process

- We know how important affordable health care is for our members, and we take our role very seriously to ensure we help keep our members informed regarding the costs they may incur and their options so they can make better health care decisions.
- We understand that members may choose to seek care from out-of-network providers, but our [STATE] members are increasingly being caught by surprise by extremely high out-of-network provider bills. Some bills are multiple times higher than what is being charged by in-network providers in the same geography for the same procedure.

- UnitedHealthcare has enhanced our out-of-network claims review and payment processes, and increased our outreach to members to make sure they understand the potential costs and their options
- UnitedHealthcare is enhancing and adapting already-existing procedures to address issues around excessive – often egregious – billing practices by out-of-network providers.
- We will review all out-of-network claims and utilization to ensure fair and reasonable charges for services based on accepted payer databases, medical records and other variables. In cases where charges are excessive based on these criteria, we will intervene on the members' behalf to negotiate a more reasonable, fair payment.
- We are making sure providers do not continue to harass members through balance billing or other punitive practices.
- In certain circumstances, such as services received in the emergency room, network gap exceptions and other select instances, out-of-network providers will be reimbursed at an appropriate percentile of FAIR Health or Medicare, based on members' plans, which is consistent with the services rendered. Members will still be responsible for their in-network copays, coinsurance and/or deductibles required under their benefit plans.
  - Under these situations, providers will be notified that they cannot balance bill members.
  - A provider may file an appeal, providing requested information, which we may accept and alter the payment accordingly.
    - In New York, providers must get members' consent to file an appeal post-payment. However, if a provider refuses to accept the lower paid amounts, he may call us to discuss each particular case, providing justification with documentation to support the billed amount.
    - [Clarifying for Arizona, California, Florida, Illinois, Missouri, New Jersey, Pennsylvania, Texas, Virginia and Wisconsin]
  - UnitedHealthcare will notify the member via a letter not to pay any additional amount over what we have paid the provider.
  - If a provider has already balance billed a member or sent the matter to collections, we ask that the member contact us immediately by calling the number on the back of his card or the number on the egregious billing notification letter.
  - If a provider continues to balance bill the member or has sent the matter to a collections agency, UnitedHealthcare may seek legal action to step in on the member's behalf.
- Members who voluntarily use their out-of-network benefits will continue to be subject to the member cost-sharing provisions of their benefit plans, including potential balance billing by out-of-network providers.

Additional Talking Points

- UnitedHealthcare is committed to collaborating with physicians, employers, public officials and others to help improve our health care system. The overall goal is to ensure that our members have access to affordable quality care by eliminating waste, fraud and abuse; ensuring adherence to evidence-based medical care; and providing members with information to make the best care decisions, among others.
- We want to thank the more than 750,000 physician and other health care providers who work with us to ensure members have in-network access to care.
  - We believe health care provider networks encourage better health care outcomes for patients by focusing on their specific needs.
  - Our intent is to work with physicians to further assist in keeping members healthy, preventing sickness and reducing unnecessary services and trips to the emergency room.
  - Our focused networks support UnitedHealthcare's efforts to work collaboratively with care providers to provide quality, affordable health care coverage for our members.
- We will continue to work with our members to ensure they understand their health benefits and have the tools necessary to make educated care and financial decisions when seeking care. For example, members can use the Health4Me app to find out the average cost for various courses of treatment by region to determine how much they may have to pay for out-of-network care.

QUESTIONS AND ANSWERS

General

Why is UnitedHealthcare undertaking this effort?

- Excessive – often egregious – billing practices by medical providers who do not participate in insurers' networks are a significant concern in addressing the quality and affordability of care. Members are free to use their out-of-network benefits and pay for this option. However, members are concerned about surprise bills – and bills for out-of-network providers when members have no choice in what provider they see or are unaware that they may be seeing out-of-network providers.
- We have seen a significant increase in customer complaints surrounding "surprise bills" or out-of-network bills that members felt were unreasonable.
- In reviewing out-of-network claims, we have identified providers who continually bill significantly over Medicare and FAIR Health rates. The most egregious are billing in excess of 500 percent of Medicare and the 90th percentile of FAIR Health with no justification for those charges. We will review providers who bill far in excess of the amount billed by their peers for similar services in the same location.
- Improving how we work with out-of-network providers will provide our members greater protection from "surprise bills" while addressing excessive – and often egregious – billing practices by some medical providers.
- We will continue to engage and collaborate with members, employers and interested providers to ensure access to affordable, quality care.

What is UnitedHealthcare doing?

UnitedHealthcare is enhancing its out-of-network claims review and payment process to address excessive out-of-network charges. While we will be reviewing all out-of-network claims under this enhanced process, we have identified a group of providers who are billing in excess of 500 percent of Medicare and the 90th percentile of FAIR Health with no justification for those charges.

For those charges deemed excessive – or worse, egregious, UnitedHealthcare will review information on submitted bills and available medical records against the amount billed. Using Medicare rates or FAIR Health rates, depending on the members' plans, UnitedHealthcare will determine what would be deemed as reasonable reimbursement. Providers may contact us to discuss payments, providing justification with documentation to support the billed amount. Out-of-network providers also are being notified that they cannot balance bill members in certain situations where UnitedHealthcare is paying them at the in-network rate. We are requesting that members notify us if providers try to balance bill them.

What is balance billing?

Physicians, other health care professionals, hospitals and other facilities bill members for the difference between what they want to charge for services and what the insurance company has already reimbursed them. Balance billing is not allowed in many states for commercial members, and for all Medicare and Medicaid enrollees. In states where balance billing is still permitted, excessive – often egregious – billing is a significant problem for insurers and members.

What is FAIR Health?

An industry standard for determining reasonable and customary rates is through the use of the FAIR Health database, which is run by an independent non-profit entity called FAIR Health Inc. It collects and compiles actual charges from physicians and other providers by geographic area to help in determining regional rates for various procedures. The reimbursement data compiled by FAIR Health is based on practice patterns and charges submitted by specialists rendering similar services in the same geographic area. For example, the 90th percentile of FAIR Health means that 90 percent of all fees billed by providers in that geographic area are at or below the level indicated by the 90th percentile.

How big is the problem? How much money does UnitedHealthcare plan to save from this enhanced process?
We have enhanced our out-of-network claims review and payment process to protect our members from excessive – often egregious – bills by helping lower members' out-of-pocket costs in the face of excessive – often egregious – bills and protecting them from threats of balance billing by providers – of course within the scope of their benefit plans. CMS sets its own fees based on a formula that includes the relative time and intensity of the service, costs, inflation and geographic variations.

UnitedHealthcare has been the subject of several stories on excessive – or egregious – billing. Why has it taken so long to address this issue?
UnitedHealthcare has ongoing efforts to address out-of-network billing practices and continues to enhance these processes to address the most excessive – often egregious – providers.

UnitedHealthcare is known for just paying charges above the members' benefits for out-of-network services in many instances. Why now start going after out-of-network providers?
UnitedHealthcare is committed to supporting our members by helping lower members' out-of-pocket costs in the face of excessive – often egregious – bills and protecting them from threats of balance billing by providers – of course within the scope of their benefit plans. Under this enhanced process, we are requiring additional information to determine if charges are justified and how best pay for those services.

Who will be affected?
UnitedHealthcare will review all claims from out-of-network physicians and other health care providers who are providing care to UnitedHealthcare and Oxford Health Plan employer-sponsored plan members in [STATE].

