Helping Consumers Protect Their Rights Under the No Surprises Act

The No Surprises Act protects consumers against surprise medical bills and provides other key consumer protections under federal law. [See No Surprises Act: Overview of Key Consumer Protections.] This document explains steps that a consumer or consumer advocate can take if they believe that a health care provider or facility, air ambulance provider, health plan, or insurer has not complied with the No Surprises Act protections.

In addition to taking the actions described below, a consumer (or their representative) may file a complaint with the No Surprises Help Desk at 1-800-985-3059, or submit a complaint online at: https://www.cms.gov/medical-bill-rights/help/submit-a-complaint.

See No Surprises Act: How to Get Help and File a Complaint for more information. All complaints will be reviewed and, if appropriate, referred to the correct enforcement authority. Depending on the type of complaint, these authorities could include state agencies (such as state departments of health, insurance, or other agencies) or federal agencies including:

- The Centers for Medicare & Medicaid Services within the Department of Health and Human Services;
- The Department of Labor;
- The Department of the Treasury; or
- The Office of Personnel Management.

If enforcement authorities determine that a health care provider or facility, air ambulance provider, health plan, or insurer has not complied with the No Surprises Act protections, the appropriate federal or state agency may be able to help consumers fix an erroneous provider bill or correct an improperly processed insurance claim. Specific actions taken by enforcement agencies to solve a compliance problem may vary by state. If No Surprises Act consumer protections were not properly applied when the initial claim or bill was generated, enforcement agency actions may result in lower out-of-pocket costs for the consumer.

While the No Surprises Act provides new federal protections for consumers, state laws also may have similar or even stronger protections. For example, a state law may prohibit surprise bills for ground ambulance services, which are not covered under the federal law. State laws may also specify how to calculate consumer cost sharing. For more detailed information on state laws and the No Surprises Act, see State Surprise Billing Laws and the No Surprises Act and Questions and Answers on the No Surprises Act and State Laws. Consumer advocates should research any state laws that may apply to a consumer's situation.

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.

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Action Scenarios

Below are some situations under the No Surprises Act that may need action to resolve them.
NOTE: These examples assume that no state law applies.

Scenario 1

Non-Compliance With Surprise Billing Requirements

A provider or facility sends a consumer a surprise bill that is prohibited under the No Surprises Act.

Scenario 2

Non-Compliance With Notice and Consent Requirements

A consumer is asked to waive their surprise billing protections in a way that is prohibited by the No Surprises Act.

Scenario 3

Non-Compliance With Good Faith Estimate Requirements

A provider did not comply with requirements for providing good faith estimates for an uninsured (or self-pay) individual.

Scenario 4

Bill for Uninsured Consumer Exceeds Amount of Good Faith Estimate

An uninsured or self-pay consumer receives a good faith estimate from a provider or facility. The provider or facility completed all of the requirements under the No Surprises Act for furnishing the estimate. However, the provider or facility sends the consumer a bill that is higher than the amount on the estimate.

Scenario 5

Bill for Insured Consumer Exceeds Good Faith Estimate

An insured consumer receives a good faith estimate as part of the notice and consent form they signed to waive their surprise billing protections. The consumer later receives a bill from a provider that is more than the estimate.

Scenario 6

Non-Compliance with Continuing Care Requirements

An in-network contract between a provider and a health plan ends (for reasons other than failure to meet certain quality standards or fraud) or the provider is no longer considered in-network. As a result, coverage under in-network rules is discontinued for an enrollee who is considered to be a continuing care consumer as defined under the No Surprises Act.

Scenario 7

Non-Compliance With PPDR Determination

A consumer's bill is not adjusted by a provider or facility after a Patient-Provider Dispute Resolution entity determines that the bill should be reduced.

Scenario 8

Non-Compliance With Provider Directory Requirements

A health plan's provider directory was not updated in the timeframe required under law. A consumer who relied on the directory inadvertently received care for covered services from a provider who was no longer in-network.

Scenario **1**

Non-Compliance With Surprise Billing Requirements

A provider or facility sends a consumer a surprise bill that is prohibited under the No Surprises Act.

