Course 10 — Coverage to Care Assistance

Module 1 – Course Introduction

Course Introduction

Coverage to Care Assistance

Welcome

Welcome to the Coverage to Care Assistance course!

I’m Jo. As an Assister, you can play an important role in helping consumers get the most from their coverage through the Marketplaces. I’ll help you learn how to work with consumers to improve their experience and to answer the following questions.

- How can I help consumers learn about their coverage costs?
- How can I help consumers confirm they’re enrolled in health coverage?
- How can I help consumers understand how to identify in-network providers and how to make and prepare for an appointment with a provider?

Course Goal

The Coverage to Care (C2C) initiative is a health insurance literacy tool. It's useful in helping consumers understand what health insurance is, how to choose coverage, and why it's important to choose coverage. Many C2C materials help consumers understand their health coverage after they've enrolled and connect to primary care and preventive services that are right for them so they can live long and healthy lives.

Goal:

This course will introduce the Centers for Medicare & Medicaid Services (CMS) Coverage to Care initiative and demonstrate how you can support consumers year-round to work through the Marketplaces to make the most of their health coverage.

By the end of this course, you will understand:

- resources available to consumers to obtain information about their plans
- techniques for explaining information like costs of coverage and services available under a plan
- protections available for all consumers, including new rights and protections made available by the No Surprises Act
- how to help consumers make premium payments, make an appointment, and understand changes to their healthcare premiums when reporting a life change

Module 2 — From Coverage to Care (C2C)

Module Introduction

During your interaction with consumers, you can help them understand basic concepts and rights related to their health coverage at every stage of the application process. By the end of this module, you should be able to understand these concepts and accomplish the associated tasks below them.

Coverage to Care (C2C) Purpose

State the purpose of the Coverage to Care (C2C) initiative.

Plan Details

Identify the basic details every consumer should know about their plan to take advantage of health coverage.

First Month’s Premium

Describe options for making the first month’s premium payment.

From Coverage to Care Initiative

Remember that Navigators and Certified Application Counselors (CACs) in the Federally-facilitated Marketplace (FFM) must provide information in a fair, accurate, and impartial manner. All Assisters must provide information that assists consumers with submitting their eligibility applications; clarify the distinctions among health coverage options, including qualified health plans (QHPs); and help consumers make informed decisions during the health coverage selection process. Navigators in the FFM must acknowledge other health programs like Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) when providing this information.

The C2C initiative provides resources that help consumers understand their health care coverage. While you're not required to use C2C resources, they can help you:

- Provide additional information about health coverage once consumers are enrolled in a Marketplace plan.
- Connect consumers with tools to better understand health care.
- Answer consumers' questions about using their coverage to navigate the health care system.

Great C2C resources for consumers include the Roadmap to Better Care and 5 Ways to Make the Most of Your Health Coverage. After consumers enroll in a QHP through a Marketplace, 5 Ways to Make the Most of Your Health Coverage can help you answer additional questions.

Confirm Your Coverage

It's always a good idea for consumers to contact their selected health plan and/or their state Medicaid or CHIP agency to confirm that their enrollment is complete. Consumers must also pay their premium, if they have one, to stay covered.

Consumers can contact their health plan to identify what services are covered and what their costs will be. Additional information may be provided on a health plan's website that can be accessed through a Quick Response code (QR code); on a physical ID card; or through a hyperlink on a digital ID card. Many health insurance companies' websites allow consumers to:

- find additional contact and coverage information
- create an account where they can access messages about coverage
- print a copy of their health insurance card and more

Know Where to Go for Answers

Once consumers have enrolled in a health plan, they should receive a health insurance card with a member service number in the mail. Pricing information appears on any physical or electronic plan or insurance identification (ID) card provided to patients that includes:

- applicable deductibles
- applicable out-of-pocket maximum limits
- a telephone number and website for consumer assistance

If consumers still have questions about key health insurance terms like “coinsurance” or “deductible” after they meet with you, they can use Roadmap to Better Care to learn more.

Find a Provider

Consumers should select a health care provider in their plan’s network who will work with them to get recommended health screenings. Consumers can find information about which providers are in network by visiting their health insurance company’s website, calling the number on their health insurance card, or by calling a provider directly. Remember, consumers might pay more if they visit a provider who is out of network.

Make an Appointment

After confirming that their provider accepts their coverage, it’s a good idea for consumers to make an appointment and discuss preventive services, ask questions about any health concerns they have, and find out what they can do to stay healthy.

Fill Your Prescriptions

Consumers should also verify that their health plan covers their prescriptions and use it to fill any prescriptions they need. Since some drugs cost more than others, consumers should ask in advance how much a prescription costs and if a more affordable option is available.

Knowledge Check

When consumers need help understanding their health care coverage, you may but aren't required to refer them to the C2C initiative. What resources does C2C provide?

Answer: C2C provides resources that will educate consumers about their health coverage and connect consumers with tools to better understand health care. C2C doesn't provide costs or lists of medical personnel for health care coverage.

Plan Basics

As described in C2C, getting health coverage is an important first step to living a long, healthy life. You should let consumers know it's a good idea for them to know specific details about their plans so they can get the most from their coverage.

Important plan information includes:

- plan name
- premium amount
- effective date
- contact number

There are many terms that consumers need to know to understand and use health coverage. Visit the Glossary of Health Coverage and Medical Terms for definitions to many commonly used terms or download the complete glossary (PDF).

Remember that when consumers apply through the Marketplace and are determined or assessed as eligible for coverage through Medicaid or CHIP, their eligibility results will provide them with next steps. Their application information will automatically be sent to the state Medicaid or CHIP office for further action.

Paying Premiums

After consumers have enrolled, it's a good idea to tell them that they must:

- Pay their first month's premium by the health plan's due date to avoid losing coverage
- Continue to pay their premiums every month of the year to stay covered

Some consumers who have Medicaid may need to pay a nominal premium.

Consumers need to pay careful attention to their due dates because each health insurance company is different. They can contact their health plan to learn what forms of premium payments are accepted. Here are the most common ways health insurance companies accept premium payments:

Online

Consumers should check for instructions on their premium bill to pay online or call their insurance company to find out if the plan takes online payments. Some plans mail online payment instructions separately.

Consumers who enroll online at HealthCare.gov can check if their "Enroll To-Do list" has a green **Pay for Health Plan** button. Selecting the green button directs the consumer to the plan's payment portal to make a payment.

Mail

Consumers should review instructions received in the mail with the bill from the insurance company on how to pay.

Phone

Consumers should call the insurance company to find out if payment can be made over the phone by using a credit card, debit card, prepaid card number, or by providing bank account information.

In Person

Consumers should contact their insurance company to find out if it has walk-in centers and ask for locations and hours of operation.

Cash

Consumers should contact their insurance company to find out if and where cash is accepted. Some insurance companies allow cash payments as a special service at local pharmacies, convenience stores, or other locations. If the insurance company doesn't accept cash payments, other options may be available, including second-chance bank accounts or prepaid cards.