How many physicians is UnitedHealthcare targeting?
UnitedHealthcare will review all claims from out-of-network physicians and other health care providers who are providing care to UnitedHealthcare and Oxford Health Plan employer-sponsored plan members. While our focus may be on those providers who are submitting the most excessive – often egregious – claims, we also will monitor any changes in billing practices by other out-of-network providers.

Physicians argue that they do not participate in insurers' networks because payments are too low – and that programs like this are just another way for health insurers to pay less than adequate rates for services. Is this initiative designed to force physicians to join networks?
Providers may opt not to join insurers' networks or select insurers' networks for a number of reasons. However, it does not mean that these providers have license to price gouge – having a responsibility to their patients and the employers that pay for these services to bill reasonably for these services.

Are other health insurers implementing similar procedures?
While UnitedHealthcare is addressing excessive – and often egregious – billing practices on behalf of its members, we are not the only health insurer addressing this issue on behalf of its members. In addition, we are collaborating with other insurers, state health associations and other organizations to address this significant health and financial issue.

Aetna has been very aggressive in going after out-of-network physicians for certain billing practices and physician groups have sued the carrier. Is UnitedHealthcare worried about this?
While we cannot comment on what Aetna or other health insurers are doing, we are reviewing all out-of-network claims and utilization to ensure fair and reasonable charges for services based on accepted payer databases, medical records and other variables. In cases where charges are excessive based on these criteria, we will intervene on the members' behalf to negotiate a more reasonable, fair payment. We cannot say what providers will do if we do not reach a mutually agreeable rate based on medical records, evidence-based guidelines and other information.

What reductions are you hoping to get?
UnitedHealthcare is reviewing all out-of-network physicians and other health care providers. While our focus may be on those providers who are submitting the most excessive – often egregious – claims, far in excess of the amount billed by their peers for similar services in the same location based on members' plans, we also are monitoring any changes in billing practices by other out-of-network providers.

Why is UnitedHealthcare applying the FAIR Health to claims by certain out-of-network providers instead of paying billed charges?
UnitedHealthcare's payment policies are based on the terms of the "Certificates of Coverage" (COCs) issued to customers and the standards set forth in the FAIR Health and CMS. Oxford's COCs use "reasonable and customary" as the payment method for out-of-network providers. An industry standard for determining reasonable and customary rates is through use of the FAIR Health database. The compensation is fair and within the range of payments typically accepted.

Why is UnitedHealthcare applying Medicare (CMS) rates to claims by certain out-of-network providers instead of paying billed charges?
UnitedHealthcare's payment policies are based on the terms of the "Certificates of Coverage" (COCs) issued to customers. UnitedHealthcare's COCs use Medicare (CMS) rates as one of the payment methods for out-of-network providers. Medicare rates are considered an objective third-party standard for payment. The compensation is fair and within the range of payments typically accepted.

Will UnitedHealthcare save as much money as it will have to expend in managing the process and negotiating with what it perceives as outliers?
This is about addressing issues that affect affordability for the long term – and protecting our members from billing surprises. Egregious billing for out-of-network services has a significant impact on health care affordability. When providers bill for services that are 400-, 500-percent or more of Medicare rates and upwards of the 90th percentile FAIR Health, without justification for these charges, there is a problem that needs to be addressed.

You mention that your networks help address the cost and quality of care. While we understand the cost piece, how do your networks help address quality?
At UnitedHealthcare, we are continuing to work to build focused networks of health care providers with whom we can collaborate more closely to have the most positive impact in our members. These networks will help us to better coordinate care and increase member satisfaction, while providing continued, comprehensive access to a robust health care delivery network.

So dollars saved on out-of-network spend will then go to reward in-network providers?
Certainly any savings from excessive – or egregious – billing can be used toward rewarding our in-network providers for helping us provide quality, affordable care to our members. It also can provide us additional resources to develop new technologies, tools and programs to help our members make more informed health care decisions and to address the quality and affordability issues that face our nation's health care system.

Is this initiative designed to force members to seek in-network care?
No. Employers pay a premium to enable their employees to be able to access out-of-network care, but members need to be aware of what "going out of network" entails and how much they may have to pay in addition to their co-insurance and deductibles for that care.

UnitedHealthcare does have one of the largest networks in the country – and in [STATE] – with world-class hospitals and world-renowned specialists. If members have been referred to out-of-network providers but want to see if there are ones in network who can address their health needs, they can call the number on the back of their cards for assistance – or go to www.uhc.com or www.oxhp.com for our online provider directories.

Will this protect members from all out-of-network bills?
No. Only members in certain circumstances, such as gap exceptions and emergency care, will be included in this process – and will receive communications about their particular charges. Of course, if a member has any questions about an out-of-network bill, he should call the number on the back of his ID card to get any additional information.

Are there exceptions where UnitedHealthcare will just pay the billed charges (i.e., gap exceptions)?
It depends on whether the billed charge is reasonable and in accordance with the member's benefit plan. The most common scenario is where we may not have a particular specialist in the geographic area to provide needed care to a member. In that case, we would cover the services of the out-of-network provider at the in-network reimbursement rate. However, even in these situations, we will work with out-of-network providers to accept reimbursement that is reasonable.

How do you think the medical societies will respond?
While we cannot speak for the medical societies, excessive – and often egregious – billing and any unethical practices by any physicians are not good for consumers, other providers and the health care system as a whole.

Do you think more providers will opt out of insurers' networks as they are being asked to do more and more while making significantly less money?
While I cannot comment on what providers will do, we know that our network continues to grow not only in [STATE], but across the country. We continue to refine how we pay providers, recognizing quality of care over quantity of services – and more hospitals and physician practices are interested in getting into some kind of accountable care relationship with us.

UnitedHealthcare has implemented a number of programs to address surprise and egregious billing, and other related issues associated with out-of-network utilization. How does this one fit into your need to rein in out-of-network utilization and costs?
We believe a more vigilant process around out-of-network payments; on-going consumer education; and further collaboration with interested third-parties will continue to advance our efforts to address this significant issue.

Why does this not apply to Medicare or Medicaid members?
Federal and state programs, like Medicare Advantage and Medicaid plans, do not offer out-of-network coverage, except in very distinct cases where providers would accept Medicare or Medicaid rates without balance billing members.

UnitedHealthcare has been kicking doctors out of its networks since last year. Now it is taking on out-of-network providers – many of whom may have been impacted by its network downsizing. It appears that UnitedHealthcare is continuing to limit choice for its members and punishing providers without cause.
At UnitedHealthcare, we are continuing to work to build focused networks of health care providers with whom we can collaborate more closely to have the most positive impact in our members. These networks will help us to better coordinate care and increase member satisfaction, while providing continued, comprehensive access to a robust health care delivery network.

With respect to out-of-network providers, some are engaging in significant price gouging – and we have no way to measure whether that care is quality care but at least we can help ensure that billed charges are fair and reasonable.

Why should members be surprised by any provider bill?
Individuals should have a basic understanding of how their benefits work; how much providers will charge for entire episodes of care; and whether they will be balance billed if carriers do not pay the full charged amount. While much of this information can only be obtained by asking providers, individuals can get some basic "cost of care" information for their regions from cost estimator tools like UnitedHealthcare's myTreatmentCostEstimator

available on myuhc.com and its Health4Me app, and some quality metrics like UnitedHealthcare's Premium Designation initiative.

