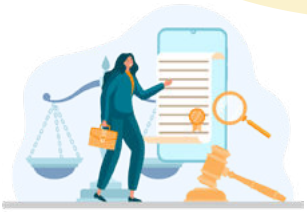
No Surprises Act
Overview of Key Consumer Protections



This document is designed for consumer advocates and others to use when helping individuals with surprise medical bills. A recent federal law called the No Surprises Act went into effect in January 2022 and gave consumers new protections from surprise medical bills in certain circumstances.[1]

Key protections under the No Surprises Act that consumer advocates need to understand to support consumers include the following, discussed in the sections of this document listed below:

Where can I go for help?

A No Surprises Help Desk is available for consumers if they receive a surprise bill. Contact the No Surprises Help Desk at 1-800-985-3059 or you can submit a complaint online at: https://www.cms.gov/medical-bill-rights/help/submit-a-complaint. For more information on contacting the No Surprises Help Desk, see No Surprises Act: How to Get Help and File a Complaint.

State Consumer Assistance Programs (CAPs) may also help with surprise billing questions. To see if your state has a CAP, please visit this state listing.

[1] Throughout this document, the terms "patient" and "consumer" are used interchangeably.

This document is intended to provide clarity to the public about requirements related to surprise billing. It does not have the force and effect of law.

Protections Against Surprise Billing

Surprises Billing Protections: At a Glance

Surprise billing is a type of balance billing, which occurs when a provider bills a consumer for the portion of a bill that the consumer's health insurance plan or coverage doesn't cover. A surprise bill is an unexpected balance bill for certain types of out-of-network costs that aren't covered. Surprise billing can often happen when a person does not have the chance to select an in-network provider, such as during a medical emergency.

The No Surprises Act protects people who are covered under group health plans, group and individual health insurance coverage, and the Federal Employees Health Benefits (FEHB) program carriers from surprise medical bills when they receive:

- **Most** emergency services**.**
- **Non-emergency items and services** from out-of-network providers with respect to patient visits to certain **in-network facilities**.[2]
- Services from out-of-network air ambulance service providers.

The No Surprises Act surprise billing protections generally **do not apply**:

- When **non-emergency** items or services are provided with respect to a patient visit to an **out-of-network** facility.
- In certain circumstances when a provider or facility is permitted to provide notice to a consumer (or their representative) and obtain the individual's consent to waive the surprise billing protections. (See When the Notice and Consent Exception Applies and When it Doesn't: Guidelines for Use.)
- When the items or services provided are **not** covered by the person's health plan or insurance.
- To ground ambulance services.

[2] For purposes of non-emergency services under regulations implementing the No Surprises Act, a health care facility is: (1) a hospital, as defined in section 1861(e) of the Social Security Act; (2) a hospital outpatient department; (3) a critical access hospital, as defined in section 1861(mm)(1) of the Social Security Act; or (4) an ambulatory surgical center, described in section 1833(i)(1)(A) of the Social Security Act. This toolkit uses the term "facility" to refer to such health care facilities.

Surprise Billing Protections: In Depth

The No Surprises Act created new protections against surprise billing. The No Surprises Act generally protects consumers covered under group health plans and group and individual health insurance coverage. This includes consumers with a plan or coverage through an employer, the Federal Employees Health Benefits program, the Health Insurance Marketplace®,[3] or an individual health insurance plan purchased directly from an insurance company. (See next section for additional details.) When the No Surprises Act applies, it prohibits surprise billing and limits the cost sharing to the consumer for certain items and services.

The No Surprises Act **prohibits surprise bills** for:

- **Most emergency services**, including post-stabilization services, from an out-of-network hospital or an independent, freestanding emergency department.[4]
- **Non-emergency services** from an **out-of-network provider** delivered as part of a patient's visit to certain types of participating health care facilities[5] (unless the out-of-network provider provided a notice of waiver of rights under the No Surprises Act and received consent from the patient).
- Services from out-of-network providers of **air ambulance services**. (Note: Ground ambulance services are not covered by the No Surprises Act).

Although consumers cannot receive surprise bills in these instances, they still may have some cost-sharing responsibility when the No Surprises Act applies. Cost-sharing requirements are outlined in a consumer's health plan and could include unmet deductibles (an amount consumer owes before the health plan begins to pay), copayments (a flat dollar amount per item or service), or coinsurance (a percentage of the contracted rate for an item or service). **However, under the No Surprises Act, the consumer's cost-sharing requirements for out-of-network items or services cannot be greater than in-network cost-sharing requirements.**

[3] Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.

[4] The definition of "independent freestanding emergency department" is intended to include any health care facility that is geographically separate and distinct from a hospital, and that is licensed by a state to provide emergency services, even if the facility is not licensed under the term "independent freestanding emergency department." Only urgent care centers that are licensed to provide emergency services and that are geographically separate and distinct from a hospital are considered freestanding emergency departments and covered by the No Surprises Act.

[5] See Table 3 below for details on which health care facilities are covered within the non-emergency services portion of the No Surprises Act.