Health Reimbursement Arrangements (HRAs)

Monthly premium payments may be made on behalf of a consumer or directly by the consumer from an individual coverage health reimbursement arrangement (ICHRA) or qualified small employer health reimbursement arrangement (QSEHRA) as long as the payments are made using a method that the individual market QHP issuer is already required to accept.

Key Points

- C2C can make the health care system easier to navigate for consumers and provides education and tools to better understand health coverage options.
- Consumers should check with their insurance company to know the type of premium payment accepted.
- It is important for consumers to know when their premium due date is, so they make their payments on time.

Module 3 — Coverage to Care Assistance

Module Introduction

In other training courses, you have learned to help consumers understand basic health care concepts and terms. This module will provide you a clear and concise way of explaining consumers' costs to them. By the end of this module, you should be able to understand these concepts and accomplish the associated tasks below them.

Consumer Protections

Describe consumer protections related to consumers' personally identifiable information (PII) and nondiscrimination.

Plan Services

Describe to consumers the services that may be covered by their plan.

Resources

Identify resources available to consumers to obtain information about their coverage.

Plan Costs

Describe the various forms of cost sharing consumers are responsible for when they use qualified health plans (QHPs) coverage (e.g., deductibles, copayments, coinsurance, and out-of-pocket limit amounts).

Know Where to Go for Answers

Millions of consumers have obtained health coverage through the Marketplaces, Medicaid, Children's Health Insurance Program (CHIP), Medicare or from their employers. Some consumers you help are getting coverage for the very first time or the first time in a long time. Many of these consumers are unsure of what they signed up for, how to use their coverage to get the care they need, and where to go for answers.

To answer some of these questions, all forms of health coverage have to provide some kind of document to explain benefits and coverage to consumers. You can also provide consumers with Roadmap to Better Care. It describes key insurance terms and other information about consumers' coverage.

Note: You can access materials for free in several languages other than English, as well as other resources like videos at CMS.gov Coverage to Care.

Summary of Benefits and Coverage

Because consumers have the right to an easy-to-understand summary about a health plan's benefits and coverage, insurance companies and employer-sponsored plans must provide consumers with:

- A short, plain-language Summary of Benefits and Coverage (SBC)
- A Uniform Glossary of terms used in health coverage and medical care

Let's say you've just helped a consumer named Lori Gomez submit a Marketplace application. Lori and her family qualified for advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs) and enrolled in a Silver plan to save on additional costs. A few weeks later, Lori returns to you with a copy of her insurance card, her plan's SBC, and several questions about her costs. Let's review how you can explain the following costs to Lori:

- Premium
- Copayment
- Deductible
- Coinsurance

Out-of-pocket limit

Coach: Hi Lori, I'm glad you came in today! Let's look at an example of how your premium, copayments, deductible, and coinsurance work together so you can understand how much your new plan will cost.

Premium

Your Premium is: $221.30 every month

Even if you don't use any health care services, your family pays a premium each month to have health insurance. Since you get APTC, your monthly premium for this plan is lower than other people who don't get APTC.

Copayment

Your copayments are:

- Primary Care Provider (PCP)-$40/50 percent
- Specialty Care Provider (SPC)-$60/50 percent
- Hospital Stay (HO)-$300
- Emergency Room (ER)-$600
- Prescription (Rx)-$0/$5

Copayment (Cont'd)

You will pay a fixed, discounted amount called a copayment for certain covered services when you get them. Copayments can vary for different services within the same plan, like prescription drugs, lab tests, and visits to specialists. Your insurance company pays the difference between the actual cost of these services and your copayment amounts.

Because of the Affordable Care Act (ACA), you won't have to pay a copayment for certain preventive services like flu shots, cholesterol screenings, and depression screenings. If you didn't have insurance, all of these things would cost a lot more money.

Key Tip: Depending on the plan, consumers pay copayments either before or after they meet their yearly deductible.

Deductible

Your deductible is $2,900 individual/ $8,700 family

Even though you get these discounts for certain covered services when you stay in your plan's network, you may have to pay 100 percent of any other medical and/or pharmacy bills each year until you meet an amount called your deductible. Once you spend enough money out of pocket to meet your plan's annual deductible, it will start to cover the majority of your costs for the rest of the plan year. Monthly premium amounts don't count toward your deductible.

Key Tips:

- All Marketplace plans must cover certain preventive services without charging a copayment or coinsurance, even if consumers haven't yet met their yearly deductible.
- Some plans have separate deductibles for certain services like prescription drugs.
- Family plans often have both an individual deductible, which applies to each person, and a family deductible, which applies to all family members.

Coinsurance

After $2,900 deductible is paid, you pay 30 percent of covered in-network services.

Once you meet your plan's deductible, you're responsible for paying a small percentage of your health care costs called coinsurance. Lori, since you qualify for extra savings on additional costs and picked a Silver plan, you'll get extra savings on copayments, annual deductibles, and coinsurance amounts. You'll find these extra savings reflected in your plan's costs on your SBC and at HealthCare.gov.

Out-of-pocket limit

There is also an out-of-pocket limit for each person on the plan and for the whole family. This is the most that you or your family could pay during a coverage period (usually one year) for your share of the costs of covered services.

Note: The maximum out-of-pocket limit for any 2026 Marketplace plan is $10,600 for an individual and $21,200 for a family. Keep in mind that this doesn't include monthly premium amounts. To find out if a consumer may qualify for savings on additional costs, use the Savings Estimator Tool.

After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100 percent of the costs of covered Essential Health Benefits (EHBs) for the rest of the plan year — as long as you stay in the plan's network.

Key Tip:

The out-of-pocket limit doesn't include monthly premiums. It also doesn't include any amount consumers may spend for services that their health plan doesn't cover or services outside of the network.

Key Tip:

Remember, consumers may qualify for CSRs if their household income is under 250 percent of the federal poverty level (FPL). Consumers may qualify for different amounts of CSRs based on their income level. Since the Gomez family earns $40,000 for a household of two, they qualify for CSRs.

Note: CSR eligibility rules are different for American Indian/Alaska Natives (AI/ANs). For more information refer to Course 6 — Serving Select Population Groups & Communities.

Insurance Card Information

Many consumers receive a health insurance card or other document as proof of coverage after they enroll. Both a health insurance card and SBC include key health plan information and contact information. Let's review an example of how you could explain this to Lori.

Consumer: I was also wondering if you could explain some of the information on my health insurance card. Since we are already enrolled in coverage, we want to start using it.

Coach: Sure, Lori! Your health insurance card is one of the first things your insurance company sends to you after you enroll. It is an important tool with a lot of information that identifies your health plan. You may get separate cards for health, dental, and other types of coverage.

Every time you visit a doctor or specialist, fill a prescription, or visit a therapist, you will need your card. If you're returning to a provider, they may not request your insurance card for follow-up visits if they have your most current information on file. But remember to keep your card with you all of the time — just like a driver's license. You'll get a new health insurance card each year so always make sure to carry the most recent one.