"Hold Members Harmless"

What does UnitedHealthcare mean by "hold harmless"? How will it hold members harmless?
"Hold harmless" means that in certain circumstances an insurer must protect a member from being financially liable for a balance bill from a provider. We strive to help members understand their benefits, including out-of-network benefits, and protect members from excessive – often egregious – billing, including:

1) Educating members about the wise use of their out-of-network benefits.
2) Notifying members through their certificates of coverage and other means that they are not financially responsible for out-of-network provider services in certain circumstances (e.g., emergency care, in-network exceptions).
3) Providing a broad network to serve the health care benefit needs of members.
4) Requiring in-network providers to use their best efforts to refer members to in-network specialists and facilities.
5) Entering into a shared savings program to reduce out-of-network provider medical expenses for members by obtaining discounted rate agreements whereby the provider agrees to accept a discounted amount as payment in full.
6) Intervening with collection agencies to negotiate a resolution to balance billing on an individual basis.
7) Bringing legal action on the member's behalf to resolve the dispute and protect the member from balance billing.
8) Assuming financial responsibility for any claims that are not ultimately resolved through initial payment to the out-of-network provider, a negotiated payment or legal action.

SCENARIO – We will intervene with providers and collection agencies related to threats of balance billing. We ask that members inform us immediately if they are balance billed or even threatened with a balance bill. We will then contact the provider and tell them that UnitedHealthcare will protect its members from any attempt to hold the member liable for any amounts more than coinsurance, copay or deductibles. We will warn them not to balance bill our members. If a collection agency is involved, we will contact the collection agency and demand that they deal with UnitedHealthcare directly to resolve the dispute. All communication with providers and collection agencies will be with UnitedHealthcare, not the member. We will make clear that we will reserve our rights to take any and all legal action if necessary, and then we will follow through with such action. One step we will take if necessary is to seek an injunction to stop providers from balance billing members for the unpaid and excessive fees at issue.

Typically, in what scenarios would you not hold the member harmless?
Generally speaking, we are not required to hold the member harmless when the member has voluntarily chosen to use out-of-network benefits. For example, I have out-of-network benefits in my Certificate of Coverage so I decide I want to see Dr. Smith for my hip replacement surgery. Dr. Smith is out of network. I could go to Dr. Anderson, another orthopedic surgeon who is in-network and in my geographic area instead. I decide that I'm willing to see Dr. Smith and pay a greater coinsurance and be billed for the difference between Dr. Smith's charges and what UnitedHealthcare pays under my Certificate of Coverage.

Why do all states not adopt legislation that does not allow for providers to balance bill members?
Each state addresses the issue over out-of-network coverage and billing differently. UnitedHealthcare works within state regulations and requirements to help protect members.

What if a provider still sends a member to collections for the balance of the unpaid bill?

In many instances, we will intervene with collections agencies to negotiate resolutions on behalf of our members.

What can members do to protect themselves from excessive – or egregious – out-of-network charges?
There are a number of things members can do to protect themselves from excessive – or even egregious – out-of-network bills.

- **There is safety in networks** – UnitedHealthcare works closely with physicians and other health care providers and hospitals to ensure that members have access to a robust network of health care professionals. In addition, UnitedHealthcare provides its members with quality and cost information through tools, like Premium Designation and myTreatmentCostEstimator.
- **Call us** – On occasion, members call customer service saying that they cannot find in-network providers to address their specific health care needs. For the vast majority of members, we identify in-network providers and members are very satisfied with the level of care they receive.
- **Don't be surprised** – Most plans with out-of-network benefits cover a certain percentage of overall costs, which is clearly stated in a member's "certificate of coverage." In most situations, UnitedHealthcare offers businesses a choice between Medicare rates and FAIR Health rates. Many sites, including UnitedHealthcare's myTreatmentCostEstimator, provide information on costs for various procedures to determine how much your out-of-network costs may be compared with using in-network providers.
- **Ask about balance billing** – In many states, non-network providers are not required to accept Medicare or FAIR Health as "payment in full" and can balance bill members the remaining amounts if they choose. Ask your provider if he accepts Medicare or FAIR Health rates as payment in full – and get it in writing. If he does not, ask how much the entire episode of care will cost.
- **Ask to see only in-network providers** – You should have a firm understanding not only what is involved in the procedure from pre-op through recovery, but how much the cost of care will be and what you will be responsible for. Even if you are seeing an in-network provider, be sure that other attending physicians, such as assisting physicians and anesthesiologists, are also in-network because you may be responsible for those costs.

UnitedHealthcare offers many plan designs that have out-of-network benefits but seem to be discouraging members from using these. Why?
We want to provide our members with the flexibility to access the health care system to best address their care needs. However, members need to understand how their benefits work; how best to maximize those benefits; and the impact of the choices they make on the cost of their care, especially when they seek care from out-of-network providers.

When are you rolling this out in other states?
We currently review out-of-network billing nationally, and are implementing a more robust review and payment process to address excessive – and often – egregious billing practices across the country.

EXAMPLES OF EXCESSIVE – OR EGREGIOUS – BILLING

FLORIDA

Florida Data

- Number of providers being reviewed – UnitedHealthcare is looking at claims from all out-of-network providers in Florida, and are reviewing providers who bill far in excess of the amount billed by their peers for similar services in the same location.
- Geographic impact – While UnitedHealthcare is looking at claims from all out-of-network providers across the state, the majority of excessive – often egregious – claims we have seen are from providers in Fort Lauderdale, Miami, Orlando and Tampa.
- Specialties – UnitedHealthcare is looking at all out-of-network providers including providers in primary care and specialties including cardiology, oncology, dermatology, anesthesiology and plastic surgery.
- Impacted number of members – n/a

Florida-Specific Questions

[Will add]

Florida Examples

- A physician's assistant charged $10,000 for breast reconstruction on an outpatient hospital basis. This is more than 18.5 times higher than Medicare and nearly 8 times higher than the 90th percentile of FAIR Health ($1,349.12). The physician's assistant charge is 29.6 times the average participating provider reimbursement in Florida for this procedure.
- A specialist in emergency medicine charged $4,184.00 for outpatient services, which is more than 22.8 times higher than Medicare and nearly 6 times higher than the 90th percentile of FAIR Health ($605.00). The payment based on FAIR Health would have been $605.00, not $4003.00. The specialist's charge is 6.7 times the average participating provider reimbursement in Florida for this procedure.
- A orthopedic specialist charged $100,300.00 for spinal fusion on an outpatient hospital basis. This is more than 18 times higher than Medicare and nearly 3 times higher than the 90th percentile of FAIR Health ($33,186.00). The orthopedic specialist's charge is 17 times the average participating provider reimbursement in Florida for this procedure.
- A general surgery specialist charged $21,900.00 for laparoscopy appendectomy on an inpatient hospital basis. This is more than 15 times higher than Medicare and nearly 5 times higher than the 90th percentile of FAIR Health ($4,288.00). The general surgery specialist's charge is 15 times the average participating provider reimbursement in Florida for this procedure.
- A general surgery specialist charged $22,205.00 for laparoscopic cholecystectomy on an inpatient hospital basis. This is more than 23 times higher than Medicare and nearly 7 times higher than the 90th percentile of FAIR Health ($3,032.00). The general surgery specialist's charge is 23 times the average participating provider reimbursement in Florida for this procedure.
- A orthopedic specialist charged $92,300.00 for removing spinal lamina and low back disk surgery on an outpatient hospital basis. This is more than 30 times higher than Medicare and nearly 5 times higher than the 90th percentile of FAIR Health ($16,114.00). The orthopedic specialist's charge is 32 times the average participating provider reimbursement in Florida for this procedure.
- A orthopedic specialist charged $36,300.00 for removing spinal lamina on an outpatient hospital basis. This is more than 23 times higher than Medicare and nearly 4 times higher than the 90th

percentile of FAIR Health ($7,911.00). The orthopedic specialist's charge is 25 times the average participating provider reimbursement in Florida for this procedure.