Example:

A consumer with coverage under an employer-based group health plan receives emergency services at a local hospital emergency department from a physician who is not in-network with the consumer's health plan. The provider sends a claim for payment to the health plan, which covers emergency services. Later, the consumer receives either:

- A balance bill from the provider that is higher than the in-network cost-sharing amount reflected on the health plan's Explanation of Benefits (EOB), or
- An EOB from the health plan, and a balance bill from the provider, each indicating that the consumer's cost sharing may have been calculated using the plan's out-of-network cost-sharing requirements.

What You Can Do

In these circumstances, consumer advocates will need to gather information to try to determine how the health plan calculated the cost-sharing amount reflected on the EOB and how the provider calculated the bill. Advocates should then compare this information to the No Surprises Act requirements to make sure the health plan and provider followed the processes required under the law.

Step 1:

Review the EOB and the bill.

- Verify that the following are accurate: consumer's name, consumer's health plan policy number and provider account number, and dates of service.
- Compare the EOB for the services received against the provider's bill to confirm that furnished items and services match.
- Identify any discrepancies in the items and services provided, including their corresponding procedure, site of service, and/or billing codes.
- Identify any duplications of items and services.

  Note: Look for language indicating that the claim is subject to the No Surprises Act. For example, the EOB may include information indicating that No Surprises Act protections apply and could include a statement that the cost sharing is calculated based on the qualifying payment amount. NOTE: Absence of this language does not mean the No Surprises Act does not apply.

Note the provider, facility, or provider of air ambulance services may also have information on how the cost sharing was calculated.

Step 2:

Determine if the No Surprises Act applies.

- Consult the Decision Tree: No Surprises Act Federal Surprise Billing Protections.
- Request the information outlined under the "Documents Needed" section.
- Review the following sections of the Decision Tree based on the information provided and conversations with the consumer:
  - The initial screening questions, and
  - The screening questions in section A, B, or C, depending on the type of items and services the consumer received. (For this example, review Section A, the emergency items and services screening questions.)

IMPORTANT: If 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 items or services were 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.

For emergency services, the health plan cannot place any limits on coverage that are more restrictive than if the provider was in-network. (This is true regardless of the state in which the items and services were received.)

Step 3:

Share your findings with the provider and, if appropriate, the health plan.

- Ask the provider to review the bill, taking this information into account.
- Ask the health plan to recalculate the consumer's cost sharing if you believe the EOB reflects an incorrect cost-sharing amount. If after speaking with the health plan, you think the health plan is not correctly processing the claim, file an internal appeal. The Explanation of Benefits (EOB) should provide information on how the claim was processed and the reason a claim may have been denied.
- You may also file a complaint with the No Surprises Help Desk if you believe either the health plan or the provider is not correctly calculating the consumer's cost sharing.

After the consumer's cost sharing is correctly calculated, ensure that the paid amount is applied to the consumer's in-network deductible and maximum out-of-pocket limit. This may require additional follow-up with the health plan or the No Surprises Help Desk.

How Bills Should Be Calculated

The No Surprises Act specifies how a consumer's cost sharing from an out-of-network provider should be calculated in instances where the No Surprise Act billing protections, and not state law surprise billing protections or an All-Payer Model Agreement, apply.

- The cost sharing generally should be based on the lesser of the billed charge or the health plan or issuer's qualifying payment amount, which is generally based on the median contracted rate for the same or similar item or service in the same geographic area. The health plan sends this information and other required information to the provider, facility, or provider of air ambulance services when sending a payment or notice of denial of payment.

  The consumer's cost-sharing requirement may not be more than the in-network cost-sharing requirement for the same item or service. For example, if the in-network cost sharing for emergency services is 20%, the consumer cost sharing for out-of-network emergency services cannot be greater than 20%.

For more information on cost-sharing calculations, see No Surprises Act: Overview of Key Consumer Protections.

Scenario **2**

Non-Compliance With Notice and Consent Requirements

A consumer is asked to waive their surprise billing protections in a way that is prohibited by the No Surprises Act.