Insurance Card Front and Back

Let's review an example of how you can help Lori understand her insurance card.

Coach: On the front of your card is your member ID number. Each health care provider you visit will need this information.

Below the member ID number is one of the most important abbreviations on your card, which is **PCP,** or primary care provider. Your PCP will help you plan annual checkups and medical tests to stay healthy. Many types of insurance plans make you visit a PCP before you can visit a specialist, like a heart or skin doctor.

PCP: $40 is your copayment amount. This means that you have to pay $40 for services you receive from an in-network PCP. If the provider is out of network, you'll have to pay 50 percent coinsurance.

SPC is a specialist. The copayment amount you pay for an in-network specialist is $60, and the amount you pay out of network is 50 percent coinsurance.

Coach: Lori, a network is a list of doctors and hospitals that you have to use to get the best price. It's important to use doctors *in your plan's network* or you will pay more. If you already have a specific provider that isn't in your plan's network, you may want to consider switching plans (if it is open enrollment period or you are eligible for a special enrollment period) or providers.

Your plan keeps a directory of providers who are in network. You can generally find it on your plan's website, or you can request a copy. Here are some tips for how to find a doctor in your plan's network.

HO: $300. For hospital stays and some other services, you'll have to pay a $300 copay. You may have to pay other costs for additional care or services you receive while you're in the hospital.

ER stands for "emergency room." Under your plan, you'll have a $600 copayment for an emergency room visit. Keep in mind that you'll still have to pay for any other services during an emergency room visit — things like MRIs and CT scans — until you meet your plan's deductible.

Coach: Lori, notice that your card says **Hospital Admissions Require Prior Approval**. If you have to be admitted to the hospital, you or someone with you should contact your insurance company as soon as possible to let them know an emergency happened.

Coach: The back of your card has other information, like your plan's deductible and coinsurance amounts. Lori, your particular plan has a deductible of $2,900 and then requires you to pay about 30 percent coinsurance for covered in-network services. You'll pay more for out-of-network services. This means you must generally pay for the first $2,900 of your medical bills every year before your insurance company starts covering the majority of your health care costs. But remember, certain preventive services are covered in full by your insurance company with no coinsurance, even before you meet your deductible.

If you have questions, there is a customer service number you can call and a mailing address where you can send any medical claims.

Beginning with Plan Year 2023, all insurance ID cards must also provide out-of-pocket maximum limits.

You'll also find a telephone number and website where you can get help and access additional applicable deductibles and maximum out-of-pocket limits. On physical ID cards, there may also be a QR code you can scan to access the website.

Finding a Provider

Coach: Lori, remember that it's important to select a primary care provider in your plan's network. Your primary care provider will form a relationship with you, learn about your personal and family medical history, work with you to get your recommended health screenings, and help you manage any chronic conditions. To get started, you can schedule a well checkup with your primary care provider. Your provider can work with you during the rest of the year to schedule routine checkups, preventive care, or visits when you're sick and it's not an emergency. Remember, you might pay more if you visit a provider who is out of network.

Consumer: This is great information. I have learned a lot about the SBC, my insurance card, and provider networks.

Primary Care Provider

A primary care provider doesn't have to be a doctor. The primary provider could be a doctor, nurse practitioner, clinical nurse specialist, physician assistant, or other type of health professional. Primary care providers can be found in many places like private offices, federally qualified health centers, or hospitals, just to name a few.

No Surprises Act Policy Changes

As of January 1, 2022, health plans and issuers (otherwise known as insurance companies) must take certain steps to ensure that provider directory information given to consumers, whether posted online, provided electronically, or by phone, is accurate. This includes the name, address, specialty, telephone number, and digital contact information of each in-network health care provider or facility.

Under the No Surprises Act, if a person receives items or services from an out-of-network provider or facility that would have been covered if provided by an in-network provider, and the individual received incorrect information from their plan or issuer regarding whether that provider or facility was in network with regard to those items or services, their plan or issuer must:

- limit billed cost sharing amounts to in-network amounts that would apply had items or services been furnished by an in-network provider
- apply the deductible or out-of-pocket maximum, if any, as if the provider or health care facility were in network

The provider or health care facility must not bill an individual more than their in-network cost sharing.

The No Surprises Act also protects certain consumers, called “continuing care patients”, when their treating provider’s network status changes or ends with the plan or issuer for plan years beginning on or after January 1, 2022. These consumers are notified of the termination of the provider’s or facility’s in-network status and provided the opportunity to request transitional care from their plan or issuer. Continuing care patients are given a 90-day transitional period during which:

- Health plans and issuers must provide the patient benefits with respect to the course of treatment furnished by the provider or facility relating to the patient’s status as a continuing care patient under the same terms and conditions that would have applied had the provider’s or facility’s in-network status not changed.
- The treating provider or facility must accept cost sharing and payment from plans and issuers under this continuing care as payment in full.

A patient is considered a “continuing care patient,” with respect to a provider or facility, if at least one of these applies. They are:

- undergoing treatment from the provider or facility for a serious and complex condition; a **serious complex condition** is defined as:
    - 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
    - in the case of a chronic illness or condition, a condition that is life threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time
- undergoing a course of institutional or inpatient care from the provider or facility
- scheduled to undergo non-elective surgery from the provider or facility, including post-operative care related to the surgery
- pregnant and undergoing treatment for pregnancy from the provider or facility
- terminally ill and receiving treatment for such illness from the provider or facility

In-network Versus Out-of-network Costs

The following scenario refers to the summary of benefits and coverage (SBC) table below.

Coach: Now that we've explained the basics of in-network and out-of-network coverage to Lori, let's look at her family's SBC. How much would Lori and her husband, John, pay for different health care services both in network and out of network?

Note: These amounts may vary with different plans.

Answer: If the Gomez family needed home health care from a participating (in-network) provider, their cost would be 20 percent coinsurance. If they used a non-participating (out-of-network) provider, their cost would be 40 percent coinsurance.

Coach: If Lori or John needed skilled nursing care from a participating (in-network) provider, their cost would be 20 percent coinsurance. If they used a non-participating (out-of-network) provider, their cost would be 40 percent coinsurance.

Note: This may change if they haven't met their deductible.

In the "Limitations, Exceptions, & Other Important Information" column, it states that their coverage is limited to 60 visits per year.

Common Medical Event	**What You Will Pay: Network Provider (You will pay the least)**	**What You Will Pay: Out-of-Network Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
If you need immediate medical attention: Emergency room care	20% coinsurance	20% coinsurance	None
If you need immediate medical attention: Emergency medical transportation	20% coinsurance	20% coinsurance	None
If you need immediate medical attention: Urgent Care	$30 copay/visit	40% coinsurance	None
If you have a hospital stay: Facility fee (e.g., hospital room) and Physician/ surgeon fees	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.

