



The No Surprises Act's Prohibitions on Balancing Billing

*Center for Consumer
Information & Insurance
Oversight (CCIIO)*



Agenda



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Legal Disclaimers

The information provided in this presentation is intended only to be a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance upon which it is based. This presentation summarizes current policy and operations as of the date it was presented. We encourage readers to refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

Legal Disclaimers (continued)

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Background: No Surprises Act Training Series



Overview of the No Surprises Act

The No Surprises Act* introduced new requirements for providers, facilities, and providers of air ambulance services to protect individuals from surprise medical bills. These requirements:

- Prohibit providers and facilities from directly billing individuals for the difference between the amount they charge and the amount that the individual's plan or coverage will pay plus the individual's cost-sharing amounts (i.e., balance billing) in certain circumstances;
- Require providers and facilities to provide good-faith estimates of charges for care to uninsured (or self-pay) individuals upon scheduling care or on request, and for individuals with certain types of coverage, to submit good-faith estimates to the individual's plan or issuer;
- Create a patient-provider dispute resolution process for uninsured (or self-pay) individuals to contest charges that are "substantially in excess" of the good faith estimate;
- Require certain providers and facilities to publicly disclose restrictions on balance billing; and
- Limit billed amounts in situations where a provider's network status changes mid-treatment or individuals act on inaccurate provider directory information.

* Title I (No Surprises Act) of Division BB of the Consolidated Appropriations Act, 2021 (CAA) amended title XXVII of the Public Health Service Act (PHS Act).

Scope of individuals protected under the No Surprises Act

Beginning January 1, 2022, these No Surprises Act requirements will apply to items and services provided to most individuals enrolled in **private or commercial health coverage**, like:

- Employment-based group health plans (both self-insured and fully insured)
- Individual or group health coverage on or outside the Federal or State-based Exchanges
- Federal Employee Health Benefit (FEHB) health plans
- Non-federal governmental plans sponsored by state and local government employers
- Certain church plans within IRS jurisdiction
- Student health insurance coverage [as defined at 45 CFR 147.145]

Scope of individuals protected under the No Surprises Act (continued)

Some requirements also apply to providers and facilities with respect to uninsured (or self-pay) individuals, like requirements that providers and facilities provide good faith estimates for scheduled care, or upon request.

Requirements under the No Surprises Act don't apply to beneficiaries or enrollees in Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE. These programs have other protections against high medical bills. The protections also don't apply to short-term limited duration insurance (STLDI), excepted benefits, or retiree-only plans; or account-based group health plans.

No Surprises Act Training Series

The training series is intended to educate providers and facilities on these major provisions of the No Surprises Act.

***Focus of today's presentation**

Summary of Provision	Statute and Regulatory Citation
*Prohibition on balance billing for emergency services provided by out-of-network providers or emergency facilities	PHS Act section 2799B-1 45 C.F.R § 149.410
*Prohibition on balance billing for non-emergency services by out-of-network providers at certain in-network health care facilities	PHS Act section 2799B-2 45 C.F.R. § 149.420
*Prohibition on balance billing for air ambulance services by out-of-network air ambulance service providers	PHS Act section 2799B-5 45 C.F.R. § 149.440
Public disclosure of individual protections against balance billing	PHS Act section 2799B-3 45 C.F.R. § 149.430
Restrictions on how much providers and facilities bill individuals in situations where the provider's or facility's network contract with the individual's plan or issuer is terminated during continuing care	PHS Act section 2799B-8
Restrictions on how much providers and facilities bill individuals in situations where an individual inadvertently receives care from an out-of-network provider or facility based on inaccurate provider directory information	PHS Act section 2799B-9
Provision of good faith estimates of charges to uninsured or self-pay individuals in advance of scheduled items or services or upon request	PHS Act section 2799B-6 45 C.F.R. § 149.610
The patient-provider dispute resolution process	PHS Act section 2799B-7 45 C.F.R § 149.620
The independent dispute resolution process	PHS Act section 2799A-1 45 C.F.R § 149.510

The No Surprises Act Prohibitions on Balance Billing



Overview of the No Surprises Act prohibitions on balance billing

The No Surprises Act requires health plans and issuers to apply in-network cost-sharing terms and prohibits out-of-network providers, facilities, or providers of air ambulance services from billing individuals more than these in-network cost-sharing limits in 3 main scenarios:

1. A person gets covered emergency services from an out-of-network provider or out-of-network emergency facility;
2. A person gets covered non-emergency services from an out-of-network provider delivered as part of a visit to an in-network health care facility; or
3. A person gets covered air ambulance services provided by an out-of-network provider of air ambulance services.

Overview of the No Surprises Act prohibitions on balance billing (continued)

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 post-stabilization services or non-ancillary, non-emergency services.

- These situations are referred to throughout this presentation as notice-and-consent exceptions.