Health Coverage Subject to the No Surprises Act

The No Surprises Act protections apply to consumers enrolled in the following types of health coverage:[6]

- Employment-based group health plans (both self-funded and fully insured).
- Individual or group health insurance coverage purchased on or outside the federal or state-based Marketplaces.
- Non-federal governmental plans that are sponsored by state and local government employers (for example, a health plan through a school district).
- Certain church plans.[7]
- Health benefits plans offered through the Federal Employees Health Benefits (FEHB) program.[8]
- Student health insurance plans offered by colleges or universities.

The No Surprises Act Protections Do Not Apply:

To consumers who have coverage through (or receive services provided by) the following government programs. These programs generally have certain protections against balance billing:

- Medicare (including Medicare Advantage).
- Medicaid (including Medicaid managed care plans).
- Indian Health Service.
- Veterans Affairs Health Care.
- The insurance programs that make up TRICARE.

To balance billing for items and services covered by certain types of health plans or insurance coverage, including:

- Short-term, limited-duration insurance.
- Retiree-only plans.
- Account-based group health plans (such as health reimbursement arrangements or HRAs).
- Disease-specific plans, such as cancer-only policies.
- Hospital indemnity policies.
- Accident-only policies.
- Items and services covered by stand-alone vision or dental plans.

Note: If consumers have a major medical health plan that includes dental or vision benefits, these protections could apply to any dental or vision service covered by their health plan.

[6] The provisions of the No Surprises Act that are applicable to group or individual health insurance coverage generally apply to grandfathered health plans.

[7] "Church plans" do not include health care sharing ministries, which are generally not considered health insurance coverage.

[8] Throughout this toolkit, the term "health plan" (or "plan") generally also includes coverage under a health benefits plan offered through the FEHB program. The term "health insurance issuer" (or "issuer") generally also includes FEHB insurance carriers. Additional explanation is provided in the toolkit introduction.

Calculating Cost Sharing Under the No Surprises Act

Under the No Surprises Act, the way that cost sharing is calculated differs from typical out-of-network cost-sharing calculations.[9] The No Surprises Act requires cost sharing to be calculated using a "recognized amount." This amount can vary depending on whether an All-Payer Model Agreement or a state law applies in a particular circumstance (see Table 1 below).

Table 1: Three Ways to Determine the Recognized Amount When an Item or Service is Covered by the No Surprises Act*

The Recognized Amount Is:		
1. The amount that a state approves under an All-Payer Model Agreement	when	• An item or service is covered by an All-Payer Model Agreement
2. The amount determined by state law	when	• An All-Payer Model Agreement does not apply to determine cost sharing; **and** • A state has an applicable law that addresses the amount payable for the item or service**
3. The amount that is the lesser of: • The amount billed by the provider or facility; or • The Qualifying Payment Amount for the item or service, which is generally based on the median contracted rate that a health plan pays to providers in the same geographic region	when	• A state law or All-Payer Model Agreement does not apply to determine the cost-sharing amount

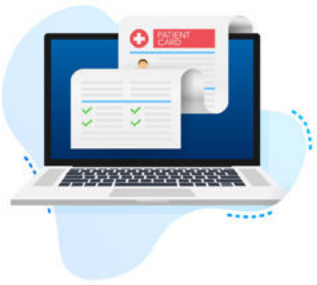
* Cost-sharing amounts for out-of-network air ambulance services must be calculated using the lesser of the billed charge or the Qualifying Payment Amount.

** Specifically, a state must have a "specified state law," which provides a method for determining the total amount payable under group or individual health coverage to an out-of-network provider.

To determine which calculation method should be used, consumer advocates will first need to identify if there is an All-Payer Model Agreement or state law in place covering the items and services received. For more information on where to research state laws, see State Surprise Billing Laws and the No Surprises Act. If the items and services received by a consumer are not covered by an All-Payer Model Agreement nor by state law and are covered under the No Surprises Act, the recognized amount will be the lower of the billed amount or the Qualifying Payment Amount (the third method shown in Table 1 above).

[9] When surprise billing protections do not apply, out-of-network cost sharing is often based on a health plan's "usual and customary rate" for an item or service. In addition, the provider may be able to bill the consumer for the difference between the provider's billed amount and what the health plan has paid.

Calculating Cost Sharing When the No Surprises Act Applies (Instead of a State Law or an All-Payer Model Agreement)



When the No Surprises Act applies (instead of a state law or All-Payer Model Agreement), a health plan or issuer must determine the Qualifying Payment Amount for the items and services received and compare it to the billed amount from the provider or facility.[10] It must then use the lower of these two amounts to determine the consumer's financial responsibility, applying any applicable in-network cost-sharing requirements. Using this process, a health plan might apply the amount of the Qualifying Payment Amount (or billed amount, whichever is lower) towards an unmet deductible or multiply the Qualifying Payment Amount (or billed amount, whichever is lower) by an in-network coinsurance percentage, if applicable.

For example, if the billed amount from a provider is $300 and the Qualifying Payment Amount is $325, the consumer's cost-sharing would be based on $300. If the consumer had fully met their deductible and their health plan required a 20% coinsurance for the item or service that was furnished, the consumer would owe 20% of $300.

