

# The No Surprises Act: An Overview for Assistants, Advocates, Agents and Brokers

*February 2022*

*This presentation is intended as a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, and formal policy guidance that it is based upon. This presentation summarizes policy and operations current as of the date it was presented. Links to certain source documents have been provided for reference. We encourage audience members to refer to the applicable statutes, regulations, and other interpretive materials for complete and current information about the requirements that apply to them. The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.*

# Today's Topics

- Important Definitions
- Introduction to the No Surprises Act
- Preventing Surprise Medical Bills
- The Good Faith Estimate and Patient-provider Dispute Resolution
- Other Protections for Consumers
- How to Get Help

# Important Definitions

- **What is surprise billing?**

Surprise billing happens when people unknowingly get care from providers that are outside of their health plan's network and can happen for both emergency and non-emergency care.

- **What is balance billing?**

Balance billing is when an out-of-network provider charges a patient the remainder of what their insurance does not pay.

# Important Definitions (Cont.)

- Surprise bills and balance bills affect many Americans, particularly when people with health coverage unknowingly get medical care from a provider or facility outside their health plan's network.
  - This can be very common in emergency situations, when people usually go (or are taken) to the nearest emergency department without considering their health plan's network.
  - It can also happen when people with health coverage receive care from an out-of-network provider at an in-network facility.

# Introduction to the No Surprises Act

# Consumer Protections in the No Surprises Act

- Preventing surprise medical bills.
- Tools to understand consumer costs in advance:
  - Good faith estimate.
- A process that takes consumers out of the middle of a payment dispute between providers and health plans.
- A payment dispute resolution process for uninsured (or self-pay) individuals.

# Consumer Protections in the No Surprises Act (Cont.)

- Expanded rights to external review (what individuals with job-based or individual health plans can use to dispute when certain claims are denied payment).
- Insurance ID cards.
- Provider directories.

# Preventing Surprise Medical Bills

# Preventing Surprise Medical Bills

The No Surprises Act and implementing regulations:

- Ban surprise billing for emergency services.
  - Emergency services, regardless of where they are provided, must be treated on an in-network basis without requirements for prior authorization.
- Ban high out-of-network cost sharing for emergency and non-emergency services.
  - Patient cost sharing, such as coinsurance or a deductible, cannot be higher than if such services were provided by an in-network doctor, and any coinsurance or deductible must be based on in-network provider rates.

# Preventing Surprise Medical Bills (Cont.)

- Ban out-of-network charges for ancillary care (like an anesthesiologist or assistant surgeon) at an in-network facility in all circumstances.
- Ban out-of-network charges for air ambulance services.
- Ban other out-of-network charges without advance notice.
  - Health care providers and facilities must provide patients with a plain-language consumer notice explaining that patient consent is required to receive care on an out-of-network basis before that provider can bill at the higher out-of-network rate.

# Who is Protected by the No Surprises Act?

- These surprise billing protections apply to consumers who get their coverage through their employer (including a federal, state, or local government employer), a multi-employer plan, or through the federal Marketplace or a state-based Marketplace, or who purchase coverage directly through a health insurance plan.
- For those who are uninsured (or self-pay for care), this rule includes protections to ensure they know how much their health care will cost before they get it and have a way to challenge a bill if it is much larger than expected.
- The rules don't apply to people with coverage through programs like Medicare, Medicaid, Indian Health Service, Veterans Affairs Health Care, or TRICARE, since each of these programs already has other protections against high medical bills.

# How are Patients Made Aware of the Rules?

The rules require certain health care providers and facilities to make publicly available, post on a public website, and provide to individuals a one-page notice about:

- The requirements and prohibitions that apply to the provider or facility.
- Any applicable state balance billing limitations or prohibitions.
- How to contact appropriate state and federal agencies if someone believes the provider or facility has violated the rules.

# Consenting to Out-of-Network Services

Beginning January 1, 2022, the No Surprises Act protects consumers from surprise medical bills in situations where they can't easily choose a provider who is in their health plan's network. This is especially common in an emergency situation, when they may get care from out-of-network providers.

- Out-of-network providers or emergency facilities may ask consumers to sign a notice and consent form before providing certain services after they are no longer in need of emergency care. These are called “post-stabilization services.” **A consumer should not receive this notice and consent form if they are receiving emergency services other than post-stabilization services.** Consumers may also be asked to sign a notice and consent form if they schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

# Consenting to Out-of-network Services (Cont.)

- The notice and consent form:
  - Informs consumers about their protections from unexpected medical bills,
  - Gives consumers the option to give up those protections and pay more for out-of-network care, and
  - Provides an estimate of what their out-of-network care might cost.
- Consumers aren't required to sign the form and shouldn't sign the form if they didn't have a choice of health care provider or facility before scheduling care. If they don't sign, they may have to reschedule their care with a provider or facility in their health plan's network.

# When Do These Surprise Billing Rules Take Effect?

- The new rules related to surprise medical bills and balance billing take effect for health care providers and facilities January 1, 2022.
- For group health plans, health insurance issuers, and Federal Employees Health Benefits (FEHB) Program carriers, the provisions take effect for plan, policy, or contract years beginning on or after January 1, 2022.

