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# NO SURPRISE ACT OF 2022

## IMPORTANT INFORMATION WE ALL NEED TO KNOW

On December 27, 2020, the U.S. Congress passed and the President signed into law the Consolidated Appropriations Act which includes numerous health care related provisions and requirements for both medical providers and health insurance companies such as NetCare Life & Health Insurance Company. These new requirements will impact both NetCare and our members. These laws include the Transparency in Coverage Rule (TiC) and the No Surprises Act (NSA). Some of the requirements of these laws overlap but the purpose for both are to provide members with cost information about medical services and to protect consumers from certain surprise medical bills such as emergency care and prescription drug spending.

# KEY HIGHLIGHTS OF THE NEW MANDATE

## *Changes to Member Identification Cards*

The new mandate requires health plans to include key information on certain benefit coverage in the member identification card. NetCare will be providing new member ID cards in December 2021 to all fully insured and self -funded clients. The member ID card will include key information such as in-network and out-of-network deductibles and the in-network and out-of-network out-of-pocket co-payment maximum.

## *Participating Provider Information*

The new mandate requires NetCare to provide up-to-date participating provider listing and/or directories to be available online or within one business day of questions regarding a participating provider and their information or status with NetCare. NetCare's participating provider directories for both on Guam, CNMI, U.S. Mainland and Asia is already included on our website at www.netcarelifeandhealth.com. This mandate goes into effect on January 1, 2022.

## *Advanced Explanation of Benefits (AEOB) Requirements*

The new mandate requires NetCare to issue AEOB that provides cost estimates for services that are scheduled at least three days in advance, based on service billing codes provided by a provider or facility. The AEOB requires specific information such as provider status, contracted rate, location of provider facility, estimate of the amount payable by

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NetCare, an estimate of the amount of the patient's cost sharing responsibility etc..

This new requirement was originally scheduled to be available on January 1, 2022, however the Federal Departments of Labor, Health and Human Services, and the Department of the Treasury are deferring enforcement of the requirement that an insurer make available an AEOB until further notice. NetCare will continue to monitor this new requirement to ensure full compliance.

## *Price Comparison and Transparency Tool*

The new mandate requires NetCare to provide a price comparison and transparency tool that will provide members with personalized out-of-pocket costs and price comparisons for specific items or bundled services. Generally, the tool should allow members to:

- Receive pricing or cost estimation for services
- Search based on billing code or description of services
- Review any accumulated deductible or other out-of-pocket expenses to date.
- Review factors that impact the cost, such as service location or prescription drug dosage.

This new mandate was originally scheduled to be effective on January 1, 2022, however, the Federal Departments of Labor, Health and Human Services, and the Department of the Treasury are deferring enforcement of the requirement

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that an insurer make available a price comparison and transparency tool either by online services, customer call center, and by hard copy request) before a plan year begins on or after January 1, 2023

## *No Surprise Billing Protection*

The new mandate protects members from balance billing costs by non-participating providers in certain specific situations such as emergency care. Generally, this protection occurs when emergency services are provided or when non-emergency services are provided by a non-participating provider in a participating facility. In addition, the mandate requires that a member can expect the applicable benefits, deductible, and maximum out of pocket cost be processed and applied at the in-network or participating provider benefit level for these services.

## *Continuity of Care Requirements*

The new mandate requires NetCare to notify members when a provider or facility is no longer a participating provider with NetCare while the provider or facility is providing ongoing care to a member. In certain situations, NetCare must also provide transitional coverage for up to 90 days or until treatment ends (whichever is earlier) at in-network rates.

## *Public Disclosure of Rates through report filing*

The new mandate requires NetCare to comply with new reporting requirement for full public disclosure on plan medical costs and prescription drug spending to the Federal Departments of Health and Human Services (HHS),

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Department of Labor and the Department of the Treasury.

The disclosure must include files that provide information on (1) in-network rates, (2) out-of-network historical rates, and (3) prescription drugs. Medical Cost and drug spending data compiled will be used by the Centers for Medicare and Medicaid Services or other third parties, for example, to guide patients to more cost-effective alternatives for care. Originally scheduled to be effective on January 1, 2022, however, the Federal Departments of Labor, Health and Human Services, and the Department of the Treasury are deferring enforcement of the requirements to publish files and enforcement provisions until July 1, 2022. Prescription drug files will be deferred until further notice from the Federal Departments.

***Required Information to be submitted to the respective Federal Departments include:***

- The top fifty (50) brand prescription drugs most frequently dispensed for claims paid by NetCare and the total number of paid claims for each drug paid.
- The fifty (50) most costly prescription drugs based on total annual spending and the annual amount spent for each drug
- The fifty (5) prescription drugs with the greatest increase in expenditures by plan year

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- Total spending on health care services including hospital, health care provider and clinical service costs broken out by primary care and specialty care; costs of prescription drugs; and other medical costs such as wellness programs
- Any impact on premium rates based on rebates, fees and other compensation paid by drug manufacturers including amounts paid for each therapeutic class of drugs and the amount paid for each of the top 25 drugs that yielded the highest amount of rebates and other compensation during the plan year
- Any reduction in premium rates and out of pocket costs associated with rebates, fees or other compensation
- Average monthly premium paid by employers on behalf of an enrollee as well as premiums paid by the enrollee

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