- A general surgery specialist charged $51,377.76 for laparo partial colectomy and a lap mobil splenic on an inpatient hospital basis. This is more than 14 times higher than Medicare and nearly 7 times higher than the 90th percentile of FAIR Health ($6,943.00). The general surgery specialist's charge is 18 times the average participating provider reimbursement in Florida for this procedure.
- A general surgery specialist charged $59,518.88 for a partial removal of colon and wedge biopsy of liver on an inpatient hospital basis. This is more than 25 times higher than Medicare and nearly 10 times higher than the 90th percentile of FAIR Health ($5,742.00). The general surgery specialist's charge is 34 times the average participating provider reimbursement in Florida for this procedure.
- A orthopedic specialist charged $60,000.00 for removal of spinal lamina and low back disc surgery on an outpatient hospital basis. This is more than 24 times higher than Medicare and nearly 4 times higher than the 90th percentile of FAIR Health ($12,644.00). The orthopedic specialist's charge is 28 times the average participating provider reimbursement in Florida for this procedure.
- A orthopedic specialist charged $36,000.00 for removal of spinal lamina on an inpatient hospital basis. This is more than 25 times higher than Medicare and nearly 4 times higher than the 90th percentile of FAIR Health ($7,441.00). The orthopedic specialist's charge is 29 times the average participating provider reimbursement in Florida for this procedure.
- A general surgery specialist charged $57,191.75 for a bronchoscope/wash and a thoracoscopy on an inpatient hospital basis. This is more than 36 times higher than Medicare and nearly 5 times higher than the 90th percentile of FAIR Health ($10,662.00). The general surgery specialist's charge is 20 times the average participating provider reimbursement in Florida for this procedure.

NEW JERSEY

New Jersey Data

- Number of providers being reviewed – UnitedHealthcare is looking at claims from all out-of-network providers in New Jersey, and are reviewing providers who bill far in excess of the amount billed by their peers for similar services in the same location.
- Geographic impact – UnitedHealthcare is looking at claims from all out-of-network providers across the state.
- Specialties – UnitedHealthcare is looking at all out-of-network providers including providers in primary care and specialties including cardiology, oncology, dermatology, anesthesiology and plastic surgery.
- Impacted number of members – n/a

New Jersey-Specific Questions

New Jersey Examples

- A cardiologist charged $22,700 for critical care (first 30-74 minutes), which is more than 75 times higher than Medicare and nearly 18 times higher than the 90th percentile of FAIR Health ($1,250). In this case, if a member was responsible for 20% co-insurance, the payment based on FAIR Health would have been $250, not $4,535. The cardiologist's charge is 95 times the average participating provider reimbursement in Northern New Jersey for this procedure.
- A general surgeon charged $17,300 to assist in the excision of an abdominal tumor, which is more than 56 times higher than Medicare and nearly 7 times more than the 90th percentile of FAIR Health ($2,400). In this case, if a member was responsible for 20% co-insurance, the payment based on FAIR Health would have been

$480, not $3,500. The surgeon's charge is 25 times the average participating provider reimbursement in Northern New Jersey for this procedure.

- An gastroenterologist charged $15,000 for a Upper GI Endoscopy with biopsy, which is more than 34 times higher than Medicare and nearly 14 times higher than the 90th percentile of FAIR Health ($1,089). In this case, if a member was responsible for 20% co-insurance, the payment based on FAIR Health would have been $218, not $3,000.
- A plastic surgeon charged $88,200 for breast reconstruction, which is 45 times greater than Medicare and nearly 12-1/2 times higher than the 90th percentile of FAIR Health ($7,071). In this case, if a member was responsible for 20% co-insurance, the payment based on FAIR Health would have been $1,400, not $17,600. The surgeon's charge is 5 times the average participating provider reimbursement in Northern New Jersey for this procedure.
- A orthopedic surgeon charged $84,650 for a Shoulder arthroscopy with rotator cuff repair procedure, which is nearly 36 times over Medicare and nearly 1-1/2 times over the 90th percentile of FAIR Health ($62,200). In this case, if a member was responsible for 20% co-insurance, the payment based on FAIR Health would have been $12,400 not $16,900.

NEW YORK

New York Data

- Number of providers being reviewed – UnitedHealthcare is looking at claims from all out-of-network providers in New York, and are reviewing providers who bill far in excess of the amount billed by their peers for similar services in the same location.
- Geographic impact – While UnitedHealthcare is looking at claims from all out-of-network providers across the state, the majority of excessive – often egregious – claims we have seen are from providers in New York City, on Long Island and in the Hudson Valley.
- Specialties – UnitedHealthcare is looking at all out-of-network providers including providers in primary care and specialties including cardiology, oncology, dermatology, anesthesiology and plastic surgery.
- Impacted number of members – n/a

New York-Specific Questions

- **Is New York the only state you are targeting? If no, what other states will you be introducing this initiative in?**
  Based on our analysis, we have identified New York-sitused members as a top priority, meaning those who have plans that were sold in New York.
- **Why New York first?**
  UnitedHealthcare has been focused on addressing the issues around excessive – often egregious – billing in the New York metropolitan area for several years – most especially New York State.
- **Did the New York State Department of Financial Services approve this initiative? CMS?**
  Like other insurers, they are aware that we review providers' out-of-network billing practices and are taking steps to address the most egregious cases.
- **How will UnitedHealthcare handle provider practices that may have multiple offices throughout the state? Will you use the Medicare percentage or the percentile of FAIR Health that is lowest if it crosses geographies?**
  UnitedHealthcare will apply Medicare or FAIR Health rates based on the zip code for the office where the procedure was performed based on members' benefit plans. We will monitor billing practices for any significant changes in practice and billing patterns for physicians with multiple locations.
- **Will UnitedHealthcare be reporting these providers to the New York State Department of Financial Services and the Department of Insurance?**

Initially, no. However, we will begin to report providers who continue to show patterns of excessive – and most significantly egregious – billing to these two departments, particularly in cases of suspected fraud or abuse, as required.

- **How does this affect the recently passed legislation in New York regarding the expansion of out-of-network coverage?**
  We agree with the spirit of the law, which takes effect in early 2015, and believe this effort is in keeping with the laws intent – to protect individuals from excessive – often egregious – billing. The law includes several requirements , including, but not limited to, an arbitration process for insurers and providers in the event of surprise billing or gap exceptions. UnitedHealthcare may need to make adjustments to its current efforts but will be compliant with the new law when it takes effect next spring.