# How are Out-of-network Payments Determined?

- The rules take consumers with job-based or individual health plans out of the middle of certain out-of-network payment disagreements and provide a process for providers, facilities, providers of air ambulance services, and health plans to negotiate those payments.
- The amount a consumer must pay is determined by a state payment agreement, state law, or the qualifying payment amount, which is generally the average in-network rate for the same or similar items or services for the health plan.

# How are Out-of-network Payments Determined? (Cont.)

- Any additional amount to be paid by the health plan to the provider is negotiated between the health plan and the provider, first through a 30-business-day open negotiation period, then, if the parties fail to determine an amount, through a new federal independent dispute resolution (IDR) process. The consumer is not involved in this process.

# **The Good Faith Estimate and Patient-provider Dispute Resolution**

# Protecting Uninsured/Self-pay Patients: The Good Faith Estimate

- The No Surprises Act also protects uninsured (or self-pay) individuals from unexpected medical bills. Starting January 1, 2022, a provider or facility has to give an uninsured (or self-pay) individual a good faith estimate of expected charges after an item or service is scheduled or upon request.
- The good faith estimate will include expected charges for the primary item or service the individual is receiving, as well as for any other items or services that would reasonably be expected to be provided as part of the same scheduled or requested items/services.

# Good Faith Estimate: Example

- For example, if a consumer is getting surgery, the estimate might include the cost of:
  - The surgery,
  - Any labs or tests, and
  - The anesthesia that might be used during the operation.
- If an item/service is something that isn't scheduled separately from the surgery itself, it will generally be included in the good faith estimate. Other items/services related to the surgery that might be scheduled separately, like pre-surgery appointments or physical therapy in the weeks after the surgery, won't be included in the good faith estimate.

# The Good Faith Estimate: Provider Requirements

- The good faith estimate must be provided:
  - For an item or service scheduled at least three business days in advance: within one business day of scheduling.
  - For an item or service scheduled at least 10 business days in advance: within three business days of scheduling.
  - For an item or service that is not yet scheduled: within three business days of the request.

# The Good Faith Estimate: Provider Requirements (Cont.)

- The provider must:
  - Include in the good faith estimate an itemized list of each item or service, grouped by each provider or facility offering care. Each item or service has to have specific details and the expected charge.\*
  - Provide a paper or electronic copy of the good faith estimate, even if the provider also provides the good faith estimate information to the consumer over the phone or verbally in person.
  - Provide the good faith estimate using clear and understandable language.

\*In 2022, providers will not be required to include estimates from the other providers involved in the individual's care. Individuals may separately ask those other providers for good faith estimates. This provision will be enforced beginning in 2023.

# What If the Bill is More Than the Good Faith Estimate?

- Consumers may use a new dispute resolution process if they are uninsured (or self-pay) and get a bill for an item/service that's substantially greater than the expected charges in the good faith estimate. Under this process, consumers can:
  - Begin dispute resolution with the provider when the actual billed charges for a particular provider/facility are at least \$400 more than the good faith estimate received. Consumers have 120 calendar days from the day they get the bill to begin the process.

# What If the Bill is More Than the Good Faith Estimate? (Cont.)

- Request that a third-party dispute resolution organization review the good faith estimate, the bill, and information submitted by the consumer and their provider/facility. The third-party dispute resolution organization will use this information to determine if the consumer must pay the additional charges, or if the consumer can only be charged what was on the good faith estimate or some other amount lower than the bill.
- To offset some of the costs of operating the dispute resolution process while keeping it accessible, HHS will charge consumers an administrative fee of \$25 in 2022. However, if the resolution ends in the consumer's favor, this fee will be credited back on their bill by the provider/facility.

# What Happens During the Dispute?

- During the patient-provider dispute resolution process, the provider and patient can continue to negotiate the bill. During this process, providers:
  - May not move the bill into collections or threaten to do so.
  - Must pause collections if the bill is already in collections.
  - Can't collect late fees on unpaid amounts.
  - Can't threaten to take any retaliatory action against the patient for initiating the patient-provider dispute resolution process.
- If the patient and provider agree on a payment amount, the provider is required to reduce the bill by at least half of the \$25 administrative fee.

# Other Protections for Consumers

# External Reviews of Denied Claims for Insured Consumers

- The external review process allows individuals with group or individual health coverage to appeal a payment for a health care item/service that was denied by their health plan due to:
  - An item/service not being covered,
  - Restrictions on coverage, or
  - The item/service not being considered medically necessary by the health plan.

# External Reviews of Denied Claims for Insured Consumers (Cont.)

- Under the No Surprises Act and implementing regulations, coverage decisions that involve whether a health plan is complying with the surprise billing and cost-sharing protections are now eligible for external review. For example:
  - A consumer's plan/issuer covers emergency care under the No Surprises Act, and
  - The consumer gets care at an emergency room, but
  - The consumer's health plan denies payment because it doesn't believe the items/services were emergency services.