In-network vs. out-of-network providers, facilities, and air ambulance providers

In-network: A provider, facility, or provider of air ambulance services that has a contractual relationship with a health plan or issuer for the item or service provided.

- Contractual relationships include single case agreements between a plan or issuer and an out-of-network facility that are used to address unique situations in which an individual requires services that typically occur out-of-network.

Out-of-network: A provider, provider of air ambulance services, or facility that doesn't have a contractual relationship with an individual's health plan or issuer for the item or service provided.

We will review the definition of terms like provider, provider of air ambulance services, and facility throughout the presentation.

Consumer insurance information that affects prohibitions on balance billing

Covered Benefits: Prohibitions on balance billing for air ambulance, emergency, and non-emergency services only apply to items or services that are covered benefits under the in-network terms of a privately insured individual's health plan or coverage.

Plan Year: Prohibitions on balance billing apply to items or services delivered in health insurance plan or policy years starting on or after **January 1, 2022.**

What facilities, providers, and air ambulance providers need to do when providing items or services for which the prohibitions on balance billing apply

In situations where balance billing is banned and a notice-and-consent exception doesn't apply, an out-of-network provider, emergency facility, or provider of air ambulance services can't:

1. Bill an individual for an amount that exceeds in-network limits on cost-sharing; or
2. Hold an individual liable for paying an amount that exceeds in-network limits on cost-sharing, and the individual can't be put in the middle of a dispute regarding the total payment amount from the plan or issuer to the provider, facility, or provider of air ambulance services.

What facilities, providers, and air ambulance providers need to do when providing items or services for which the prohibitions on balance billing apply (continued)

After an out-of-network provider, facility, or provider of air ambulance services furnishes items or services to an individual, the out-of-network provider or facility receives an initial payment from the health plan or issuer. However, the final payment they receive from the plan may be determined by:

- An all-payer model agreement (APMA) or specified state law depending on the item or service, geographic area where the care was provided, and type of plan or issuer and provider or facility involved.
- If there is no APMA or specified state law that applies, the provider, facility, or air ambulance provider may accept the initial payment as payment in full or may enter into a 30-business-day period of open negotiations with the health plan or issuer to determine the final total amount.
- If negotiations fail, the two parties may enter an independent dispute resolution (IDR) process to determine final total payment.

An upcoming training session will discuss the IDR process in more detail.

Determining the cost-sharing amount that a provider, facility, or air ambulance provider can bill and collect from an individual

In situations where balance billing is banned under the No Surprises Act, health plans and issuers must determine the amount that out-of-network providers, facilities, or providers of air ambulance services can charge an individual by imposing cost-sharing requirements that are not higher than the in-network cost-sharing terms of an individual's plan.

Health plans and issuers calculate the dollar amount of cost-sharing applying the cost-sharing terms to the "recognized amount," which is further specified in regulations.

Depending on the type of item or service and geographic area where care is provided, plan or issuer, and provider or facility, this amount can be set by an all-payer model agreement (if applicable to the plan/issuer and provider/facility), a specified state law (if applicable to the plan/issuer and provider/facility), or the lesser of (1) billed charges or (2) the plan's **qualifying payment amount (QPA)** for the item or service.

Determining the cost-sharing amount that a provider, facility, or air ambulance provider can bill and collect from an individual (continued)

The QPA is defined in regulation and is generally the plan or issuer's median contracted rate for the item or service in the geographic area where the item or service was delivered from January 31, 2019, indexed for inflation.

Amount used to calculate individual cost-sharing	
Emergency and Non-Emergency Services	<p>The recognized amount which is:</p> <p>An amount determined by an All-Payer Model Agreement (e.g., Maryland's All Payer Model)</p> <p><i>If no All-Payer Model Agreement exists:</i></p> <p>Amount determined by specified state law</p> <p><i>If no All-Payer Model Agreement or specified state law exists, the lesser of:</i></p> <ul style="list-style-type: none">a) the amount billed by the provider/facility orb) the qualifying payment amount for the item or service
Air Ambulance Services	<p>The lesser of:</p> <ul style="list-style-type: none">a) the amount billed by provider of air ambulance services orb) the qualifying payment amount for the item or service

Best practices to ensure compliance with the No Surprises Act prohibitions on balance billing

To ensure compliance with the No Surprises Act, providers, facilities, and providers of air ambulance services may need to bill the plan or issuer directly for services to determine whether No Surprises Act protections apply.

Out-of-network providers must also determine whether the facility where they delivered care is an in-network health care facility for a particular individual's health plan and coverage, as well as whether the individual received items or services provided in conjunction with a visit at an in-network facility (e.g., laboratory services).

If out-of-network providers, facilities, or providers of air ambulance services bill an individual in violation of the No Surprises Act, they may be subject to civil fines or other corrective action.

Prohibition on Balancing Billing for Air Ambulance Services



Overview of the No Surprises Act prohibition on balance billing for air ambulance services

Generally, out-of-network air ambulance service providers are banned from balance billing an individual for covered **air ambulance services**.