New York Examples

- A neurosurgeon charged $55,200 for a back procedure (spinal fusion), which is more than 60 times higher than Medicare. The neurosurgeon's charge is 20 times the average in-network reimbursement in New York County (Manhattan) for this procedure. In this case, if a member was responsible for 20% co-insurance, the payment based on FAIR Health would have been $4,488, not $11,040.
- A physician's assistant charged $25,200 to assist in skin flap surgery for a wound, which is more than 95 times higher than Medicare. The physician assistant's charge is 98 times the average in-network reimbursement for Long Island for this procedure. In this case, if a member was responsible for 20% co-insurance, the payment based on FAIR Health would have been $960, not $5,040.
- An ENT specialist charged $79,000 for a tonsil/adenoid removal and throat drainage, which is more than 70 times higher than Medicare. The ENT specialist's charge is 83 times the average in-network reimbursement for Long Island for this procedure. In this case, if a member was responsible for 20% co-insurance, the payment based on FAIR Health would have been $1,318, not $15,800.
- A surgeon charged $21,000 for breast reconstruction, which is 28 times greater than. The surgeon's charges were 31 times the average in-network reimbursement on Long Island for this procedure. In this case, if a member was responsible for 20% co-insurance, the payment based on FAIR Health would have been $1,000, not $4,200.
- A cardiologist charged $11,960 for an angioplasty/catheterization procedure, which is nearly 30 times over Medicare. The cardiologist's charges were 8 times the average in-network reimbursement in New York City for this procedure. In this case, if a member was responsible for 20% co-insurance, the payment based on FAIR Health would have been $990, not $2,392.
- A plastic surgeon charged $134,500 for an injured finger, which is more than 45 times higher than Medicare. The plastic surgeon's charge is 33 times the average in-network reimbursement on Long Island for this procedure. In this case, if a member was responsible for 20% co-insurance, the payment based on FAIR Health would have been $3,838, not $26,900.

TEXAS

- A physician's assistant charged $15,405.00 for total knee arthroplasty through inpatient hospital services, which is more than 69 times higher than Medicare and nearly 13 times higher than the 90th percentile of FAIR Health ($1,232.64). In this case the payment based on FAIR Health would have been $1,232.64, not $15,405.00. The physician's assistant charge is 66 times the average participating provider reimbursement in Texas for this procedure.
- A plastic and reconstructive specialist charged $32,625.00 for an injection agent with image guidance, which is more than 49 times higher than Medicare and nearly 5 times higher than the 90th percentile of FAIR Health ($6,047.00). In this case the payment based on FAIR Health would have been $6,047.00, not $26,982.28. The specialist's charge is 44 times the average participating provider reimbursement in Texas for this procedure.

- An internist in internal medicine charged $4,600.00 for subsequent hospital care through inpatient hospital services, which is more than 16.3 times higher than Medicare and nearly 5.6 times higher than the 90th percentile of FAIR Health ($808.00).
- An internist in internal medicine charged $7,200.00 for subsequent hospital care through inpatient hospital services, which is more than 17 times higher than Medicare and nearly 6 times higher than the 90th percentile of FAIR Health ($1,182.00).
- An internist in internal medicine charged $6,000.00 for subsequent hospital care through inpatient hospital services, which is more than 17 times higher than Medicare and nearly 6 times higher than the 90th percentile of FAIR Health ($985.00).

EXHIBIT 20

EXHIBIT 20

FILED UNDER SEAL PURSUANT TO PENDING MOTION TO SEAL FILED CONCURRENTLY HEREWITH

EXHIBIT 21

EXHIBIT 21

From: Ullsperger, Dewayne E [/O=UHG-EXCHANGEMAIL/OU=FIRST ADMINISTRATIVE GROUP/CN=RECIPIENTS/CN=7F899A76-C13CD9C1-85256CFD-419696]
Sent: 2/10/2016 1:39:46 PM
To: Ullsperger, Dewayne E [dewayne_e_ullsperger@uhc.com]; Ho, Sam [Sam.Ho@uhc.com]; Rosenthal, Daniel I [daniel_i_rosenthal@uhc.com]; Prospect, Theodore A [ted_prospect@uhg.com]; Sutin, Jessica L [jessica.sutin@uhc.com]

Subject: Out-of-network proposal
Attachments: OONDraft with edits.docx
Location: 1-763-957-6400 ID: 2101752 | Dewayne to Host (9796423)

Start: 2/18/2016 10:00:00 AM
End: 2/18/2016 10:30:00 AM
Show Time As: Busy

Required Attendees: Ho, Sam; Rosenthal, Daniel I; Prospect, Theodore A; Sutin, Jessica L


OONDraft with edits.docx

Per the email sent on 2/10, It should be very good research, however, at present, only UHC data will be used. So, I'd like to have Sam and Dan comment on any guardrails we should include in the data use agreement, concerns they may have, etc

Please note: We appreciate any flexibility in your schedules, but we understand schedules are tight.

Thank you

Tracy Starling, Executive Assistant | BSL | Notary Public
Dewayne Ullsperger, Vice President and Chief Actuary
Thomas Gehlbach, Sr. Vice President, Underwriting
Paul Stordahl, Vice President, Actuarial Pricing
UnitedHealthcare | Employer & Individual Shared Services
9700 Health Care Lane | Mail Stop MN017-W900 | Minnetonka MN 55343
P/952-979-6434 F/952-979-7824
Tracy_Starling@uhc.com

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Plaintiffs' Exhibit
PX 31

EXHIBIT 22

EXHIBIT 22

Out-of-Network providers at In-Network Hospitals: theory and evidence

Zack Cooper, Yale University
Vivian Ho, Rice University
Fiona Scott Morton, Yale University and NBER

February 2016

Bills for healthcare services can take a particularly undesirable form: an out of network bill generated by a provider delivering care inside an in-network hospital. Commonly, physicians do not work for a hospital, but have admitting privileges and treat patients at that hospital. (Despite the fact that hospitals contract with hospital-based physicians), Hospitals and physicians make separate decisions about whether to join networks of different insurers or plans. If the hospital has joined a particular network, a patient may choose to go there to get care. But what she may not realize is that the physician treating her has not signed the agreement with the insurer or plan. In the past, insurers would generally cover these situations as in-network benefits. As insurers and self-funded plan sponsors have attempted to better control these costs and offer more competitive premiums, they have increasingly implemented benefit plan designs that limit coverage for these situations. Therefore, the care provided by that physician ~~is out of network and~~ may be either not covered, or covered at less favorable terms, by her insurance plan. The physician then "balance bills" the patient, who is surprised to receive the bill because she chose to seek care at an in-network hospital.

In what follows, we sketch out plans for two papers focused on identifying the scale of out-of-network billing, understanding the drivers of out-of-network billing, and making policy-recommendations. We will focus on out-of-network billing for anesthesiologists, emergency room physicians, and assistant surgeons for several procedures cited in the popular press. Our aim is to rapidly produce a paper that quantifies the scale of the issue and makes policy recommendations. We will propose a collaboration with the New York Times Upshot featuring the results of this analysis. A second paper, done in the longer term, will focus on understanding how market conditions (i.e. physician market power) influence out-of-network billing.

Out-of-network billing is more common in services where consumers are not able to learn about the physician before getting care (e.g. emergency department care). If a patient has a planned surgery, she will locate and choose a surgeon that belongs to her network as well as a hospital that belongs to her network. But the anesthesiologist who appears during the surgery to help cannot be selected *ex ante* – under current practices – and may be out of network. If so, that anesthesiologist is able to bill whatever he or she chooses. Similarly, in an emergency, patients are likely to travel to the closest in-network hospital where they expect to have coverage. If the entire emergency department is formed of out-of-network physicians, the patient will get treated and then later discover that she effectively went to an

out of network provider. Depending on the benefit plan of the plan sponsor, these charges may be treated as in-network or out-of-network services.