Common Medical Event	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services: Outpatient services	$35 copay/office visit and 20% coinsurance for other outpatient services	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services: Inpatient services	20% coinsurance	40% coinsurance	None
If you are pregnant: Office visits; Childbirth/ delivery professional services; Childbirth/ delivery facility services	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound)
If you need help recovering or have other special health needs: Home health care	20% coinsurance	40% coinsurance	60 visits/year
If you need help recovering or have other special health needs: Rehabilitation services	20% coinsurance	40% coinsurance	60 visits/year. Includes physical therapy, speech therapy, and occupational therapy.
If you need help recovering or have other special health needs: Habilitation services	20% coinsurance	40% coinsurance	60 visits/year. Includes physical therapy, speech therapy, and occupational therapy.
If you need help recovering or have other special health needs: Skilled nursing care	20% coinsurance	40% coinsurance	60 visits/calendar year

Common Medical Event	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs: Durable medical equipment	20% coinsurance	40% coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment
If you need help recovering or have other special health needs: Hospice services	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
If your child needs dental or eye care: Children's eye exam	$35 copay/visit	Not covered	Coverage limited to one exam/year
If your child needs dental or eye care: Children's glasses	20% coinsurance	Not covered	Coverage limited to one exam/year
If your child needs dental or eye care: Children's dental check-up	No charge	Not covered	None

Encouraging Consumers to Advocate for Themselves

When you help families like the Gomez family, it's important to let them know that they can visit other participating providers in their network. Let's review the following question Lori Gomez has about changing providers.

Consumer: I went to a doctor, and I really don't think they were a good fit for me. Can I change providers?

Coach: Yes, you have the right to a change in provider. You can find information about other providers on your plan's website or by directly contacting your plan. Make sure you choose a provider in your network, or you will pay more for your care.

It is OK to ask for changes or to find another provider.

Preventive Services Without Cost Sharing

All health plans offered inside the Marketplaces and many health plans offered outside the Marketplaces must cover a certain set of preventive services without requiring consumers to pay copayments or coinsurance, as long as the services are delivered by a doctor or other provider in their plan's network. This is true even if they haven't met their annual deductible.

Preventive services are grouped into categories for all adults, women, and children, and they include things like shots or screening tests. You should review preventive services with consumers before and after they enroll in coverage. Let consumers know these services can be used right away once their coverage starts — even before they meet their deductible.

Preventive services for all adults include:

- alcohol misuse screening and counseling
- blood pressure screening
- cholesterol screening
- depression screening
- flu shot and other immunizations and vaccines
- obesity screening and counseling
- tobacco use screening

For a complete list, visit preventive care benefits for adults.

Preventive services for women include:

- cervical cancer screening
- domestic and interpersonal violence screening and counseling
- prenatal screening, including gestational diabetes screening, preeclampsia prevention and screening, and Rh incompatibility screening
- urinary tract or other infection screening
- well-woman visits

For a complete list, visit preventive care benefits for women.

Preventive services for children include:

- autism screening
- behavioral assessments
- flu shot and other immunizations and vaccines
- height, weight, and body mass index (BMI) measurements
- obesity screening and counseling
- vision screening
- well-baby and well-child visits

For a complete list, visit preventive care benefits for children.

Making an Appointment

When consumers start using preventive services and other benefits offered in their health plans, it's a good idea for them to understand how to make appointments with doctors and other health care professionals. You can help consumers understand how to find a provider and make an appointment; however, you shouldn't perform certain patient advocacy services (e.g., making an appointment on behalf of a consumer) or case management functions in your role as an Assister. Review the steps below to educate consumers on the most efficient process for making and preparing for appointments. Consumers can review Roadmap to Better Care on how to make an appointment.

When making an appointment, consumers should:

- give the name of their insurance plan and ask if the provider accepts their insurance
- mention any special needs they may have - like wheelchair accessible equipment or a medical translator
- mention whether or not they're a new patient
- specify the name of the provider they want to visit and why they want an appointment
- request days or times that work best with their schedule

For their first appointment, consumers should:

- bring their insurance card
- be ready to pay the copayment if they have one and ask for a receipt for their records
- know their family's health history. For example, does anyone in their family have health problems like heart disease, cancer, or high blood pressure?
- bring a list of any medicines, vitamins, or herbs that they take
- prepare a list of questions to ask the doctor and bring it with them to their appointment so they don't forget

After each appointment, consumers should:

- Be sure to follow their health care provider's instructions and follow your care plan.
- Schedule any follow-up appointments before they leave.
- Pay any fees or bills. If they can't pay the bill, call the number on the bill. Don't ignore it.
- Fill any prescriptions you have.

Formulary Drug Tiers

Once consumers understand how to find a provider and access covered preventive services, they'll need to be familiar with their plan's drug formulary. A drug formulary is a list of prescription drugs that a health insurance plan covers, including generic, brand-name, and specialty drugs. Select this link for tips to help consumers find out if their prescriptions are covered by their new plan. Prescription drug formularies are typically separated into three different tiers of drugs. Drugs are generally separated into tiers based on how much consumers have to pay for them.

Key Tip: Some plans have different numbers of tiers, and the types of drugs listed under each tier may vary from those described in this list. Consumers should call their insurance company to find out if a particular drug or prescription they're taking is covered by their plan and, if so, at what tier.

Tier 1:

Tier 1 includes mostly generic drugs or the lowest-cost drugs. Sometimes other regularly lower-price branded drugs will fall into this tier too.

Tier 2:

Tier 2 typically includes formulary brand-name drugs. If a brand-name drug is required, an insurance company will have a list of branded drugs it prefers because they cost less.

Tier 3:

Tier 3 generally includes non-formulary brand-name drugs or specialty drugs. Chemotherapies (cancer medications) fall into this category. Many plans group certain drugs into third, fourth, or even fifth drug tiers because:

(1) they're new and not yet proven to be safe or effective
(2) a similar drug is available in a lower tier of the formulary that may provide the same benefit at a lower cost

For more information, refer to the Coverage to Care resource webpage Tips for Understanding Your Drug Coverage & Prescriptions.

Costs of In-network Versus Out-of-network

The scenario below refers to the costs and limitations for medical services and prescription drugs SBC table below.

You reviewed the in-network and out-of-network costs on the Gomez family's SBC. Now let's examine their costs and limitations for each of the prescription drug tiers.

Coach: If the Gomez family uses a generic drug from a network provider, they would have to pay a $10 copayment. If they use an out-of-network provider, they will have to pay 40 percent coinsurance.

Notice that the "Limitations, Exceptions, & Other Important Information" column states that their plan covers up to a 30-day supply for a retail subscription and a 31-90-day supply for a mail order prescription.

Coach: If the Gomez family uses a preferred brand drug from a network provider, they would have to pay a $30 copay. If they use an out-of-network provider, they'll have to pay 40 percent coinsurance.

Coach: If the Gomez family uses a non-preferred brand drug from a network provider, they would have to pay 40 percent coinsurance. They would have to pay 60 percent coinsurance for drugs from an out-of-network provider.