Under the No Surprises Act, a consumer's cost-sharing requirement cannot be greater than their health plan's in-network cost-sharing requirement.* This means that:

- If the item or service is subject to coinsurance and the health plan requires 20% coinsurance for an item or service furnished by an in-network provider and 30% coinsurance when the item or service is furnished by an out-of-network provider, the consumer would only be responsible for the 20% coinsurance; and
- If the consumer receives an item or service that requires a $25 copay when furnished by an in-network provider and a $35 copay when furnished by an out-of-network provider, the consumer would only be responsible for the $25 in-network copay.

* This is true regardless of the state in which the items and services were received and any state laws or All-Payer Model Agreements that may apply.

[10] Note that when the No Surprises Act and no state law nor All-Payer Model Agreement applies, the amount that a health plan pays an out-of-network provider may be determined through negotiation or dispute resolution. That process is separate from the process for determining consumer cost sharing.

Surprise Bills for Emergency Services

Under the No Surprises Act, surprise bills for most **emergency services** for an **emergency medical condition** are prohibited (see Table 2). In addition, when the No Surprises Act applies, the consumer's cost-sharing requirement for out-of-network items or services cannot be greater than the requirement that would apply if the item or service was provided in-network. For example, a consumer's costs for the out-of-network service would be determined using in-network copay amounts or coinsurance percentages.

Table 2: Emergency Services, Facilities, and Providers Included in Surprise Billing Protections

Types of emergency services included	Facilities included	Types of health care providers included
• Medical screening exams, including ancillary services, to evaluate whether an emergency medical condition exists • Examination and treatment needed to stabilize the patient • Post-stabilization services (as part of outpatient observation or an inpatient or outpatient stay with respect to the visit for pre-stabilization emergency services)*	• Hospital emergency departments (EDs) or emergency rooms (ERs) • Hospital departments caring for ER patients once stabilized • Independent, freestanding EDs that are separate from hospitals[11] • Urgent care centers that meet the definition of independent, freestanding emergency departments	• Physicians • Physician assistants • Nurse practitioners • Other medical providers acting within their scope of practice under state law

** In limited circumstances, an out-of-network provider or emergency facility can use the No Surprises Act's notice-and-consent exceptions to obtain voluntary consent from an individual to waive the balance billing protections for post-stabilization services. See description in the No Surprises Act Exceptions for Notice and Consent section below.*

Under the No Surprises Act:

- If plans or issuers cover any emergency services, they must cover emergency services as defined in the regulations, even when provided at an out-of-network emergency facility.
- Health plans and health insurance issuers are prohibited from requiring prior authorization for emergency care and must determine whether a condition is an emergency medical condition based on an individual's presenting symptoms and not on a final diagnosis code.
- Even when a person is treated at an in-network emergency department, the treating physician and other providers might be out-of-network. Out-of-network providers of emergency services may not bill more than the in-network cost sharing allowed based on the consumer's plan or insurance coverage.
- Consumers cannot be balance billed for post-stabilization care unless they give consent to waive protections after receiving a written notice (in instances where consent is permitted).

[11] If under state licensure laws, a facility that provides behavioral health crisis response services is permitted to provide emergency services as described in 26 CFR 54.9816- 4T(c)(2), 29 CFR 2590.716-6(c)(2), and 45 CFR 149.110(c)(2), and is geographically separate and distinct from a hospital, then such a facility would fall within the definition of "independent freestanding emergency department" under the July 2021 Interim Final Rule, and the surprise billing protections would apply with respect to the emergency services provided with respect to a visit to the facility. See FAQ Part 55 Question 10.

Prudent Layperson Standard of "Emergency Medical Condition"

Balance billing and out-of-network cost sharing aren't allowed for emergency services when an individual gets care for an emergency medical condition, which is defined using a "prudent layperson" definition:

A person, who has typical knowledge of health and medicine, experiences a medical condition (including a mental health condition or substance use disorder) that is so severe they believe:

- They need immediate medical care; and
- Failing to get immediate medical care could:
  - Result in their health or the health of their unborn child being in serious jeopardy; or
  - Result in serious impairment to bodily functions; or
  - Lead to serious dysfunction of any bodily organ or part.

Surprise Bills for Non-Emergency Services

Under the No Surprises Act, surprise bills for **non-emergency services** are prohibited when these services are provided by **out-of-network providers with respect to a patient visit to an in-network health care facility**. (Table 3 below provides more details.)

In addition, when the No Surprises Act applies, the consumer's cost-sharing requirement for out-of-network items or services cannot be greater than the requirement that would apply if the item or service was provided in-network. For example, a consumer's costs for the out-of-network service would be determined using in-network copay amounts or coinsurance percentages.

Table 3: Non-Emergency Services, Facilities, and Providers Included in Surprise Billing Protections

Participating health care facilities included	Examples of non-emergency items and services included*	Examples of out-of-network providers included
• Hospitals • Hospital outpatient departments • Ambulatory surgical centers • Critical access hospitals	• In general, covered non-emergency services are subject to the No Surprises Act when delivered by an out-of-network provider as part of a patient's visit to a participating health care facility. • Such services include but are not limited to: ○ Pre-operative and post-operative services ○ Equipment and devices ○ Telemedicine services • Ancillary services** (see box below)	• Physicians • Physician assistants • Nurse practitioners • Assistant surgeons • Hospitalists • Intensivists • Anesthesiologists • Laboratories • Others acting within their scope of practice under state law

* These services don't need to take place at the in-network facility to be considered part of a visit (for example, offsite laboratory services).