This practice is destructive in several ways. First, consumers attending an in-network facility can face substantial and unexpected bills for out-of-network providers. Often, these out-of-network bills are not covered in full by their insurers and will expose patients to substantial costs. At the extreme, this type of billing practice can lead to bills in the tens of thousands of dollars.

Second, it makes it very difficult for an insurer attempting to create and compete with a narrow network plan. The whole point of such a plan is that it shifts share to a limited set of participating providers and is cheaper as a consequence. But if patients carefully go to the providers in the narrow network and end up with a huge bill anyway, then they will not conclude the product is delivering good value. A consumer might as well sign up for a broad plan at a high price if they are going to pay a high price in the narrow network plan also. Therefore, the competitive advantage of the narrow network plan is reduced. Differentiation among these types of plans is eroded by out of network billing which reduces consumer choice.

Third, competition among physicians is reduced because they can gain surprise access to patients without allowing choice on the basis of price first. If physicians had to join a plan in order to be allowed to treat that plan's patients, they would need to bargain over price and compete with other physicians. Plans would choose among physicians to place in the network based on quality and price. This price competition would tend to lead to lower prices. Similarly, if consumers chose a hospital on the basis of whether the physician was in-network or not, physicians would lose volume by staying out of network. Physicians would have an interest in lowering the price they charge to get access to plans in order to attract consumers who care about the costs they bear.

The extent of this problem is unknown in the United States outside the state of Texas, which did a study last year. The largest 3 plans in Texas do not have contracts with 80% of Emergency Department physicians.[1] Going forward, it is difficult to formulate a policy response without knowing the prevalence, departments, and magnitude of out of network billing. The New York Times featured three substantial articles on out of network billing, but referred to no nationwide information on the prevalence of this practice.[2]

Our analysis will begin by quantifying the issue. First, we will identify the share of emergency visits per state and per hospital that have an in-network facility claim and an out-of-network physician claim. Second, we will identify the share of joint-replacement surgeries per state and per hospital performed at

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[1] http://forabettertexas.org/images/HC_2014_09_PP_BalanceBilling.pdf.

[2] http://www.nytimes.com/2014/09/21/us/drive-by-doctoring-surprise-medical-bills.html?_r=0; http://www.nytimes.com/2014/09/29/us/costs-can-go-up-fast-when-er-is-in-network-but-the-doctors-are-not.html; http://www.nytimes.com/2013/10/19/your-money/out-of-network-not-by-choice-and-facing-huge-health-bills.html.

an in-network facility with an out-of-network anesthesiologist. Third, we will examine spinal fusions, gallbladder removals, and joint replacements (procedures featured in the New York Times analysis) per state and per hospital and identify the share of visits with an out-of-network assistant surgeon that are carried out at in-network facilities with in-network surgeons and anesthesiologists. We will also examine out-of-network charges to identify the monetary scale of the charges for each of these three sets of procedures/visits.

We will write up this analysis for a high impact medical or policy journal (i.e. Health Affairs or the New England Journal of Medicine) and work collaboratively with the popular press to highlight results. This output will also highlight potential policy responses. We will work with Optum to develop a data extract. With suitable data, this analysis could be completed within four months of receipt of data.

The best policy response is likely state law that requires any physician treating a patient in a hospital to charge the hospital's network rate for that patient (this may be a challenge, as the hospital and physician rates are on a different basis). If the physician thought that was too low, he or she could admit or work at a different hospital. The pressure of physicians leaving when negotiated rates were too low would incentivize the hospital to bargain for high enough physician rates to staff the hospital.

Going forward, we want to also analyze the drivers of these out-of-network bills. We would also like to carryout more detailed analysis focusing on how facility and physician market power influence out-of-network billing and explore how these practices influence insurer network design. This would be a longer-term project we could explore after publishing our initial analysis.

EXHIBIT 23

EXHIBIT 23

Exhibit 3 – Study Addendum No. 2
To Master Research Agreement
With an Effective Date of March 25, 2016
Out of Network (OON) Billing

Zack Cooper, Yale University
Vivian Ho, Rice University
Fiona Scott Morton, Yale University and NBER

Overview:

Medical bills for healthcare services can take a particularly undesirable form: an out of network medical bill generated by a provider delivering care inside an in-network hospital. Commonly, physicians do not work for a hospital, but may have admitting privileges and treat patients at that hospital. Despite the fact that hospitals contract with hospital-based physicians, hospitals and physicians make separate decisions about whether to join networks of different insurers or plans. If the hospital has joined a particular network, a patient may choose to go there to get care. But what she may not realize is that the physician treating her in that hospital may not have signed a participation agreement with her insurer or health plan. In the past, insurers may have covered these situations as in-network benefits. As insurers and self-funded plan sponsors have attempted to better control costs and offer more competitive premiums, they have increasingly implemented benefit plan designs that limit coverage for these situations. Therefore, the care provided by that physician may be either not covered, or covered at less favorable terms by her insurer or health plan. The physician may then "balance bill" the patient, who may be surprised to receive the bill because she believed she chose to seek care at an in-network hospital.

Out-of-network medical billing is more common in services where patients/consumers are not able to learn about the physician before getting care (e.g. emergency department care). If a patient has a planned surgery, she will locate and choose a surgeon that belongs to her network as well as a hospital that belongs to her network. But members may not always be able to select the anesthesiologist who attends to the surgery who may be out of network. If so, that anesthesiologist is able to bill whatever he or she chooses. Similarly, in an emergency, patients are likely to travel to the closest in-network hospital where they expect to have coverage. If the entire emergency department is formed of out-of-network physicians, the patient will get treated and then later discover that she effectively went to an out of network provider. Depending on the benefit plan of the plan sponsor, these charges may be treated as in-network or out-of-network services.

This practice is destructive in several ways. First, patients/consumers attending an in-network facility can face substantial and unexpected bills for out-of-network providers. Often, these out-of-network bills are not covered in full by their insurers and will expose patients to substantial costs. At the extreme, this type of billing practice can lead to bills in the tens of thousands of dollars.

Second, it makes it very difficult for an insurer attempting to create and compete with a narrow network plan. The whole point of such a plan is that it shifts care to a limited set of participating providers and is cheaper as a consequence. But if patients carefully go to the providers in the narrow network and end up with a huge bill anyway, then they will not conclude the product is delivering good value. A

patient/consumer might as well sign up for a broad plan at a high price if he/she is going to pay a high price in the narrow network plan. Therefore, the competitive advantage of the narrow network plan is reduced. Differentiation among these types of plans is eroded by out of network billing which reduces consumer choice.

Third, competition among physicians is reduced because they can gain surprise access to patients without allowing choice on the basis of price first. If physicians were required to join a plan in order to be allowed to treat that insurer's patients, they would need to bargain over price and compete with other physicians. Insurers would choose among physicians to place in the network based on quality and price. This price competition would tend to lead to lower prices. Similarly, if consumers chose a hospital on the basis of whether the physician was in-network or not, physicians would lose volume by staying out of network. Physicians would have an interest in lowering the price they charge to gain access to insurers in order to attract consumers who care about the costs they bear.