Note that ground ambulance services aren't covered under this prohibition.

We will review each of these terms throughout the presentation.

Scope of air ambulance services and providers subject to the prohibition on balance billing for air ambulance services

Out-of-network air ambulance service providers can't balance bill for the following **air ambulance services**, including medical supplies and services provided in transport:

1. Medical transport by helicopter (“rotary wing” ambulance); and
2. 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.

Air ambulance service providers may **NEVER** seek an individual's consent to waive No Surprises Act protections for these services through notice-and-consent exceptions.

Knowledge check

Carol is a 58-year-old female with Marketplace coverage. Over 2 days, she develops worsening abdominal pain, nausea, and constipation, which prompts her to call 911 for medical assistance. She is driven by ground ambulance transport to her local in-network emergency department for exam and treatment.

How much can the ambulance provider bill Carol under the rules of the No Surprises Act?

Knowledge check answer

The ambulance provider isn't banned from balance billing under the No Surprises Act because it is a ground ambulance provider.

Note: Air ambulance service providers, but not ground ambulance service providers, are banned from balance billing under the No Surprises Act. As such, no restrictions are placed on the amount the ambulance provider can bill an individual under the No Surprises Act.

Prohibition on Balancing Billing for Emergency Services



Overview of the No Surprises Act prohibition on balance billing for emergency services

Generally, **out-of-network providers** and **out-of-network emergency facilities** can't balance bill an individual who gets covered **emergency services** for an **emergency medical condition**.

We will review what each of these terms mean throughout the presentation.

Scope of providers that must comply with the No Surprises Act prohibitions on balance billing for emergency services

The following types of providers can't send a balance bill for **covered emergency services when providing care as an out-of-network provider** at an emergency facility:

1. Physicians;
2. Other health care providers acting within their scope of practice under applicable state law (e.g., a certified nurse practitioner or physician assistant).

Scope of facilities that must comply with the No Surprises Act prohibitions on balance billing for emergency services

The following types of facilities can't send a balance bill for covered emergency services when providing care as an **out-of-network emergency facility**:

1. **Emergency departments of a hospital**, defined as hospital outpatient departments that provide emergency services;
2. **Hospitals**, regardless of the department, when providing post-stabilization services; and
3. **Independent, freestanding emergency departments**, defined as health care facilities that:
 - Are geographically separate and distinct and licensed separately from a hospital under applicable state law; and
 - Provide any emergency services.

Note: Urgent care centers can be treated as independent, freestanding emergency departments if they meet this definition of an independent, freestanding emergency department.

Individuals may never be balance billed for emergency services

Out-of-network providers and emergency facilities are **ALWAYS** banned from balance billing for the following **emergency services**:

- An appropriate **medical screening examination** that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, including ancillary services routinely available to the emergency department, to evaluate whether an emergency medical condition exists; and
- Such **further medical examination and treatment** as may be required **to stabilize** the individual (regardless of the department of the hospital in which the further medical examination and treatment is furnished) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department.

Balance billing protections apply to these emergency medical conditions

Balance billing isn't allowed for emergency services when an individual gets care for an **emergency medical condition**, using a “prudent layperson” definition:

- A person, who has average 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.

Knowledge check

Zoe is a 26-year-old female with Marketplace coverage. She works as a teacher and has an average knowledge of health and medicine. She has severe pain, swelling and redness of her right calf, and becomes concerned that this may be dangerous. So, she travels to the local hospital emergency department that is in her health plan's network. She has a venous ultrasound. 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.

Do the No Surprises Act's balance billing protections related to emergency services apply to the radiologist?

Knowledge check answer

Yes, it would.

Zoe sought care for a medical condition that, using reasonable layperson judgment, she thought was an emergency medical condition that needed immediate medical attention to avoid serious jeopardy, impairment, or dysfunction. Per the No Surprises Act, out-of-network providers are banned from balance billing for emergency services provided for emergency medical conditions. Emergency services include ancillary services available to the emergency department to evaluate whether an emergency medical condition exists, such as services of a radiologist who reads an imaging study.

Post-stabilization services where notice-and-consent exceptions may be used

Under the No Surprises Act, certain **post-stabilization services** are considered emergency services, and prohibitions on balance billing generally apply.

Post-stabilization services are covered services that are provided after the individual is stabilized, as part of an outpatient observation, or an inpatient or outpatient stay related to the emergency visit (regardless of the department of the hospital).

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.