Common Medical Event and Services You May Need	**What You Will Pay: Network Provider (You will pay the least)**	**What You Will Pay: Out-of-Network Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
If you visit a health care provider's office clinic: Primary care visit to treat an injury or illness	$35 copay/office visit and 20% coinsurance for other outpatient services; deductible does not apply	40% coinsurance	None
If you visit a health care provider's office clinic: Specialist visit	$35 copay/office visit and 20% coinsurance for other outpatient services; deductible does not apply	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service
If you visit a health care provider's office clinic: Preventive care/ screening/ immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Then check what your plan will pay for.
If you have a test: Diagnostic test (x-ray, blood work)	$10 copay/test	40% coinsurance	None
If you have a test: Imaging (CT/PET scans, MRIs)	$50 copay/test	40% coinsurance	None

Common Medical Event and Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition: Generic drugs (Tier 1)	$10 copay/ prescription (retail & mail order)	40% coinsurance	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription)
If you need drugs to treat your illness or condition: Preferred brand drugs (Tier 2)	$30 copay/ prescription (retail & mail order)	40% coinsurance	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription)
If you need drugs to treat your illness or condition: Non-preferred brand drugs (Tier 3)	40% coinsurance	60% coinsurance	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription)
If you need drugs to treat your illness or condition: Specialty drugs (Tier 4)	50% coinsurance	70% coinsurance	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription)
If you have outpatient surgery	$100/day copay	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service
If you have outpatient surgery	20% coinsurance	40% coinsurance	50% coinsurance for anesthesia

Primary Care Versus the Emergency Department

Some other services listed on a plan's SBC include primary care and emergency care. Remember, primary care is preventive care or care received when it's not an emergency. Primary care providers generally form an important relationship with a consumer; become familiar with the consumer's medical history; and work with the consumer to provide preventive services or manage chronic conditions. However, a consumer gets emergency care when he or she needs immediate medical assistance in a serious, unexpected, and often dangerous situation.

New Primary Care Provider

- You'll pay your primary care copay, if you have one. This may cost you between $0 and $50.
- You go when you feel sick and when you feel well.
- You call ahead to make an appointment.
- You may have a short wait to see the provider after you arrive. But you will usually be seen around your appointment time.
- You'll usually see the same provider each time.
- Your provider will usually have your health record.
- Your provider works with you to take care of your chronic conditions and your overall health.
- Your provider will check other areas of your health, not just the problem that brought you in that day.

If you need to see other providers or manage your care, your primary care provider can help you make a plan, get your medicines, and find specialists.

Emergency Department

- You'll likely pay a copay, coinsurance, and have to meet your deductible before your health plan pays for your costs, especially if it's not an emergency. Your copay may be between $50 and $150.
- You should only go when you're injured or very sick.
- You show up when you need to and wait until they can get to you.
- You may wait for several hours before you're seen if it's not an emergency.
- You'll see the provider who is working that day.
- The provider who sees you probably won't have access to your health records.
- The provider may not know what chronic conditions you have.
- The provider will only check the urgent problem you came in to treat, but might not ask about other concerns.
- When your visit is over you will get instructions to follow up with your provider. There may not be any follow-up support.

Knowledge Check

What are considered examples of recommended preventive services that enrollees can be eligible to receive with no additional cost under current recommendations and guidelines?

Answer: Well-woman visits, cholesterol screening, flu shots, and other immunizations and vaccines are all considered preventive services. X-ray services are not included in this group.

Personally Identifiable Information

In this course, you reviewed examples of how you can assist consumers by explaining how they can use their coverage to get care. Remember that you must get consumers' consent before accessing their PII (like health plan documents) for purposes related to your Assister functions.

For more information, refer to the Centers for Medicare & Medicaid Services (CMS) model consent form for FFM Navigators and CMS guidance on Obtaining Consumer Authorization and Handling Consumer's PII in the FFM, and refer to the *Privacy, Security, and Fraud Prevention Standards* course.

Nondiscrimination Protections

- Remember, under the Affordable Care Act (ACA), health insurance companies can't refuse to cover consumers, charge them more, or limit their benefits because of a pre-existing condition. Pre-existing conditions are medical conditions, like asthma or diabetes, which existed before a consumer enrolled in a health insurance plan.
- If a consumer isn't comfortable with a provider, let them know it is okay to ask for changes or to find another provider. Consumers should call their health plan or visit the health plan's website to make a change. The right provider will meet a consumer's needs when they ask.
- Also remember that certain factors including age, tobacco use, family size, and geography can affect consumers' premiums.
- Not all of the ACA's consumer protections apply to large group plans, self-insured businesses, grandfathered plans, or short-term health insurance.

Federal civil rights laws also prohibit certain health programs and activities from discriminating on the basis of race, color, national origin, sex, age, or disability. These laws include Section 1557 of the ACA, Title VI of the Civil Rights Act of 1964, Title IX of the Education Act of 1973, the Age Discrimination Act, and Section 504 of the Rehabilitation Act of 1973. Other federal laws protect the exercise of conscience and prohibit religious discrimination in certain federally funded programs.

Key Points

- Roadmap to Better Care is a good resource for consumers to reference after enrolling in coverage through the Marketplaces.
- Under the ACA, health insurance companies can't refuse to cover someone or charge them more because of a pre-existing condition.
- Consumers have the right to change providers.
- A drug formulary is a list of drugs that are covered by a particular health insurance plan.

Module 4 — Consumer Protections in the No Surprises Act

Module Introduction

In this module, you'll learn about rights and protections for consumers implemented by the No Surprises Act (NSA) to end certain surprise medical bills, help consumers better understand costs before getting care, and remove them from payment disagreements between their health care providers, health care facilities, and health plans.

Beginning January 1, 2022, the No Surprises Act implements several consumer protections, including:

- preventing certain surprise medical bills
- tools to understand consumer costs in advance
- a process that takes consumers out of the middle of a payment dispute between providers/facilities and health plans and issuers
- a payment dispute resolution process for uninsured (or self-pay) individuals
- expanded rights to external review
- new requirements to include deductibles and out-of-pocket maximums on insurance ID cards, as well as a phone number and website where consumers can get more information
- new requirements to improve the accuracy of provider directories
- ensuring continuity of care when a provider's network status changes

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

These requirements under the No Surprises Act (NSA) don't apply to beneficiaries or enrollees in public health programs like Medicare, Medicaid, Indian Health Service (IHS), Veterans Affairs (VA) health care, or TRICARE, since each of these programs already has other protections against balance billing. The protections under the NSA also don't apply to short-term limited duration insurance (STLDI), excepted benefits, or retiree-only plans or account-based group health plans.

Definitions

Here are some important terms related to No Surprises Act consumer protections.

Surprise Billing

Surprise billing happens when people get care from providers or facilities outside of their health plan's network for both emergency and certain non-emergency care.