Example A:

A consumer with employer-based group health coverage is asked to waive their surprise billing protections for an ancillary service associated with a scheduled (non-emergency) procedure at an in-network hospital. For example, a week before a scheduled surgery, an out-of-network radiologist asks a consumer to sign a consent form to allow balance billing for radiology services that will be provided during the procedure.

What You Can Do

Step 1:

Consult the Decision Tree: Notice and Consent for information on when a provider may ask a consumer to waive their federal surprise billing protections.

Step 2:

In situations where it appears that a provider or facility has asked a consumer to waive their surprise billing protections when doing so is prohibited, such as for the ancillary services (radiology services) in this example:

- Tell the provider that the No Surprises Act prohibits waiving of surprise billing rights in this situation. Providers may never seek a consumer's consent to waive the No Surprises Act surprise billing protections for non-emergency ancillary services.
- If the consumer has not yet undergone surgery, the consumer can revoke any consent they have signed. If they have not signed a consent form, the consumer may request a written assurance that the consumer will not be balance billed for the radiology services (although federal law does not require a provider to respond). However, even if the consumer takes no action, the radiology provider is not permitted to balance bill because the notice and consent exception to the balance billing protection does not apply to ancillary services such as radiology services.

- If the consumer has undergone surgery and receives a balance bill from the provider, inform the provider that they cannot balance bill because the surprise billing protections under the No Surprises Act apply and cannot be waived. Tell the provider they should file a claim with the consumer's health plan or insurer if they have not already done so. The provider should use the information provided by the health plan to calculate the correct amount that the consumer may be billed.
- If the provider continues to pursue payment from the consumer, file a complaint with the No Surprises Help Desk. The Help Desk may ask you to share relevant information about why you think the provider is not complying with the No Surprises Act. Therefore, it is important to document your findings as you work with the consumer.
- If the consumer is having an issue with debt collection, consider filing a complaint with the Consumer Financial Protection Bureau by calling (855) 411-CFPB (2372).

Example B:

A consumer with individual coverage purchased on the Health Insurance Marketplace®[1] is asked to waive their surprise billing protections by an out-of-network provider. The provider does not follow the proper notice and consent procedures. For example, an out-of-network head surgeon asks a consumer to waive their protections for an upcoming procedure at an in-network ambulatory surgical center. However, the delivery method, timing, or content of the notice and consent form does not meet requirements under the No Surprises Act.

What You Can Do

Step 1:

Consult the Decision Tree: Notice and Consent for information on the requirements providers must follow related to the notice and consent process.

Step 2:

- If the consumer has not yet received the items or services: If the provider refuses to provide the scheduled items and/or services unless the consumer signs the form, then the provider cannot charge the consumer for canceling the appointment. Be aware that a provider can refuse to treat a consumer who refuses to sign the consent form unless state law says otherwise.
- If the consumer receives the services and later receives a balance bill for out-of-network charges: Contact the provider to explain that they cannot balance bill because the balance billing protections under the No Surprises Act apply and were not properly waived. The No Surprises Act protections apply as though the consumer did not sign the consent form and the consumer cost sharing should be calculated accordingly. The provider should file a claim with the consumer's health plan if they have not already done so. The provider should use the information provided by the health plan to calculate the amount that the consumer may be billed.

If needed, contact the health plan or insurer to ensure the final cost-sharing amount is correctly applied to the consumer's in-network deductible and maximum out-of-pocket limit.

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

Scenario **3**

Non-Compliance With Good Faith Estimate Requirements

A provider did not comply with requirements for providing a good faith estimate for an uninsured (or self-pay) individual.

Example:

An uninsured or self-pay consumer either:

- Did not receive a good faith estimate; or
- Received an estimate, but it:
  - Was not provided in clear and understandable language;
  - Was not provided within the required timeframe;
  - Was not provided in the manner requested by the consumer (paper or electronically); or
  - Did not include all required information.

What You Can Do

Step 1:

Consult the Decision Tree: Requirements for Good Faith Estimates for Uninsured (or Self-Pay) Individuals for more information on requirements related to estimates.