When notice-and-consent exceptions can be used for post-stabilization services

A provider or emergency facility can get written consent from an individual to waive their balance billing protections under the No Surprises Act for post-stabilization services **only if all the following requirements are met:**

Requirement	Additional Details
1. An individual is stable enough to travel using nonmedical or nonemergency medical transport to an available in-network provider/facility located within a reasonable travel distance given the individual's medical condition.	<ul style="list-style-type: none">• Determined by attending emergency physician or treating provider.• Provider determination is binding on a facility.
2. The individual or their authorized representative is in a condition where they can receive information and provide informed consent.	<ul style="list-style-type: none">• Determined by attending emergency physician or treating provider.• An authorized representative CAN'T be a provider affiliated with the facility or an employee of the facility, unless such provider or employee is a family member of the participant, beneficiary, or enrollee.
3. The provider/facility provides written notice and obtains written consent from the individual to waive balance billing protections, in compliance with all related statutory and regulatory requirements.	<ul style="list-style-type: none">• Details provided starting on slide 51.
4. The provider/facility complies with state laws.	<ul style="list-style-type: none">• This may include state laws that further restrict balance billing for post-stabilization services.

We will review additional requirements that must be met when using notice-and-consent exceptions later in the presentation.

Knowledge check

Carlos is a 62-year-old male with employer-sponsored health coverage. He is involved in a motor vehicle accident and sustains multiple injuries. He is taken to the closest hospital, 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 safest form of transport, given his medical state, would be via ambulance. Carlos knows that the hospital he is in has an excellent reputation and wishes to stay there for his recovery. The hospital provides a written notice and gets his written consent to waive his balance billing protections under the No Surprises Act. He remains inpatient for two additional days and is ultimately discharged to home.

Does the No Surprises Act's prohibition on balance billing for emergency services apply to all days of care Carlos received from this hospital?

Knowledge check answer

Yes.

The hospital is banned from balance billing Carlos for items and services provided prior to his being stabilized. The hospital is also banned from balance billing him for post-stabilization services provided after surgery, despite obtaining written consent from Carlos to waive his balance billing protections under the No Surprises Act. Because he could only safely be transferred via ambulance, the hospital can't seek consent from him to waive his balance billing protections under the No Surprises Act specific to post-stabilization services.

Prohibition on Balancing Billing for Non-Emergency Services



Overview of the No Surprises Act's prohibition on balance billing for non-emergency services

Generally, **out-of-network providers** are banned from balance billing an individual who gets covered, non-emergency services that are **part of a visit to an in-network health care facility**.

We will review each of these terms throughout the presentation.

Scope of providers that must comply with the No Surprises Act's prohibition on balance billing for non-emergency services

The following types of providers are banned from balance billing when providing non-emergency services as an **out-of-network provider** at an in-network health care facility:

- Physicians;
- Other health care providers acting within their scope of practice under applicable State law (e.g. a certified nurse practitioner or physician assistant).

Scope of facilities that can be in-network facilities

The No Surprises Act's prohibitions on balance billing for non-emergency services only apply to covered non-emergency services that are furnished as part of a visit to one of the following **in-network health care facilities**:

- **Hospitals** (including critical access hospitals);
- **Hospital outpatient departments**; or
- **Ambulatory surgical centers**.

Reminder: To be considered **an in-network health care facility**, a facility must be:

- In-network; or
- Have a single case agreement with a health plan or issuer for a specific individual.

Scope of non-emergency services that are considered part of visit to a facility

Out-of-network providers can't balance bill for **non-emergency items and services that are part of a visit** at an in-network health care facility. This includes the following:

1. Equipment and devices;
2. Imaging services;
3. Telemedicine services;
4. Lab services;
5. Preoperative services and postoperative services.

These items or services don't need to happen physically within the in-network health care facility to be treated as part of a visit (e.g., offsite laboratory services).

Reminder: The No Surprises Act's ban on balance billing for non-emergency services only apply to plan covered services. If a non-emergency service is not covered under the in-network benefits and terms of coverage under an individual's health plan, then the No Surprises Act's rules on balance billing do not apply for these services.

Non-emergency services for which individuals may never be balance billed

Ancillary services, which individuals typically have little control over, are **ALWAYS** subject to balance billing prohibitions.

The No Surprises Act defines **ancillary services** as:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, provided by either a physician or non-physician practitioner;
- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services; and
- Items and services provided by an out-of-network provider when there is no in-network provider who can provide the item or service at the in-network health care facility.

Non-emergency services for which individuals may never be balance billed (continued)

Providers and facilities may **NEVER** seek an individual's consent to waive the No Surprises Act's balance billing protections for **non-emergency ancillary services** through use of notice-and-consent exceptions.

Notice-and-consent exceptions also **NEVER** apply to waive the No Surprises Act's balance billing protections related to non-emergency services when:

- Items or services are provided due to unforeseen urgent medical needs in the course of care delivery; or
- Banned by state laws.

Non-emergency services for which notice-and-consent exceptions can be used

A provider/facility can use the No Surprises Act's notice-and-consent exception to get consent from an individual to voluntarily waive their balance billing protections under the No Surprises Act for non-ancillary, non-emergency services furnished in an in-network facility.

All requirements for providing notice and consent documents and getting proper consent must be met.