**The consumer could appeal this decision** using the external review process, which will help determine whether the health plan needs to cover the care received.

# Insurance ID Cards

- Starting in 2022, new pricing information will be shown on any physical or electronic plan or insurance identification (ID) card provided to patients. This will include:
  - Applicable deductibles.
  - Applicable out-of-pocket maximum limits.
  - A telephone number and website where consumer assistance will be provided.
- Additional information may be provided on a health plan's website that can be accessed through a Quick Response code (commonly referred to as a QR code) on a physical ID card or through a hyperlink on a digital ID card.

# Continuity of Care Requirements

The No Surprises Act protects continuing care patients in circumstances where their treating provider's or health care facility's plan network status changes, allowing a 90-day transitional care period. During this time:

- Health plans and issuers must limit cost sharing to in-network terms.
- Treating providers and facilities must accept cost sharing and payment from plans and issuers as payment in full.

# Continuity of Care Requirements (Cont.)

**Continuing care patients** are defined as individuals who, with respect to a provider or facility, are at least one of the following:

1. Undergoing treatment from the provider or facility for a **serious and complex condition**, defined as:
  - a. In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm.
  - b. In the case of a chronic illness or condition, a condition that is:
    - i. Life-threatening, degenerative, potentially disabling, or congenital; and
    - ii. Requires specialized medical care over a prolonged period of time.

# Continuity of Care Requirements (Cont.)

2. Undergoing a course of institutional or inpatient care from the provider or facility.
3. Scheduled to undergo non-elective surgery from the provider or facility, including receipt of post-operative care from such provider or facility with respect to such a surgery.
4. Pregnant and undergoing treatment for pregnancy from the provider or facility.
5. Terminally ill and receiving treatment for such illness from the provider or facility.

# Provider Directories

Beginning January 1, 2022, plans and issuers must:

- Update and verify the accuracy of provider directory information, and
- Establish a protocol for responding to requests by telephone and electronic communication from a participant, beneficiary, or enrollee about a provider's network participation status.

# Provider Directories (Cont.)

Under the No Surprises Act, if an individual relies on incorrect provider directory information and, as a result, receives items or services from an out-of-network provider or out-of-network health care facility:

- Their plan or issuer must:
  - Limit cost-sharing to in-network terms that would apply had items or services been furnished by an in-network provider.
  - Apply the deductible or out-of-pocket maximums as if the provider or health care facility were in-network.
- Their provider or health care facility must:
  - Not bill an individual more than their in-network cost-sharing.

# How to Get Help

# No Surprises Help Desk

- Consumers who have questions about the No Surprises rules or believe the rules aren't being followed may contact the No Surprises Help Desk at 1-800-985-3059 from 8 am to 8 pm EST, seven days a week, to submit questions or complaints; or
- Complaints may be submitted online at [CMS.gov/nosurprises/consumers/complaints-about-medical-billing](https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing). Consumers may be asked to provide supporting documentation like medical bills and their Explanation of Benefits.
  - The Help Desk will send a confirmation email when they receive the complaint to notify the consumer of next steps and let them know if any additional information is needed.
  - To check on the status of a complaint or to see what documentation is needed, consumers can contact the No Surprises Help Desk at 1-800-985-3059.

# No Surprises Help Desk (Cont.)

## What the Help Desk can do:

- Review the complaint to make sure the insurance company, medical provider, or health care facility followed surprise billing rules.
- Investigate and enforce federal laws and policies under our jurisdiction.
- Try to find patterns of problems that may need further review.
- Help consumers understand what documentation they need to submit or what next steps they should take.
- Help answer questions or direct consumers to others who can.

# No Surprises Help Desk (Cont.)

## What the Help Desk can't do:

- Require medical providers or health care facilities to adjust their charges.
- Act as a lawyer or give legal advice.
- Make medical judgments or determine if further treatment is necessary.
- Determine the value of a claim or the amount owed to consumers.
- Address issues we can't legally enforce.

If consumers still need help with their health insurance and have a problem or question, they can contact their state [Consumer Assistance Program](#). These programs help consumers experiencing problems with their health insurance or seeking to learn about health coverage options.

# Key Takeaways

- The No Surprises Act and implementing regulations provide important new protections for health care consumers, including:
  - Prohibiting surprise medical bills in certain situations.
  - Taking consumers out of the dispute process between plans/issuers and out-of-network providers/facilities for covered services.
  - Requiring good faith estimates of expected charges and providing a process for consumers to dispute charges that are significantly higher than the estimate.

# Key Takeaways (Cont.)

- Expanding rights to the external review process.
- Requiring certain information be included on insurance ID cards.
- Requiring provider directories be kept up-to-date and providing help to consumers who rely on incorrect information.
- Consumers can get help from the No Surprises Help Desk:
  - 1-800-985-3059, 8 am to 8 pm EST, 7 days a week.
  - No Surprises Complaint Form:  
[CMS.gov/nosurprises/consumers/complaints-about-medical-billing](https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing).

# Q&A