Step 2:

If you believe that a provider did not follow these requirements, contact the provider to explain your concerns. Depending on the circumstance, you could:

- Ask why an estimate was not provided. Generally, uninsured and self-pay consumers should receive a good faith estimate when they request one or upon scheduling an appointment three or more days in advance.
- Describe any problems you see with the estimate or how it was provided. If applicable, explain how these issues caused confusion about the final cost of an item or service.
- If relevant, request that the provider or facility re-calculate the bill based on these concerns. For example, if an item or service that was expected to be provided was not included on the estimate, the final bill should not include a charge for that service.

Scenario **4**

Bill for Uninsured Consumer Exceeds Amount of Good Faith Estimate

An uninsured or self-pay consumer receives a good faith estimate from a provider or facility. The provider or facility completed all of the requirements under the No Surprises Act for furnishing the estimate. However, the provider or facility sends the consumer a bill that is higher than the amount on the estimate.

What You Can Do

Step 1:

Consult the Decision Tree: Requirements for Good Faith Estimates for Uninsured (or Self-Pay) Individuals for more information about good faith estimates.

Step 2:

Contact the provider to ask why the bill is higher than the estimate. NOTE: The good faith estimate is not required to include charges for unanticipated items or services that could not reasonably have been foreseen by the provider at the time the estimate was created (e.g., in the case of medical complications).

If you still believe that the bill is not correct, you may:

- Ask the provider or facility to modify the bill to match the estimate;
- Try to negotiate a lower price; or
- Ask if financial assistance is available.

If the bill from a single provider or facility is at least $400 more than the amount reflected on the estimate for that provider or facility, the consumer may use the Patient-Provider Dispute Resolution process.

Scenario 5

Bill for Insured Consumer Exceeds Good Faith Estimate

An insured consumer receives a good faith estimate as part of the notice and consent form they signed to waive their surprise billing protections. The consumer later receives a bill from a provider that is more than the estimate.

What You Can Do

Contact the provider to try to negotiate a better price. A good faith estimate provided as part of the notice and consent form is not eligible for review through the Patient-Provider Dispute Resolution process.

Scenario 6

Non-Compliance with Continuing Care Requirements

An in-network contract between a provider and a health plan ends (for reasons other than failure to meet certain quality standards or fraud) or the provider is no longer considered in-network.

As a result, coverage under in-network rules is discontinued for an enrollee who is considered to be a continuing care consumer as defined under the No Surprises Act.* The consumer would need to switch providers in the middle of treatment to have additional services covered under in-network rules.

What You Can Do

- Ask the consumer if they were notified by their health plan that the provider was no longer in-network and that the consumer could elect to receive continued transitional care from that provider for up to 90 days under in-network rules. If not, contact the health plan to explain that the No Surprises Act continuity of care requirements might not have been followed.
- Ask the health plan to provide notification as required under the No Surprises Act to enable the consumer to opt to receive continued care under in-network rules. This will allow the provider to be reimbursed at the previous contract rate for up to 90 days following the consumer's notification by their health plan (unless the consumer is not considered a continuing care patient). The consumer cost sharing should also be calculated based upon the previous in-network level.

*See the No Surprises Act: Overview of Key Consumer Protections for a description of who is eligible for continuing care under the No Surprises Act.

Scenario 7

Non-Compliance With PPDR Determination

A consumer's bill is not adjusted by a provider or facility after a Patient-Provider Dispute Resolution entity determines that the bill should be reduced.

What You Can Do

In addition to contacting the No Surprises Help Desk, a consumer can contact the provider directly and ask them to adjust the bill to match the amount in the Patient-Provider Dispute Resolution determination.

Scenario 8

Non-Compliance With Provider Directory Requirements

A health plan's provider directory was not updated in the timeframe required under law.

A consumer who relied on the directory inadvertently received care for covered services from a provider who was no longer in-network. The provider billed the consumer for more than what the in-network cost sharing would otherwise have been.

What You Can Do

- Contact the health plan to request that the cost-sharing amount be reduced to the in-network level and that the subsequent payment should be applied to the in-network deductible or out-of-pocket maximum. You could also contact the provider to request adjustment of the bill.
- If the consumer paid the bill, the provider should reimburse the consumer for the amount in excess of the in-network cost-sharing amount, plus interest, if the provider directory requirements were violated.