We will review requirements that must be met when using notice-and-consent exceptions later in the presentation.

Situations when the No Surprises Act does not regulate provider billing practices for non-emergency services

The No Surprises Act does not regulate billing for non-emergency services in the following circumstances:

- When non-emergency covered items or services are provided in an **out-of-network** hospital, outpatient hospital department, ambulatory surgical center, or other facility type specified by the Secretary of Health and Human Services (HHS).
- When the items or services provided are not covered under the in-network terms of an individual's health plan or coverage, even if provided in an in-network hospital, outpatient hospital department, ambulatory surgical center, or other facility type specified by the Secretary of HHS.

Reminder: Providers may need to bill plans or issuers directly to determine whether No Surprises Act requirements apply, given the terms of an individual's health plan/coverage and a facility's participation status.

Knowledge check

Rhonda is a 50-year-old female with employer-sponsored health insurance who discovers a lump in her breast. Her primary care provider orders a mammogram, which shows a suspicious mass. She is referred to the local in-network hospital's outpatient department for a biopsy. The biopsy is reviewed and found to be negative for malignant cells by a pathologist who happens to be out-of-network.

How much can the pathologist bill Rhonda under the rules of the No Surprises Act?

Knowledge check answer

Under the No Surprises Act, the pathologist is banned from billing Rhonda more than the in-network cost-sharing amounts, as determined by her health plan. The pathologist, as an ancillary service provider, is banned from obtaining consent from the individual to waive these balance billing protections.

Notice-and-Consent Exceptions to Balance Billing Prohibitions



Recap of when out-of-network providers or facilities can and cannot use notice-and-consent exceptions

Emergency services, including post-stabilization services

Use of Notice-and-Consent Exception <u>Not</u> Allowed	<p>When providing any emergency services prior to post-stabilization services, including medical exams and treatment to stabilize an individual</p> <p>When providing items or services due to unforeseen urgent medical needs in the course of care delivery</p> <p>When providing post-stabilization services if any one of the requirements listed below are not met</p> <p>Additional situations banned by state law</p>
Use of Notice-and-Consent Exception <u>Allowed</u>	<p>When providing post-stabilization services and all the following are true:</p> <ul style="list-style-type: none">• An individual is stable enough to travel using nonmedical or nonemergency 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/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.• The provider/facility complies with applicable state laws.

Recap of when out-of-network providers or facilities can and cannot use notice-and-consent exceptions (continued)

Non-emergency services

Use of Notice and Consent Exception Not Allowed

When providing ancillary services, defined as:

- Emergency medicine, anesthesiology, pathology, radiology, neonatology items or services provided by physician or non-physician practitioner;
- Items or services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services;

Items or services of an out-of-network provider if there is no in-network provider who can provide the item or service at the facility.

When providing items or services due to unforeseen urgent medical needs in the course of care delivery.

Additional situations banned by state law.

Use of Notice and Consent Exception Allowed

When providing non-emergency services (i.e., not post-stabilization services) in an in-network facility and all the following are true:

- The items or services do not meet the definition of ancillary services;
- 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.

Information providers and facilities must include in the notice and consent documents provided to individuals

When giving notice and seeking consent from individuals to waive their balance billing protections under the No Surprises Act, providers and facilities must use standard notice and consent documents developed by HHS.

The standard notice and consent documents were published as part of [CMS Form Number 10780](#) and are available for download on CMS.gov.

Providers and facilities must tailor the standard notice with individual- and provider-specific information.

Information providers and facilities must include in the notice and consent documents provided to individuals (continued)

Provider/Facility supplied information in notice document:

- Patient Name
- Out-of-network provider(s) or facility name
- Statement that the health care provider is an out-of-network provider, with respect to the health plan or coverage
- Good faith estimates of the amount the individual may be charged for items or services delivered by the out-of-network provider(s) or facility
- Statement that prior authorization or other care management limitations may be required
- *For post-stabilization services furnished by an out-of-network provider in an in-network emergency facility: A list of in-network providers at the facility able to deliver needed items or services*

Estimate of what you could pay

Patient name: _____

Out-of-network provider(s) or facility name: _____

Total cost estimate of what you may be asked to pay:	
--	--

► Review your detailed estimate. See Page 4 for a cost estimate for each item or service you'll get.

► Call your health plan. Your plan may have better information about how much you will be asked to pay. You also can ask about what's covered under your plan and your provider options.

► Questions about this notice and estimate? Call [Enter contact information for a representative of the provider or facility to explain the documents and estimates to the individual, and answer any questions, as necessary.]

► Questions about your rights? Contact [contact information for appropriate federal or state agency]

Prior authorization or other care management limitations

[Enter either (1) specific information about prior authorization or other care management limitations that are or may be required by the individual's health plan or coverage, and the implications of those limitations for the individual's ability to receive coverage for those items or services, or (2) include the following general statement:

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage.]