** Ancillary services provided at participating facilities, which individuals typically have little control over, are always subject to balance billing prohibitions. For a full definition of ancillary services under the No Surprises Act, see the No Surprises Act Consumer Advocate Toolkit: Glossary.

Ancillary Services

Ancillary services include items and services related to:

- Emergency medicine
- Anesthesiology
- Neonatology
- Pathology
- Radiology
- Diagnostic services, including radiology and laboratory services
- Items and services provided by assistant surgeons, hospitalists, intensivists
- Items and services provided by a nonparticipating provider if there is no participating provider who can furnish the item or service at that facility.

Surprise Bills for Air Ambulance Services

Under the No Surprises Act, surprise bills are generally prohibited for covered **air ambulance services** provided by **out-of-network air ambulance providers**. In addition, when the No Surprises Act applies, the consumer's cost-sharing requirement for covered air ambulance services cannot be greater than the requirement that would apply if the services were provided in-network.

If a plan or issuer covers air ambulance services only for emergencies, the No Surprises Act does not require the plan or issuer to cover non-emergency air ambulance services or limit the amount a consumer may be charged for those non-emergency air ambulance services.

Table 4: Air Ambulance Services and Providers Included in Surprise Billing Protections.

Types of Service Included*	Providers Included
• Medical transport by helicopter ("rotary wing" ambulance) and • Medical transport by airplane ("fixed wing" ambulance) This applies to situations where air ambulance services are covered under the in-network terms of an individual's health plan/coverage, even if there are no in-network air ambulance service providers within an individual's plan/coverage.	Entities that are licensed under applicable state and Federal law to provide air ambulance services.

* Note that the surprise billing protections for air ambulance services may apply even if the point of pickup is outside of the United States. For more information, see FAQ Part 55 Question 8.

No Surprises Act Exceptions for Notice and Consent: Patients May *Explicitly Consent* to Waive Their Rights in Certain Circumstances

In limited situations, the No Surprises Act allows some out-of-network providers and facilities to seek written consent from individuals to voluntarily waive their protection against balance billing for 1) post-stabilization services and 2) non-ancillary, non-emergency services. These are referred to as notice and consent exceptions.

Providers must follow strict requirements for the process and timing of obtaining consent from consumers. This includes the requirement for providers to use the Standard Notice and Consent documents provided by the Centers for Medicare & Medicaid Services to secure consumer consent to waive No Surprises Act balance billing protections. (For a detailed description of the process, see Decision Tree: Notice and Consent and When Notice and Consent Applies and When it Doesn't: Guidelines for Use.)

1. Use of the notice and consent exception is only allowed for post-stabilization services (following emergency services) if all the following requirements are met:

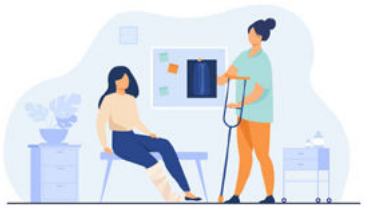
- ✓ An individual is stable enough to travel using nonmedical or non-emergency medical transport to an available in-network provider/facility located within a reasonable travel distance given the individual's medical condition;
- ✓ The individual or their authorized representative is in a condition where they can receive information and provide informed consent;
- ✓ The provider or facility provides written notice and obtains written consent from the individual to waive balance billing protections under the No Surprises Act, in compliance with all related statutory and regulatory requirements; and
- ✓ The provider or facility complies with applicable state laws.

2. Use of the notice and consent exception is only allowed for non-emergency services if all of the following requirements are met:

- ✓ The items or services do not meet the definition of ancillary services;
- ✓ The items or services are not furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished;
- ✓ Another in-network provider can deliver the items or services at the in-network health care facility; and
- ✓ The provider gives written notice and gets written consent from the individual to waive the balance billing protections under the No Surprises Act, in compliance with all related statutory and regulatory requirements.

Before a consumer waives their balance billing and cost-sharing protections, the provider or facility must provide the individual with a good faith estimate of expected charges for the items and services that are reasonably expected to be provided.

Example: How Surprise Billing Protections Work for Emergency Services

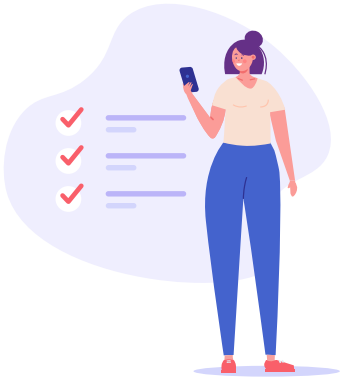


Zoe is a 26-year-old with Marketplace coverage. She has severe pain, swelling, and redness of her right calf. Using reasonable layperson judgment, she becomes concerned that this may be dangerous and may place her health in serious jeopardy. She goes to her local hospital's emergency department, which is in her health plan's network. She has a venous ultrasound (a type of imaging used for diagnosis). The radiologist, who is out-of-network, reads the ultrasound, which shows a deep vein thrombosis. Zoe is started on medication and discharged from the emergency department. A few weeks later, Zoe gets a surprise bill from the radiologist, asking her to pay the difference between the in-network rate for his services and the billed charges (out-of-network rate). She is confused because the hospital was in her health plan's network.