Balance Billing

Balance billing is when a provider or facility bills a consumer for the balance remaining on the bill that the plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount (the maximum payment the plan will pay for a covered health care service). This happens most often when a consumer visits an out-of-network provider or out-of-network facility. These balance bill costs are separate from what the consumer pays out of pocket for out-of-network services according to the consumer's health plan coverage. An in-network provider generally may not balance bill the consumer for covered services.

Good Faith Estimate

A good faith estimate is an estimate of expected charges that a provider or facility must provide after an item or service is scheduled but before an uninsured or self-pay consumer gets an item or service, or upon request.

Self-pay Individual

A consumer is generally considered a self-pay individual if they don't plan to use their insurance to pay for a medical item or service.

Consumers With Health Insurance: Billing

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 get care from an out-of-network provider at an in-network facility.

The No Surprises Act protects people covered under group and individual health plans from surprise medical bills when they get most emergency services, non-emergency services from out-of-network providers at certain in-network facilities, and services from out-of-network air ambulance service providers.

These new rules:

- ban surprise bills for most emergency services, even if consumers get them out of network and without prior authorization
- ban surprise bills for certain non-emergency services furnished by out-of-network providers as part of a patient's visit to an in-network facility
- ban surprise bills for covered air ambulance services
- ban plans and issuers from charging more than the in-network cost-sharing requirement for most emergency services
- ban plans and issuers from charging more than the in-network cost-sharing requirement for certain non-emergency services furnished by out-of-network providers as part of a patient's visit to an in-network facility
- ban plans and issuers from charging more than the in-network cost-sharing requirement for covered air ambulance services
- require that health care providers and facilities give consumers an easy-to-understand notice explaining the applicable surprise billing protections, who to contact if they have concerns that a provider or facility has violated the protections, and that patient consent is required to waive certain billing protections (i.e., consumers must receive notice of and consent to being balance billed by an out-of-network provider, where applicable)

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 Federally-facilitated Marketplace (FFM) or a State-based Marketplace (SBM), or who purchase individual health insurance coverage directly through a health insurance plan.

Consumers With Health Insurance: Notice and Consent Form

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, however, 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.

Consumers also can't be balanced billed for ancillary services (such services are always subject to balance billing prohibitions). Ancillary services are defined by the No Surprises Act 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 and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility

Post-stabilization services

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).

Notice and Consent Form Continued

However, consumers may be asked to sign a notice and consent form if they schedule certain non-emergency services furnished in an in-network facility and all of the following are true:

- the items or services don't meet the definition of **ancillary services,** including that another in-network provider can deliver the items or services at the in-network health care facility
- 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

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
- provides an estimate of what their out-of-network care might cost

Consumers aren't required to sign the form. If they don't sign, they may have to reschedule their care with a provider in their health plan's network.

See the No Surprises Act Consumer Advocate Toolkit for more information about the notice and consent form.

Ancillary services

Ancillary services are defined by the No Surprises Act 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 and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility

Consumers With Health Insurance: Out-of-network Payments

The rules take consumers with health insurance plans in the group and individual market 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.

Under the NSA, cost-sharing amounts for out-of-network emergency services and applicable non-emergency items and services must be calculated based on the recognized amount, which is either:

1) an amount determined by an applicable All-Payer Model Agreement
2) if there is no such All-Payer Model Agreement, an amount determined by a specified state law
3) if there is no such All-Payer Model Agreement or specified state law, the lesser of the billed charge or the qualifying payment amount (QPA)

If either party can't agree on an out-of-network rate through negotiation, there is a 30-business-day open negotiation period. Then, if the parties still fail to agree upon an out-of-network payment amount, it is determined through the federal independent dispute resolution (IDR) process. The consumer is not involved in this process.

Consumers With Health Insurance: External Review Process

If a plan or issuer denies payment of a health care item/service, and upholds this decision after its internal review process, the consumer may be eligible for an additional review (known as external review) by an independent third-party reviewer.

The external review process allows individuals with non-grandfathered group or individual health coverage to appeal certain decisions by their plan, such as rescissions of coverage and their plan's denial of a payment for a health care item/service based on:

- determinations that involve medical necessity
- appropriateness
- health care setting
- level of care
- effectiveness of a covered benefit
- experimental and investigational treatments
- Individuals may not request an external review of determinations that involve only contractual or legal interpretation and do not involve medical judgment.

Expansion of External Reviews to Include No Surprises Act Compliance Matters (New):

Effective January 1, 2022, the No Surprises Act and implementing regulations expanded the types of adverse determinations eligible for external review related to a health plan or issuer's compliance with No Surprises Act protections like:

- patient cost sharing and surprise billing for emergency services
- patient cost sharing and surprise billing protections related to care provided by nonparticipating providers at participating facilities
- whether patients are in a condition to get notice and provide informed consent to waive the No Surprises Act protections
- whether a claim for care received is coded correctly and accurately reflects the treatments received in accordance with the associated No Surprises Act protections related to patient cost sharing and surprise billing

Section 110 of the No Surprises Act and implementing regulations extend these protections to grandfathered plans to make external review available to individuals enrolled in grandfathered health plans or coverage.

Consumers Without Health Insurance or Self-pay Consumers

The No Surprises Act requires that health care providers and facilities give uninsured or self-pay individuals a "good faith estimate" for the cost of their health care when scheduling the item or service or upon request.

If, after receiving the items or services, the uninsured (or self-pay) individual is billed for an amount at least $400 above the good faith estimate, the individual may be eligible to dispute the bill through the patient-provider dispute resolution (PPDR) process by submitting a request to the Department of Health & Human Services (HHS) and paying an administrative fee ($25).

Good Faith Estimates

The good faith estimate will generally include:

- a list of items and services that the scheduling provider or facility reasonably expects to provide the consumer for that period of care
- applicable diagnosis codes and service codes
- expected charges or costs associated with each item or service from each provider and facility
- information on how to dispute the bill if it is at least $400 higher for any provider or facility than the good faith estimate the consumer received from that provider or facility

See the No Surprises Act Consumer Advocate Toolkit for more information about the good faith estimate.

The estimate should be based on information known at the time the estimate was created and doesn't include any unknown or unexpected costs that may arise during the course of treatment. For example, an individual could be charged more if complications or special circumstances occur.

Consumers should find information about the availability of good faith estimates on their provider or facility's website and in the provider or facility's office or on-site where consumers might schedule items or services or have questions about their costs. If consumers have questions about the cost of items or services, their provider or facility must inform them in writing or orally about requesting a good faith estimate. All of this information must also be available in accessible formats and languages.

If a consumer schedules an item or service at least three business days before the date they will receive the item or service, they must be given a good faith estimate no later than one business day after scheduling. If a consumer schedules the item or service at least 10 business days before the date they will receive the item or service, or requests cost information about an item or service without scheduling it, the provider or facility must give them a good faith estimate no later than three business days after scheduling or requesting.