The extent of this problem is unknown in the United States, outside the state of Texas, which did a study in 2015. The largest 3 plans in Texas do not have contracts with 80% of Emergency Department physicians.[1] Going forward, it is difficult to formulate a policy response without knowing the prevalence, departments, and magnitude of out of network billing. The New York Times featured three substantial articles on out of network billing, but referred to no nationwide information on the prevalence of this practice.[2]

It appears that, but more to come through the Study papers, the best policy response is likely state law that requires any physician treating a patient in a hospital to charge the hospital's network rate for that patient (this may be a challenge, as the hospital and physician rates are on a different basis) or placing a cap on out-of-network hospital and physician charges (i.e. 150% of Medicare reimbursement). If the physician thought that was too low, he or she could admit or work at a different hospital. The pressure of physicians leaving when negotiated rates were too low would incentivize the hospital to bargain for high enough physician rates to staff the hospital.

Research Study Objectives:

Principal Investigators will create 2 Study papers that identify the scale of out-of-network billing, understand the drivers of out-of-network billing, and make policy-recommendations about how to change this out of network billing situation. Principal Investigators will focus on out-of-network billing for anesthesiologists, emergency room physicians, and assistant surgeons for several procedures cited in the popular press, and as specified below.

Study Paper Number 1: Principal Investigators analysis for Study paper number 1 will begin by quantifying the issue. First, Principal Investigators will identify the share of emergency visits per state and per hospital that have an in-network facility claim and an out-of-network physician claim. Second, Principal Investigators will identify the share of joint-replacement surgeries per state and per hospital performed at an in-network facility with an out-of-network anesthesiologist. And, third, Principal Investigators will examine spinal fusions, gallbladder removals, and joint replacements (procedures featured in the New York Times analysis) per state and per hospital and identify the share of visits with an out-of-network assistant surgeon that are carried out at in-network facilities with in-network surgeons

[1] http://forabettertexas.org/images/HC_2014_09_PP_BalanceBilling.pdf.

[2] http://www.nytimes.com/2014/09/21/us/drive-by-doctoring-surprise-medical-bills.html?_r=0; http://www.nytimes.com/2014/09/29/us/costs-can-go-up-fast-when-er-is-in-network-but-the-doctors-are-not.html; http://www.nytimes.com/2013/10/19/your-money/out-of-network-not-by-choice-and-facing-huge-health-bills.html.

and anesthesiologists. Principal Investigators also will examine out-of-network charges to identify the monetary scale of the charges for each of these three sets of procedures/visits.

Principal Investigators' aim is to rapidly produce study paper number 1 that quantifies the scale of the issues outlined above, and makes policy recommendations. If the Parties agree that it is necessary and appropriate to release Study paper number 1 to the public and/or the popular press and media, Research Entity, Principal Investigators and UHS will work collaboratively to discuss the best approach for such a release in order to ensure that UHS agrees with a public release of the study paper and any third-party collaboration.

Study Paper Number 2: Study paper number 2 will focus on understanding how market conditions (i.e. physician market power) influence out-of-network billing. If the Parties agree that it is necessary and appropriate to release Study paper number 2 to the public and/or the popular press and media, Research Entity, Principal Investigators and UHS will work collaboratively to discuss the best approach for such a release in order to ensure that UHS agrees with a public release of the study paper and any third-party collaboration.

EXHIBIT 24

EXHIBIT 24

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EXHIBIT 25

EXHIBIT 25

From: Johnson, Emma [emma.johnson@MultiPlan.com]
Sent: 4/21/2016 11:13:27 AM
To: Sarah R Peterson (sarah_r_peterson@uhc.com) [sarah_r_peterson@uhc.com]; Rickmyer, Marie A (marie_rickmyer@uhc.com) [marie_rickmyer@uhc.com]; Barker, Amy (ambarker@unitedhealthone.com) [ambarker@unitedhealthone.com]
CC: Ginther, Bill [bill.ginther@MultiPlan.com]; Petrozzelli, Patricia [patricia.petrozzelli@MultiPlan.com]; Carolyn S Larson (carolyn_s_larson@uhc.com) [carolyn_s_larson@uhc.com]
Subject: Data iSigt HCFA nd UB ER (GRI and UNET) and other questions

Hi –
As a follow up to our GRIC (UHONE) DiS call, I wanted to send out the definition of HCFA ER claims we currently use to identify the claim as ER:

POS 23 and/or CPT Code 99281-99290

Please confirm your agreement with this definition for both UNET and GRI. Using this definition Data iSight would then apply the rule of 350% of CMS override to never allow less than 350% CMS on the ER HCFA claims. Pricing would be 350% of CMS or the DiS rate whichever is greater.

Specifically for GRI (already in place on UNET) the definition for UB claims we currently use to identify the claim as ER:
Rev Code 450-459, not including 456

Please confirm your agreement with this definition for GRI implementation. Using this definition Data iSight would then apply the rule of 350% of CMS override to never allow less than 350% CMS on the ER UB claims. Pricing would be 350% of CMS or the DiS rate whichever is greater.

Also, for GRI specifically we would like to verify if there will be any U&C/R&C values or liability values that will need to be considered when applying the DiS rate or will DiS be calculating the DiS rate irrespective of any U&C/R&C or liability values?

The ER rules are pretty critical for us to approve so we can get started and complete the required system work to accommodate.

Let me know.
Thanks,
Emma

Emma Johnson
Director, Sales and Account Management
National Accounts
emma.johnson@multiplan.com

MultiPlan
1250 Copeland Rd, Ste 1200
Arlington, TX 76011
ph: 817-436-5304
m: 817-821-1681

Plaintiffs' Exhibit
PX 35

This message was secured by ZixCorp(R).

EXHIBIT 26

EXHIBIT 26

From: Richard, Daryl P [daryl_richard@uhg.com]
Sent: 5/20/2016 7:05:08 AM
To: Rosenthal, Daniel I [daniel_i_rosenthal@uhc.com]
CC: Abbate, Megan [megan.abbate@uhc.com]
Subject: Yale/HCCI OON Study
Attachments: MRA - Yale (OON Study) Study Addendum No 2 Overview (4.4.16).docx

Dan – do you have 15 min. in the next couple of days to chat about this Yale/HCCI study on out of network billing at in-network hospitals? Have some thoughts and ideas I want to discuss. Thx.

From: Perez, Brenda [Communications]
Sent: Thursday, May 19, 2016 6:59 PM
To: Mason, Tyler
Cc: Richard, Daryl P
Subject: RE: Hi Brenda

The first meeting I attended on this was this afternoon and it was quite preliminary.
Cheryl Hegland and Bod Oneil hosted the call and I asked Kirsti McCabe to attend as well.

In addition to giving us a heads up on the *Times/New England Journal of Medicine* piece, Cheryl and Bob:

- Shared the attached overview, which, according to Cheryl, Ted Prospect had also sent to several Network parties, including Dan Rosenthal.

- Noted that we have been providing data to Yale since March through the first part of May and that Yale has started their analysis.
- Reported that the study is meant to produce two pieces— a high level piece (due on June 20th) to be published in the *Times,* and the *New England Journal of Medicine* blog sometime between the end of June and early July; and a much more in-depth piece, more suitable for venues such as industry conferences, tentatively expected to be published on March 8, 2017.
- Submitted that, unless how our data is portrayed in the study findings merits revision, the company will be referred to in the piece simply as "a large carrier." As was the case with the HCCI piece, our support of Zack is expected to remain "behind-the-scenes." With that said, Bob pointed out that this time around, outside of the HCCI context, it will be easier to deduct that we are behind the study. Since findings will bring up what's been happening in the clinician world under a less-than-positive light, we'll have to look into the possibility of further distancing ourselves from the piece and messaging in anticipation of media inquiries. Cheryl and Bob expect preliminary findings from Yale, beginning the first week in June, and an early read version of the piece before June 20th. As information comes in, we will address the aforementioned issues accordingly. I'll keep you posted.