Per the No Surprises Act, the out-of-network radiologist cannot bill Zoe more than the cost-sharing amount determined by her plan consistent with the surprise billing protections.

What actions can Zoe take to resolve this issue?

- Zoe or her advocate can call the No Surprises Help Desk for assistance with handling this surprise bill. (See No Surprises Act: How to Get Help and File a Complaint for detailed information on how to file a complaint.)
- Zoe or her advocate can refer to Helping Consumers Protect Their Rights under the No Surprises Act for information on additional steps to enforce her rights under the No Surprises Act.
- If Zoe lives in a state with a Consumer Assistance Program, Zoe or her advocate can reach out to seek help with a surprise bill for emergency care.



Example: How Surprise Billing Protections Apply to Post-Stabilization Services

Carlos is a 62-year-old with employer-sponsored health coverage. He is involved in a ski accident and sustains multiple injuries. He is taken to the closest hospital emergency department, which is out-of-network. He undergoes surgery to repair multiple leg fractures.

Once he is stable and out of surgery, he is counseled on the option to transfer care to another local in-network hospital for the duration of his recovery. His treating physician determines the only safe form of transport, given his medical state, would be via ambulance. Carlos knows that the hospital he is in has an excellent reputation and he wishes to stay there for his recovery. The hospital provides a written notice and gets his written consent to waive his surprise billing protections under the No Surprises Act. He remains an inpatient for two additional days and is ultimately discharged to home.

The No Surprises Act's prohibition on balance billing and out-of-network cost sharing for emergency services applies to all days of care Carlos received from this hospital.

- The hospital is banned from balance billing Carlos for items and services provided prior to his being stabilized, and he cannot be charged out-of-network cost sharing.
- The hospital is also banned from balance billing him for post-stabilization services provided after surgery, and he cannot be charged out-of-network cost sharing for those services, despite the hospital's obtaining written consent from Carlos to waive his surprise billing protections under the No Surprises Act. This is because he could only safely be transferred via ambulance, rather than using non-medical or non-emergency medical transport.
- The hospital's consent from him to waive his surprise billing protections under the No Surprises Act specific to post-stabilization services is not valid, and the prohibitions against balance billing continue to apply to the hospital. In the event that an individual requires medical transportation to travel, the individual is not in a condition to receive notice or provide consent.

Example: How Notice and Consent Works in Emergency Settings

Sebastian is a 55-year-old with employer-based group coverage. One evening Sebastian experiences chest pain and, using reasonable layperson judgment, believes he may be experiencing the symptoms of a heart attack. He goes to the closest emergency department, which is part of a hospital that is in Sebastian's health plan network. At the hospital, he is evaluated by an emergency physician who is not a participating provider with Sebastian's health plan. The physician determines that Sebastian is having a heart attack. The out-of-network provider and hospital staff stabilize Sebastian and admit him as an inpatient for follow-up care.

Per the No Surprises Act, the out-of-network provider may not ask Sebastian to sign a notice and consent form to waive his surprise billing rights while he is receiving pre-stabilization emergency services (i.e., while he is being evaluated and stabilized). Once Sebastian is stabilized, out-of-network providers who treat Sebastian may ask him to sign a notice and consent form to waive his surprise billing protections for non-ancillary services **only** if specific conditions are met. (For additional details, see Decision Tree: Notice and Consent.)

Note: If the hospital does not have any available treating providers who are in-network with Sebastian's health plan, then Sebastian cannot be asked to sign a consent to waive his surprise billing protections. In addition, providers and facilities may **never** seek an individual's consent to waive the No Surprises Act's surprise billing protections for non-emergency ancillary services or for unforeseen, urgent medical needs that arise at the time an item or service is furnished.

Good Faith Estimates for Uninsured (or Self-Pay) Individuals and Patient-Provider Dispute Resolution

Beginning January 1, 2022, health care providers and facilities must provide an estimate of expected charges to individuals who do not have health coverage (or those who lack coverage for a particular item or service) and individuals who have certain health coverage but who are not seeking to have claims submitted to their insurance for items or services (also known as "self-pay" individuals). This estimate of charges is known as a "good faith estimate" (estimate).

The estimate also must include expected charges for items or services reasonably expected to be provided along with the primary item(s) or service(s). See: Standard Form: "Good Faith Estimate for Health Care Items and Services" Under the No Surprises Act for more information.

If items or services are expected to be furnished by more than one provider or facility, the provider or facility who receives the initial request and who is (or in the case of a request, would be) responsible for scheduling the primary item or service will become the **convening provider**. The No Surprises Act requires good faith estimates from a convening provider to include any item or service that is reasonably expected to be provided in conjunction with a scheduled or requested item or service by a **co-provider or co-facility**. However, CMS is not currently enforcing this requirement, pending future rulemaking.

If the actual bill for health care items or services from a provider or facility is at least $400 higher than the estimate for that provider or facility, then the consumer may be able to challenge the bill using the Patient-Provider Dispute Resolution process. To learn more about the dispute resolution process, including eligibility requirements and what information or documents are needed to start a dispute, see Dispute a medical bill.