[In the case where this notice is being provided for post-stabilization services by a nonparticipating provider within a participating emergency facility, include the language immediately below and enter a list of any participating providers at the facility that are able to furnish the items or services described in this notice]

Understanding your options

You can also get the items or services described in this notice from these providers who are in-network with your health plan:

More information about your rights and protections

Visit [website] for more information about your rights under federal law.

When and how providers and facilities must deliver the notice and consent documents to individuals

Requirement	Information
Timing of delivery	<ul style="list-style-type: none">• If an individual schedules an appointment at least 72 hours before the date of the appointment, notice and consent documents must be given to the individual no later than 72 hours before the date of appointment.• If an individual schedules an appointment within 72 hours of the date of the appointment, notice and consent documents must be given on the day the appointment is made, but at least 3 hours before the time when items or services are to be provided.
Method of delivery	<p>Notice and consent documents must be delivered:</p> <ul style="list-style-type: none">• Together.• Physically separate from other forms. They must not be attached or incorporated into other documents or hidden among other forms.• On paper or electronically, as preferred by individual. <p>A representative of the provider/facility must be physically present or available by phone to answer questions.</p>

Language accessibility requirements for notice and consent documents

Notice and consent documents must be available in the 15 most common languages in the state or a facility's geographic service region.

If an individual can't understand any of the languages in which the notice and consent documents are provided, they can't give consent.

If the documents aren't available in an individual's preferred language, a provider or facility must provide a qualified interpreter to get consent.

Note: Providers and facilities that get federal financial assistance must provide such documents in a manner that complies with other federal civil rights laws, as applicable, including Section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act.

Parties allowed to provide notice and obtain consent

The following parties may provide notice and get signed consent from individuals to waive balance billing protections under the No Surprises Act:

- Out-of-network providers;
- Out-of-network emergency facilities; and
- In-network facilities on behalf of out-of-network providers.

Using a single set of notice and consent documents for multiple providers

An individual can provide consent to waive the No Surprises Act's balance billing protections for multiple providers involved in the delivery of care through a single set of notice and consent documents.

If multiple providers are using a single set of notice and consent documents, the documents must:

- Identify each provider, the services or items furnished by each provider, and the good faith estimate for each provider's services or items.
- Allow the individual to waive No Surprises Act protections for each provider separately.

Obtaining proper consent to waive balance billing prohibitions

- Consent does not represent a contractual agreement of the individual to any estimated charge or to be treated by that provider or facility.
- Consent documents may be signed electronically by the individual or their authorized representative.
- For the signed consent form to be valid, it must not be revoked in writing by the individual before they get the items or services related to the consent form.
- If a provider or facility doesn't comply with any one requirement related to providing notice and consent documents and getting consent, the provider or facility can't balance bill the individual. This is true even if the provider or facility gets the individual's signed consent.
- A provider or facility can refuse to treat an individual if they don't consent to waive their balance billing protections under the No Surprises Act, so long as this is allowed under state law. However, no fees can be imposed on an individual for cancelling an appointment if they don't consent to waive their No Surprises Act protections.

Maintaining and sharing document records

- Signed consent documents must include the time and date when the individual got the notice, and the time and date when the individual signed the consent document.
- Providers and facilities must retain a copy of notice and consent documents for at least 7 years after the date when the item or service is provided.
- Providers and facilities must give a copy of the signed notice and consent documents to the individual in-person or through mail or email (based on individual preference).
- Providers and facilities must timely notify a health plan or issuer about items or services delivered for which proper consent to waive balance billing prohibitions was obtained and give the plan or issuer a copy of the signed documents, preferably with the claim.

Knowledge check

Shawn is a 35-year-old male who has insurance through the Marketplace. He is playing soccer and sustains a knee injury, which is later diagnosed as a torn ACL. He is advised by his friends to go to a specific orthopedist who has an excellent reputation. His surgery is scheduled at an in-network ambulatory surgical center a week in advance. One day before his surgery, he gets an email with the written notice and consent documents, informing him that the orthopedist is out of-network and requesting that he consent to waive his balance billing protections under the No Surprises Act in order to be treated by the orthopedist. Shawn signs the consent to waive balance billing protections, as he would like to see this specific provider for his knee surgery. Several weeks after his surgery, Shawn gets a balance bill from his orthopedist.

Did the orthopedist comply with requirements of the No Surprises Act?

Knowledge check answer

No, the provider violated No Surprises Act requirements related to when notice and consent documents must be provided to individuals.

Since Shawn scheduled his surgery more than 72 hours in advance, written notice and consent must be provided to the individual no later than 72 hours before the date of the appointment. In this case, the provider sent notice and consent documents one day before the appointment.

Because all requirements related to using notice-and-consent exceptions were not met, the orthopedic surgeon is banned from balance billing Shawn for services provided as part of the surgery even though he signed the consent form.