Note: Providers and facilities aren't required to provide good faith estimates to enrollees in federal health care programs (like Medicaid, Medicare, or TRICARE), requirements under the NSA that don't apply to beneficiaries or enrollees in these programs.

The Patient-Provider Dispute Resolution (PPDR) Process

The Patient-Provider Dispute Resolution (PPDR) process is for:

- people without health insurance
- people with health insurance who don't plan to use their plan or coverage to pay for the item or service

When a consumer's billed charges for any provider or facility are at least $400 more than the good faith estimate for that provider or facility, the items or services may be eligible for payment determination by an independent party called a selected dispute resolution (SDR) entity through the PPDR process.

A good faith estimate could contain the expected charges for items or services that are to be provided by a co-provider or co-facility (in addition to the provider or facility the consumer scheduled items or services with or requested a good faith estimate from). If it does, eligibility for the PPDR process is determined separately for each specific provider or facility listed on the good faith estimate.

However, the requirement to include charges from multiple providers and facilities is not currently being enforced. Any charges from co-providers or co-facilities that don't appear on the good faith estimate with expected charges aren't eligible for PPDR.

PPDR Process Eligibility

Eligibility for PPDR is determined separately for each unique provider or facility listed on the good faith estimate.

- For each provider or facility, the total expected charges for each item or service should be added up.
- This total amount is then compared with the total of all billed charges for the provider or facility, including billed charges for items and services that were furnished but not included in the good faith estimate, to determine eligibility for PPDR.
- Review the example good faith estimate.

Provider	Item or Service	Expected Charge
Provider A	Item A1	$300
Provider A	Item A2	$1275
Provider A	Item A3	$550
Provider A Total Expected Charges	Items A1-3	$2125
Provider B	Item B1	$500
Provider B Total Expected Charges	Item B1	$500

Initiating the PPDR Process

To start the PPDR process, a consumer must submit an initiation notice either electronically or postmarked within 120 calendar days of getting the initial bill containing charges for the items or services that are substantially in excess of the expected charges in the good faith estimate.

The consumer, or the consumer's authorized representative, can start the PPDR process by submitting an initiation notice to HHS:

- Through the online federal IDR portal:
  - HHS strongly recommends that consumers submit the initiation notice through the online federal IDR portal to help ensure efficient processing.
- By fax:
  - Consumers may fax the initiation form using the fax number on the form.
- By mail:
  - Consumers can download the initiation notice, and consumers can mail them to:

    C2C Innovative Solutions Inc.

    Patient-Provider Dispute Resolution

    P.O. Box 45105

    Jacksonville, FL 32232-5105

The initiation notice must include:

- information sufficient to identify the items or services under dispute, including the date of service or date the item was provided, and a description of the item or service
- a copy of the bill for the items and services under dispute (the copy can be a photocopy or an electronic image, like a photo taken with the consumer's phone, so long as the document is readable)
- a copy of the good faith estimate for the items and services under dispute (the copy can be a photocopy or an electronic image, like a photo taken with the consumer's phone, so long as the document is readable)
- the consumer's contact information, including name, email address, phone number, and mailing address and the contact information (name, email address, phone number, and mailing address) of the provider or facility
- the state where the consumer received the items or services in the dispute
- the consumer's communication preference: email, paper mail, or phone

The consumer, as the uninsured or self-pay individual, will need to pay a $25 administrative fee to initiate the PPDR process. If the Selected Dispute Resolution (SDR) entity decides that the consumer should pay anything less than the billed charge, the $25 administrative fee will be subtracted from the final amount the SDR entity determines the consumer must pay the provider or facility. If the SDR entity decides that the billed charge from the provider or facility is the appropriate amount, the consumer must pay the full billed charge, and the $25 administrative fee will not be subtracted from the consumer's bill.

Visit the No Surprises Act for more information on the protections against unexpected medical bills.

During the PPDR Process

While the PPDR process is pending, the provider or facility must not move the bill for the disputed item or service into collection or threaten to do so. If the bill has already moved into collection, the provider or facility must cease collection efforts. The provider or facility must also suspend the accrual of any late fees on unpaid bill amounts until after the PPDR process has concluded. Lastly, the provider or facility must not take or threaten to take any retaliatory action against the consumer for utilizing the PPDR process to seek resolution for a disputed item or service.

Review the process that occurs after a consumer submits the initiation notice and pays the fee.

Step 1

HHS will select a Selected Dispute Resolution (SDR) entity to conduct the payment determination.

Step 2

The SDR entity will notify the consumer and the provider or facility by electronic or paper mail that the initiation request has been received and is under review.

Step 3

The SDR entity will review the initiation notice to ensure that the items or services in dispute meet the eligibility criteria for the PPDR process and that the initiation notice contains all the required information.

- The SDR entity will also notify the consumer in cases where the initiation notice is determined to be incomplete, or the item or service is determined ineligible for dispute resolution.
- In these cases, the consumer will be provided 21 calendar days to submit any missing information or provide more information to demonstrate that the item or service is eligible for the PPDR process.

Step 4

Once the SDR entity has determined that an item or service is eligible for dispute resolution, the SDR entity must notify both parties (the consumer and the consumer’s provider or facility) and request the provider or facility provide certain information within 10 business days through the online federal IDR portal.

Step 5

The SDR entity will review the billed charges to determine if the items and services were included on the good faith estimate, as well as all documentation submitted by the uninsured (or self-pay) individual or their authorized representative and all documentation submitted by the provider or facility.

Step 6

No later than 30 business days after receipt of the information from the provider, the SDR entity must make a determination regarding the amount the consumer must pay:

- the good faith estimate
- the billed amount
- an amount between the good faith estimate and the billed amount

This amount is based on whether the provider or facility has provided credible information to demonstrate that the difference between the billed charge and the expected charge for the item or service in the good faith estimate:

- reflects the costs of a medically necessary item or service
- is based on unforeseen circumstances that couldn't have reasonably been anticipated by the provider or facility when the good faith estimate was provided

PPDR Process Outcomes

Here are some examples of PPDR process outcomes.

Scenario 1: The billed charge is equal to or less than the expected charge in the good faith estimate

The SDR entity would determine that the billed amount isn't substantially in excess of the good faith estimate and in this case isn't eligible for the PPDR process. The SDR entity would inform the consumer or their authorized representative that the case is ineligible for review via this dispute resolution process. For example:

- Billed charge = $500
- Expected charge (i.e., the good faith estimate) = $975

Scenario 2: The billed item or service is "substantially in excess" of, or at least $400 more than, the good faith estimate — not due to unforeseen circumstances

The SDR entity determines the provider or facility hasn't provided credible information that the difference between the billed charge and the good faith estimate reflects the costs of a medically necessary item or service and is based on unforeseen circumstances. Therefore, the SDR entity must determine the amount to be paid by the consumer for the item or service to be equal to the good faith estimate amount. For example:

- Billed charge = $875
- Expected charge = $450
- Payment amount = $450

Scenario 3: The billed charge is substantially in excess of, or at least $400 more than, the good faith estimate — due to unforeseen circumstances

The SDR entity determines that the provider or facility has provided credible information that the difference between the billed charge and the good faith estimate reflects the cost of a medically necessary item or service and is based on unforeseen circumstances. Therefore, the SDR entity must select as the amount to be paid by the consumer the lesser of:

- the billed charge
- the median payment amount paid by a plan or issuer for the same or similar service by a same or similar provider in the geographic area where the services were provided that is reflected in an independent database

For example:

- Bill charge = $900
- Expected charge = $450
- Median rate reflected in an independent database = $2,000
- Payment amount = $900

Scenario 4: Billed items or services are not listed on the good faith estimate — not due to unforeseen circumstances

If the SDR entity determines the provider or facility didn't provide credible information that demonstrates that the difference between the billed charge for the new item or service, and the good faith estimate reflects the costs of a medically necessary item or service and is based on unforeseen circumstances, then the SDR entity must determine the amount to be paid for the new item or service to be equal to $0.