Providers Who Must Comply with Requirements

All licensed or certified health care providers must comply with these requirements to provide estimates for uninsured (or self-pay) individuals and the dispute resolution process. Examples of providers include:

- Physicians
- Physician Assistants and Nurse Practitioners
- Providers of air ambulance services
- Other providers and practitioners acting within their scope of practice under state law

Facilities that Must Comply with Requirements

All licensed or certified health care facilities must comply with these requirements to provide estimates for uninsured (or self-pay) individuals and the dispute resolution process. Examples of facilities include:

- Hospitals
- Hospital outpatient departments
- Independent, freestanding emergency departments
- Critical access hospitals
- Ambulatory surgical centers
- Rural health clinics
- Federally Qualified Health Centers
- Laboratories and laboratory centers
- Imaging centers

Eligibility to Receive a Good Faith Estimate for an Uninsured (or Self-Pay) Individual

Providers and facilities must offer to provide a good faith estimate to all uninsured and self-pay individuals upon scheduling a health care item or service, or if the uninsured (or self-pay) individual requests an estimate, subject to certain timeframes. In addition, providers and facilities must treat any discussion or inquiry about the cost of items or services by an uninsured or self-pay consumer as a request for an estimate. The convening provider or facility must provide written notice of the right to receive a good faith estimate in a clear and understandable manner. The notice must also be prominently displayed (and easily searchable from a public search engine) on the convening provider's or convening facility's website, in the office, and on-site where scheduling or questions about the cost of items or services occur.

Determining Health Coverage or Insurance Status

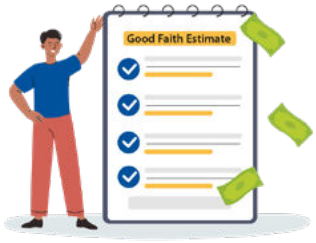
Before providing an estimate, a provider or facility first must determine if a consumer who has contacted them about health care is uninsured or self-pay. To determine if an individual is uninsured or self-pay, the provider or facility must ask if the individual is enrolled in any of the following:

- A group health plan or group health insurance (such as through an employer or union).
- Individual coverage purchased through the Marketplace or directly from an insurance company.
- A federal health care program (such as Medicare (including Medicare Advantage), Medicaid (including Medicaid managed care plans), Veterans Affairs Health Care, or TRICARE);
- A health benefits plan offered through the Federal Employees Health Benefits (FEHB) program.

If the individual is **not** enrolled in any of the above (or is covered under a short-term, limited duration plan), the individual is considered uninsured for the purposes of the estimate.

If the individual has a group health plan or group health insurance, individual health insurance or FEHB coverage, the provider or facility must ask if the individual is seeking to have a claim submitted for items or services being scheduled or requested. If not, the individual is considered self-pay for the purposes of the estimate.

Required Information for Good Faith Estimates



A good faith estimate must include, among other information, expected charges for the main health care item or service the consumer is seeking. It must also include expected charges for any other items or services that will be provided within the same period of care for that health care item or service. In addition, a complete good faith estimate must include a disclaimer that the information is only an estimate of reasonably expected charges and that actual charges may differ.

- Note that individuals may qualify for a provider's or facility's sliding fee discounted price. These individuals may receive a complete good faith estimate with the undiscounted price for items and services if the provider or facility lacks current information to calculate the discounted prices. For additional information about good faith estimates when sliding scale discounts are offered, see CMS FAQ Part 4 on good faith estimates.

- If a provider or facility does not expect to bill an individual for any items or services, the consumer may receive an **abbreviated** good faith estimate. An abbreviated good faith estimate does not list any items or services and must state the provider's commitment not to bill the consumer. For additional information on the requirements for an abbreviated good faith estimates see CMS FAQ Part 4 on good faith estimates.

Sometimes the estimated costs can change—for example, if a provider listed on the estimate becomes unavailable. In that case, the convening provider or facility must provide a new estimate no later than one business day before the item or service is scheduled to be furnished. If any changes in expected providers or facilities represented in a good faith estimate occur less than one business day before items or services are expected to be furnished, the "replacement" provider or facility must accept the expected charges reflected on the original provider's or facility's estimate.

The estimate will show the expected charges for items or services that a provider or facility expects to charge the individual. This estimate is based on information known at the time the estimate is created and does not include any unknown or unexpected costs that may arise during the course of treatment. For example, an individual could be charged more if complications develop.

Required Timeframes for Providing Good Faith Estimates

Facilities and convening providers must provide good faith estimates within the following timeframes:

- The estimate must be provided no later than one business day after scheduling if the service is scheduled 3 to 9 business days in advance of the date the item or service is to be furnished.
- The estimate must be provided no later than three business days after scheduling if the service is scheduled at least 10 days in advance of the date the item or service is to be furnished.
- When an estimate is requested by an uninsured or self-pay individual, the estimate must be provided no later than three business days after the date of the request.

Good faith estimates are not required if the service is scheduled fewer than three business days in advance of the item or service to be furnished.