Main Takeaways

The No Surprises Act prohibits balance billing in three major scenarios:

1. A person gets covered emergency care from an out-of-network provider or out-of-network emergency facility;
2. A person gets covered non-emergency care from an out-of-network provider as part of a visit to an in-network health care facility; or
3. A person gets covered air ambulance services by an out-of-network air ambulance provider.

In situations where balance billing is banned, out-of-network providers, emergency facilities or air ambulance providers can't bill or hold an individual liable for paying an amount that exceeds in-network limits on cost-sharing.

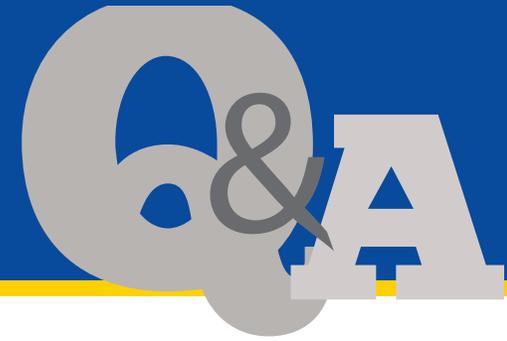
Main Takeaways (continued)

In situations where balance billing may be banned, providers, emergency facilities and air ambulance providers should bill health plans and issuers directly to determine whether No Surprises Act protections apply.

In limited circumstances, the No Surprises Act permits some out-of-network providers and facilities to use notice-and-consent exceptions to get an individual's consent to waive No Surprises Act balance billing protections related to post-stabilization emergency services and non-ancillary, non-emergency services provided by out-of-network providers in in-network facilities.

When use of notice-and-consent exceptions are permitted, out-of-network providers and facilities must ensure that notice and consent documents and procedures comply with all No Surprises Act requirements.

Questions



Send any questions about the provider requirements and provider enforcement to provider_enforcement@cms.hhs.gov.

Appendix: Glossary



Glossary

Term	Definition	Citation in the CFR	Originating No Surprises Act Rule
Air ambulance service	Medical transport by a rotary wing air ambulance, as defined in 42 CFR 414.605 (transportation by a helicopter that is certified as an ambulance and such services and supplies as may be medically necessary), or fixed wing air ambulance (transportation by a fixed wing aircraft that is certified as a fixed wing air ambulance and such services and supplies as may be medically necessary), as defined in 42 CFR 414.605, for patients.	45 CFR 149.30	Requirements Related to Surprise Billing; Part I IFC
Ancillary services	(i) Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner; (ii) Items and services provided by assistant surgeons, hospitalists, and intensivists; (iii) Diagnostic services, including radiology and laboratory services; and (iv) Items and services provided by an out-of-network provider if there is no in-network provider who can furnish such item or service at such facility.	45 CFR 149.420(b) (1)	Requirements Related to Surprise Billing; Part I IFC
Cost sharing	The amount a participant, beneficiary, or enrollee is responsible for paying for a covered item or service under the terms of the group health plan or health insurance coverage. Cost sharing generally includes copayments, coinsurance, and amounts paid towards deductibles, but does not include amounts paid towards premiums, balance billing by out-of-network providers, or the cost of items or services that are not covered under a group health plan or health insurance coverage.	45 CFR 149.30	Requirements Related to Surprise Billing; Part I IFC
Emergency department of a hospital	Includes a hospital outpatient department that provides emergency services.	45 CFR 149.30	Requirements Related to Surprise Billing; Part I IFC

Glossary

Term	Definition	Citation in the CFR	Originating No Surprises Act Rule
Emergency medical condition	A medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). (In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.)	45 CFR 149.110(c)(1)	Requirements Related to Surprise Billing; Part I IFC

Glossary

Term	Definition	Citation in the CFR	Originating No Surprises Act Rule
Emergency services	<p>With respect to an emergency medical condition—</p> <p>(i) In general.</p> <p>(A) An appropriate medical screening examination (as required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and</p> <p>(B) Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).</p> <p>(ii) Inclusion of additional services. (A) Subject to paragraph (c)(2)(ii)(B) of this section, items and services— (1) For which benefits are provided or covered under the plan or coverage; and (2) That are furnished by an out-of-network provider or out-of-network emergency facility (regardless of the department of the hospital in which such items or services are furnished) after the participant, beneficiary, or enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in paragraph (c)(2)(i) of this section are furnished. (B) Items and services described in paragraph (c)(2)(ii)(A) of this section are not included as emergency services if all of the conditions in § 149.410(b) are met.</p>	<p>45 CFR 149.110(c)(2)</p>	<p>Requirements Related to Surprise Billing; Part I IFC</p>