It wasn't clear during today's call whether Jeanne de Sa will be assisting with putting Zack in contact with policy circles' point people, speaking circuits, etc., which she did for last year's paper. I would assume that will be the case, but I don't want to assume anything. Checking.

Daryl—let me know if you would like to join or have someone in your team join subsequent calls on this. The next one will likely take place the first week of June, unless anything changes.

We can discuss this further during our next staff call.

Brenda

Plaintiffs' Exhibit
PX 37

RA000538

From: Mason, Tyler
Sent: Thursday, May 19, 2016 4:00 PM
To: Perez, Brenda [Communications]
Subject: Hi Brenda

Can we make sure to keep Daryl and his team in the loop on everything we are doing to support the Zack Cooper work. I just connected with Tom and Ted and on something else and they mentioned that Margo from the Times and the New England Journal are going to sync up for the announcement.

EXHIBIT 27

EXHIBIT 27

UnitedHealthcare

OCM Optimization
July 11, 2016

Plaintiffs' Exhibit
PX 43

DATE: 07/11/2016

UHC/UHOne PARTICIPANTS

x	Marie Rickmyer		Jolene Bradley	x	Jodie Mckie
	Sarah Peterson		Carolyn Larson	x	Heather Hughes
x	Alison Flint		Angela Logan		David Bowyer
	Cathy LeBrecque				

TOPICS OF DISCUSSION

01.	Background: Implementing Outlier Cost Management program for FI Business on UNET Physician Egregious Billing done with a Seal Team edit. Non-Par Providers for FI INN Benefit Level for claims that could be reimbursed at billed charges and the sam/seal edit looks for these claims and then re-prices at 350% of CMS (if no other programs apply—MNRP, etc). We will shut off the Seal edit and move it to Data iSight (owned by Multiplan—a vendor that works with UHC on pricing, processing, consistency, legally sound process vs. our random calculated amounts). Implementation date is scheduled for 8/1/2016.
	Agenda: 1. Discuss Risk and Timeline—work on the P&P's, drafting, posting can't be completed by 8/1. Can't train on this until after it is posted—Facility piece is written with IS, need to update with physician claims and that process could be completed. Not a quick process and not that easy. They can use the facility as a base, but need to create entire new SOP's for Professional (Provider customer care). And transactions can't support an 8/1 due to the updates needed--Linda DuPey. 2. Sharepoint site—who will set this up? d Roma's approval 3. Recon code update: Still Outstanding for adjustments. Language is at MP for approval. 4. ORS box route for IS remark code—might push through everything through that ORS box—then we can follow the facility and just copy over for Professional P&P. 5. Appeals has their own separate P&P's—different audiences for Appeals—Alison has SME for Appeals 6. Assistant Surgeon program—need to keep existing P&P in place for any disputes that come in processed before 8/1. But after 8/1, Asst. Surgeon program won't have a special process and will follow SOP. 7. Operations Update: Meetings scheduled 8. ASO Client: Suffolk County—(Sarah, Carolyn and Marie need to discuss internally due to IT

	work for MP) 9. Review project plan, timelines and identify risks and subsequent mitigation
	Discussion 1. Notification to team and first team meeting was June 15th.
	Next Steps: 1. Marie to send Alison Paulette's work flows and appeal/letters 2. Ben Ops—Jodie and Alison to set up daily meetings with teams to create these P&P's and SOP's to ensure we have a working plan 3. Jolene to verify the ORS box for IS Remark code to simplify process 4. Customer service and transaction folks first due to calls coming in first 5. Written appeals will follow 6. Jodie to update team on how training process/session would be executed and timeline for training 7. Alison to supply timeline for the following: a. P&P's b. Transactions c. Appeals d. Training

EXHIBIT 28

EXHIBIT 28

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EXHIBIT 29

EXHIBIT 29

Balance Billing: Out of network physicians practicing at in-network facilities
November 9, 2016

Media statement on Yale study:
Out-of-network physicians should not be using emergencies as an opportunity to bill patients excessive amounts when they are at their most vulnerable. When a physician chooses to practice at a hospital that participates in an insurer's network, the physician should charge rates that are consistent with what other in-network physicians bill for their services.

Talking Points:
One of the most troubling trends leading to out-of-network costs is when consumers are appropriately seeking care at in-network facilities, but the treatment is being provided by an out-of-network physician.

- This trend is driving up overall health care costs and often takes consumers by surprise with unexpected bills because out-of-network physicians are allowed – in most states – to bill the patient for additional money above and beyond what the insurance plan pays.
- Nearly half of UnitedHealthcare's out-of-network spend in 2015 was related to members seeking care at in-network facilities, but being treated by out–of-network providers.

This dynamic is completely out of the consumer's and insurance company's control and sometimes results in patients receiving unexpected medical bills.

- A newly released study by Yale University highlights how prevalent and egregious this trend is.
  - The study found that of the 99.35% of emergency room visits that occurred at in-network facilities, 22% involved out-of-network physicians.
  - The out-of-network emergency physicians charged an average of 798% of Medicare rates (compared to 297% of Medicare rates for in-network emergency physician claims).
  - The study concluded that the potential additional cost for patients would be on average $622.55.

According to the Yale study, in certain locations (Boulder, CO and South Bend, IN) the surprise billing rate was near zero, suggesting that this problem can be solved. UnitedHealthcare is taking a number of steps to help protect consumers from high, out-of-network costs.

1) Shared Savings Program (SSP):
   - UnitedHealthcare works with a third-party vendor to negotiate discounted rates with providers who may be out of network.
   - The out-of-network facilities and providers are listed in a "Non-contracted Provider Directory" to help inform consumers of their options.
   - The program helps lower costs, predicts a member's out-of-pocket expenses when going out of network and protects them from balance billing.

2) Extended Non-Network Reimbursement (ENRP):
    - ENRP helps manage costs from out-of-network physicians practicing at in-network facilities.
    - For emergency services, we will reimburse the out-of-network care provider based on federal regulations (PPACA), which require the highest of the following:
        - The median in-network contracted rate for the emergency service provided;
        - The amount that we would typically reimburse any out-of-network care provider; or
        - An amount based on Medicare
    - For non-emergency services, we pay eligible expenses based on what we would typically reimburse any out-of-network care provider for the type of service provided.

3) Outlier Cost Management Program (OCM):
    - The OCM program shields consumers from excessive billing practices by out-of-network providers.
    - OCM is used when other programs like SSP or ENRP don't apply.
    - When a member receives what is considered an egregious or excessive bill from an out-of-network provider, UnitedHealthcare will advocate for a lower bill on his/her behalf.
    - We will work with the provider to put a cap (often 350% of Medicare) on the charges billed.

4) Support of state legislation to regulate out-of-network billing practices:
    - UnitedHealthcare is actively working with states on ways we can effectively stop out-of-network providers who choose to practice at in-network facilities from charging excessively high rates or balance billing members.