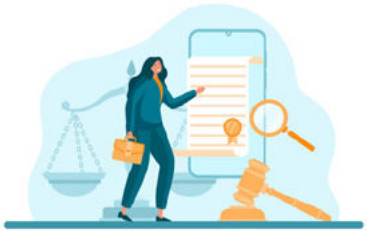
Example: How the Good Faith Estimate Works

Tonya is a 40-year-old with a long history of right knee pain. She does not have any form of health insurance. Tonya schedules an appointment with her orthopedist to receive a cortisone injection in her knee. Upon scheduling the appointment, her orthopedist sends her a good faith estimate totaling $300. Tonya receives the injection and subsequently receives a bill from the orthopedist. The total billed charge is $850.

Tonya would be able to challenge the bill using the Patient-Provider Dispute Resolution process because she is uninsured and the total billed charge from the orthopedist is at least $400 above the good faith estimate.

For additional information, please see the Decision Tree: Requirements for Good Faith Estimates for Uninsured (or Self-Pay) Individuals; Sample Good Faith Estimate for Uninsured or (Self-Pay) Individuals; and Sample Good Faith Estimate Abbreviated Version.

No Surprises Act Expansion of External Review Rights



External review is a process where consumers can challenge a health plan's or health insurance issuer's denial of payment for a submitted claim for care. Internal appeals and external review laws require health plans and health insurance companies to provide a clear basis for claims denials and also require that consumers have the right for certain decisions by health plans or health insurance companies denying payment for care to be reviewed by an independent third party (sometimes referred to as an Independent Review Organization).

The No Surprises Act expands the right for consumers to seek an external review of health claim payment denials. The law extends external review to include consideration of whether a plan or issuer is in compliance with the No Surprises Act.[12]

How to Request an External Review

- **State External Review Processes:** Some states have their own external review processes. If there is a state external review process, the consumer should follow the instructions provided by their health plan or issuer or contact their state's Department of Insurance for more information. See if your state has its own process here.
- **Federal External Review Process:** If a consumer's state does not have its own external review process or if the state's external review process does not apply (for example, the consumer has a self-insured employer plan that is not subject to a state external review process), the consumer will need to use the federal external review process.[13] Please see externalappeal.cms.gov for more information and to file a request for external review, or call 888-866-6205.
- Consumer advocates should determine if a consumer lives in a state with a Consumer Assistance Program and request assistance with insurance appeals and external review where appropriate. The steps to follow for filing an external review may differ based on the type of health coverage and where the consumer lives.

Note: In lieu of the external review process, individuals who are covered through an FEHB plan must use the Office of Personnel Management's disputed claims process to challenge an FEHB plan's coverage decisions regarding its compliance with surprise billing and cost-sharing protections under the No Surprises Act. The FEHB disputed claims process is explained in section 8 of FEHB plan brochures, which may be found at https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plans.

Please see the following additional resources related to the external review process:

- Healthcare.gov Appealing a Health Plan Decision: External Review
- Affordable Care Act: Working with States to Protect Consumers
- Department of Labor: Internal Claims and Appeals and External Review

[12] Additionally, for plan years beginning on or after January 1, 2022, grandfathered plans are subject to external review processes for any adverse benefit determination involving the protections of the No Surprises Act.

[13] If the consumer is covered by a self-funded health plan sponsored by a private-sector employer, they should check their Summary Plan Description for information about the plan's external review process.

Examples: Denials Eligible for External Review

Example: Maria has health insurance through her employer. One day, she wakes up with severe pain in her abdomen. She is worried that it might be an appendicitis attack and goes to her local emergency room. Fortunately, it was not appendicitis, but the pain required immediate attention. Maria was treated for a stomach bug and discharged later that day. The plan denies payment because it doesn't believe the items and services received were emergency services. Because the denial of payment involves consideration of whether the issuer used the layperson's definition of an emergency medical condition required under the No Surprises Act, Maria can appeal the denial under the plan and, if the plan denies the appeal, Maria can use the external review process.

Example: A group health plan provides benefits for anesthesiology services. Duane has knee replacement surgery at a participating health care facility, and during the course of the surgery, receives anesthesiology services from an out-of-network provider. Because the provider was out-of-network, the health plan denies the claim. As a result, Duane is asked to pay out-of-network cost sharing. Because the No Surprises Act prohibits cost-sharing requirements in excess of in-network cost-sharing requirements for services from an out-of-network provider (including ancillary services) delivered at a participating health care facility, Duane can appeal this decision under the plan and, if the plan denies the appeal, Duane can use the external review process.

Transparency on Health Insurance Identification (ID) Cards

Note: In the future, regulations will be issued to implement this provision. In the meantime, health plans are expected to comply with ID card requirements using a good faith, reasonable interpretation of the No Surprises Act.

The No Surprises Act requires that health plans and issuers include information in clear writing on any ID cards (physical or electronic) issued to consumers. This information must explain:

- Any deductibles that may apply.
- Any out-of-pocket maximum limitations that may apply.
- A telephone number and website address to contact for more information.

See FAQ Part 49 Question 4 for more information.

Improving the Accuracy of Provider Directory Information

Note: In the future, regulations will be issued to implement this provision. In the meantime, plans and issuers are expected to implement these provisions using a good faith, reasonable interpretation of the statute.

The No Surprises Act established processes and standards to improve the accuracy of health plan and issuer provider directories. Provider directories tell consumers whether their doctor or hospital is in-network with the plan. The directories can be found on the plan's public website.