Glossary

Term	Definition	Citation in the CFR	Originating No Surprises Act Rule
Health care facility	<p>With respect to a group health plan or group or individual health insurance coverage, in the context of non-emergency services, is each of the following:</p> <p>(1) A hospital (as defined in section 1861(e) of the Social Security Act);</p> <p>(2) A hospital outpatient department;</p> <p>(3) A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and</p> <p>(4) An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.</p>	45 CFR 149.30	Requirements Related to Surprise Billing; Part I IFC
Independent freestanding emergency department	A health care facility (not limited to those described in the definition of health care facility with respect to non-emergency services) that—(1) Is geographically separate and distinct and licensed separately from a hospital under applicable State law; and (2) Provides any emergency services as described in § 149.110(c)(2)(i).	45 CFR 149.30	Requirements Related to Surprise Billing; Part I IFC
Out-of-network emergency facility	An emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to services that pursuant to § 149.110(c)(2)(ii) are included as emergency services), that does not have a contractual relationship directly or indirectly with a group health plan or group or individual health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage, respectively.	45 CFR 149.30	Requirements Related to Surprise Billing; Part I IFC
Out-of-network provider	Any physician or other health care provider who does not have a contractual relationship directly or indirectly with a group health plan or group or individual health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage, respectively.	45 CFR 149.30	Requirements Related to Surprise Billing; Part I IFC

Glossary

Term	Definition	Citation in the CFR	Originating No Surprises Act Rule
In-network emergency facility	Any emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to services that pursuant to § 149.110(c)(2)(ii) are included as emergency services), that has a contractual relationship directly or indirectly with a group health plan or health insurance issuer offering group or individual health insurance coverage setting forth the terms and conditions on which a relevant item or service is provided to a participant, beneficiary, or enrollee under the plan or coverage, respectively. A single case agreement between an emergency facility and a plan or issuer that is used to address unique situations in which a participant, beneficiary, or enrollee requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement.	45 CFR 149.30	Requirements Related to Surprise Billing; Part I IFC
In-network health care facility	Any health care facility described in this section that has a contractual relationship directly or indirectly with a group health plan or health insurance issuer offering group or individual health insurance coverage setting forth the terms and conditions on which a relevant item or service is provided to a participant, beneficiary, or enrollee under the plan or coverage, respectively. A single case agreement between a health care facility and a plan or issuer that is used to address unique situations in which a participant, beneficiary, or enrollee requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement.	45 CFR 149.30	Requirements Related to Surprise Billing; Part I IFC
In-network provider	Any physician or other health care provider who has a contractual relationship directly or indirectly with a group health plan or health insurance issuer offering group or individual health insurance coverage setting forth the terms and conditions on which a relevant item or service is provided to a participant, beneficiary, or enrollee under the plan or coverage, respectively.	45 CFR 149.30	Requirements Related to Surprise Billing; Part I IFC

Glossary

Term	Definition	Citation in the CFR	Originating No Surprises Act Rule
Physician or health care provider	A physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law, but does not include a provider of air ambulance services.	45 CFR 149.30	Requirements Related to Surprise Billing; Part I IFC
Post-stabilization services	Items and services—(1) For which benefits are provided or covered under the plan or coverage; and (2) That are furnished by a nonparticipating provider or nonparticipating emergency facility (regardless of the department of the hospital in which such items or services are furnished) after the participant, beneficiary, or enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in paragraph (c)(2)(i) of this section are furnished.	45 CFR 149.110(c)(2)(ii)	Requirements Related to Surprise Billing; Part I IFC
Air ambulance services provider	An entity that is licensed under applicable State and Federal law to provide air ambulance services.	45 CFR 149.30	Requirements Related to Surprise Billing; Part I IFC

Glossary

Term	Definition	Citation in the CFR	Originating No Surprises Act Rule
Qualifying payment amount	<p>With respect to a sponsor of a group health plan or health insurance issuer offering group or individual health insurance coverage, the amount calculated using the methodology described in paragraph (c) of this section.</p> <p>(c) Methodology for calculation of the qualifying payment amount—(1) In general. (i) For an item or service (other than items or services described in paragraphs (c)(1)(iii) through (vii) of this section) furnished during 2022, the plan or issuer must calculate the qualifying payment amount by increasing the median contracted rate (as determined in accordance with paragraph (b) of this section) for the same or similar item or service under such plans or coverage, respectively, on January 31, 2019, by the combined percentage increase as published by the Department of the Treasury and the Internal Revenue Service to reflect the percentage increase in the CPI-U over 2019, such percentage increase over 2020, and such percentage increase over 2021.</p>	45 CFR 149.140(a)(16)	Requirements Related to Surprise Billing; Part I IFC
To stabilize	The term ‘to stabilize’, with respect to an emergency medical condition, has the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).	45 CFR 149.110(c)(3)	Requirements Related to Surprise Billing; Part I IFC
Visit	With respect to items and services furnished to an individual at a health care facility, includes, in addition to items and services furnished by a provider at the facility, equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services, regardless of whether the provider furnishing such items or services is at the facility.	45 CFR 149.30	Requirements Related to Surprise Billing; Part I IFC