Under the No Surprises Act, health plans and issuers must take steps to update and verify the accuracy of their provider directory information at least once every 90 days.

Health plans and issuers must:

- Establish a process to remove providers they are unable to verify as in-network providers within a specified timeframe.
- Establish a process to update their database within two business days of receiving directory changes from a provider or facility.
- Put provider directories or databases on a public website and include the name, address, specialty, telephone number, and digital contact information of each in-network provider or facility.
- Develop a process for responding, within one business day, to questions about the network status of a provider or a facility.

Under the No Surprises Act, providers and health care facilities also must have certain business processes in place to submit information to help keep provider directories current.[14]

If the Provider Directory Is Not Correct

If a health plan or issuer provider directory has the wrong information and the consumer receives care from an out-of-network provider or facility as a result, the plan is limited in what cost sharing they can impose on the consumer. The consumer cannot be subject to cost sharing that is more than the cost-sharing amount that would be charged for in-network services. In addition, the health insurance plan must count cost-sharing amounts toward any in-network deductible or in-network out-of-pocket maximum and include on each applicable explanation of benefits certain required disclosures regarding balance billing protections.

The consumer is entitled to a full refund from a provider of any money paid over the in-network cost-sharing amount, plus interest, if:

- The consumer received out-of-network care due to inaccurate provider information;
- The provider or facility billed the enrollee for an amount in excess of the in-network cost-sharing amounts; and
- The consumer paid the bill.

[14] See slide 22 of: The No Surprises Act's Continuity of Care, Provider Directory, and Public Disclosure Requirements.

Continuity of Care Protections

Note: In the future, regulations will be issued to implement this provision. In the meantime, health plans, health insurance issuers, providers, and facilities are expected to provide continuity of care using a good faith, reasonable interpretation of the No Surprises Act.

If a provider or facility ceases to be an in-network provider of a plan or issuer because the provider experiences a change in network status, the No Surprises Act allows consumers to have up to 90 days of continued health care benefits with that provider or facility under the same health plan terms and conditions if the patient is:

- Undergoing treatment for a serious and complex condition.
  - In the case of an acute illness, this is defined as a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm.
  - In the case of a chronic illness or condition, this is defined as a condition that is life-threatening, degenerative, potentially disabling, or congenital, and which requires specialized medical care over a prolonged period of time.
- Undergoing a course of institutional or inpatient care.
- Scheduled for non-elective surgery (including receipt of postoperative care from a surgery).
- Pregnant and receiving treatment for pregnancy.
- Receiving treatment for a terminal illness.

What Plans and Issuers Must Do

If a patient meets one of the above five criteria, the plan or issuer must:

- Notify the patient of the termination of their provider's in-network status and the patient's right to elect up to 90 days of continued transitional care from the provider or facility in a timely manner;
- Provide the patient an opportunity to notify the plan or issuer of the need for transitional care; and
- Permit the patient to elect to continue to have the same benefits provided, with respect to the course of treatment furnished by the provider or facility. Care must be provided under the same terms and conditions as would have applied under the plan or coverage had the termination not occurred.

What Providers and Facilities Must Do

For 90 days (starting on the date their plan or issuer notifies them of the change in network status), or until care is completed, whichever comes sooner, the treating provider or health care facility must:

- Accept payment from the health plan (and cost sharing from the individual) for items and services as payment in full; and
- Continue to adhere to the same policies, procedures, and quality standards.

Changes in Network Status

Protections apply for patients who are receiving covered services or items from a treating provider or health care facility, and their treating provider or health care facility experiences a change in network status due to one of the following:

- The provider or health care facility's contractual relationship with the individual's plan or issuer is terminated for reasons other than failure to meet applicable quality standards or for fraud;
- The provider or health care facility's terms of participation in the plan or coverage change, resulting in a termination of benefits with respect to the provider or health care facility; or
- A group health plan's contract with a health insurance issuer offering health insurance coverage in connection with the plan is terminated, resulting in a loss of benefits provided under such plan with respect to the provider or health care facility.

If an individual is enrolled in a health benefits plan offered through the FEHB program, they have "transitional care" protections that are comparable to the No Surprises Act's "continuity of care" protections. They should refer to section 3 of their FEHB plan brochures which are available at https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plans. To align with the No Surprises Act, FEHB plans must provide the current transitional care protections to persons in any trimester of pregnancy instead of just those in the second or third trimester.

Example: When Continuity of Care Provisions Apply

Joan is a 30-year-old who is insured through her employer. She is 30 weeks pregnant and following up with her obstetrician regularly. At her next visit, Joan is told that her obstetrician no longer maintains a contract with her issuer due to the obstetrician voluntarily not renewing her contract.

Per the No Surprises Act, continuity of care protections would apply to Joan with respect to the obstetrician, as the contract between the obstetrician and the plan was terminated for reasons other than failure to meet applicable quality standards or for fraud. In scenarios where a contract is terminated due to failure to meet quality standards or fraud, continuity of care protections wouldn't apply.

In this example, Joan meets the standard for a continuing care patient since she is pregnant and receiving care for pregnancy from the obstetrician. As a result, she is eligible for continuity of care protections because she is receiving covered services from a treating provider who has since been terminated from her plan's network.