Scenario 5: Billed items or services are not listed on the good faith estimate — due to unforeseen circumstances

If the SDR entity determines that a provider or facility has provided credible information that the billed charge for an item or service not listed on the good faith estimate reflects the costs of a medically necessary item or service and is based on unforeseen circumstances, then the SDR entity must determine the charge to be paid by the uninsured (or self-pay) individual for the new item or service as the lesser of:

- the billed charge
- the median payment amount paid by a plan or issuer for the same or similar service by a same or similar provider in the geographic area where the services were provided that is reflected in an independent database

Settling Disputes During the PPDR Process

Consumers can settle payment disputes with providers and facilities during the PPDR process by settling on a payment amount.

At any point after the PPDR process has been initiated but before a determination is made by the SDR entity, the parties can settle the payment amount through either an offer of financial assistance or an offer to accept a lower amount, or the consumer agrees to pay the billed charges in full.

If the parties agree to settle on a payment amount, the provider or facility should notify the SDR entity through the federal IDR portal, electronically, or in paper form as soon as possible, but no later than three business days after the date of the agreement. The settlement notice must document that the provider or facility has applied a reduction to the consumer's settlement amount that is equal to at least half of the administrative fee ($12.50).

Consumer Help With the PPDR Process

Consumers can use authorized representatives to help them with the PPDR process.

- Authorized representatives, on a consumer's behalf, will be allowed to submit initiation notices, upload documents, receive notices from HHS and the SDR entity, upload additional supporting documentation, and view the SDR entity's payment determination.
- Authorized representatives from state Consumer Assistance Programs (CAPs), personal attorneys, or legal aid organizations may also be resources for helping consumers with the PPDR process.
- Consumers can't use as authorized representatives any providers directly represented in the good faith estimate, providers associated with such providers, or non-clinical staff associated with such providers, or individuals employed by or associated with a facility that had included services in the good faith estimate.

Consumers can also contact the No Surprises Help Desk at 1-800-985-3059, weekdays from 8:00 am — 8:00 pm ET, weekends from 10:00 am — 6 pm ET.

No Surprises Act Help and Resources for Consumers

The 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 either by phone or online.

By phone: Consumers can call 1-800-985-3059 weekdays from 8:00 am – 8:00 pm ET, weekends from 10:00 am – 6:00 pm ET, to submit questions or complaints. TTY users can also call 1-800-985-3059.

Online: Consumers may also submit complaints online. 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 get 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 find out what documentation is needed, consumers can contact the No Surprises Help Desk at 1-800-985-3059. TTY users can also call 1-800-985-3059.

What the Help Desk CAN Do

- answer your questions about the No Surprises Act
- help you submit a complaint against your provider or facility direct you to other resources or agencies that can help you if your situation isn't covered by the No Surprises Act

What the Help Desk CAN'T Do

- act as legal counsel
- give medical advice
- offer financial assistance

If consumers still need help with their health insurance and have a problem or question, they can contact their state CAP. These programs help consumers experiencing problems with their health insurance or seeking to learn about health coverage options.

Consumers can also visit CMS.gov | Medical Bill of Rights to learn more about their billing rights.

Assisters and advocates can use the No Surprises Act Consumer Advocate Toolkit to help consumers with surprise billing issues.

Key Points

- The No Surprises Act provides new consumer protections when seeking and receiving care, including for consumers with group health plan or group or individual health insurance coverage, consumers without coverage, and consumers either with or without coverage who are self-pay.
- These protections include prohibitions against certain surprise billing and balance billing, requirements to provide good faith estimates so consumers know their costs before receiving care, an expanded external review process, a dispute process for out-of-network providers or facilities and plans or issuers that removes the consumer from the dispute process, and a dispute process for uninsured or self-pay consumers.
- Health insurance issuers are also required to include additional information on insurance ID cards, maintain up-to-date provider directories, and ensure continuity of care when a provider’s network status changes.

Module 5 — Coverage Costs and a Life Change

Module Introduction

In this module, you'll learn how a life change can affect a consumer's cost of their healthcare premiums. Consumers can report a life change and add a new family member to a Marketplace application. This can affect consumers' costs. By the end of this module, you should be able to understand these concepts and accomplish the associated tasks below them.

Costs of Coverage

Describe techniques for explaining the costs of coverage to a consumer.

Report a Life Change

Describe techniques for demonstrating how to report a life change to a consumer.

Scenario: Introduction

Consumer: Hello, I wanted to let you know that I am pregnant! Our new family member will arrive in January. Can you tell me how much my premium might change, what I will be responsible for paying, and what the plan will pay for the delivery of our baby?

Coach: Congratulations! Lori, if you were able to keep this plan next year, without the addition of your baby on your policy, your premiums would cost a total of $2,655.60. This is $221.30 each month from January until December. In addition to your premium, you also have to meet your deductible. Your deductible is $2,900 per year. This is the amount you pay within the plan's network for the full cost of all medical expenses.

Consumer: That doesn't seem like much. I've heard that having a baby can be very expensive.

Coach: You're right. However, one of the major benefits of having health coverage is that you may not have to pay those much larger costs on your own. Based on your plan's Summary of Benefits and Coverage (SBC) it looks like routine delivery of a baby costs about $7,540, but your plan will help you cover some of those costs.

Consumer: Okay, can you explain what my costs would be?

Coach: If I show you all of your costs on your plan's SBC, it may help you understand.

Scenario: Costs of Coverage

Coach: Lori, even if your bill were $7,540, your out-of-pocket limit is currently $5,400 per year. That means the total you would pay for care if you stay in your plan's network is $5,400, which includes your $2,900 deductible. Remember, this doesn't include your plan's monthly premiums which add up to about $2,655.60 for the year. So, in total, the most you could spend if you stay in your plan's network is about $8,055 for the entire year.

The rest of your bills from the delivery — and for the rest of the coverage year after your delivery — will be covered by your insurance. If you need any other medical care during the year, your insurance company will pay for all the costs if you receive care from in-network providers for essential health benefits. Again, your SBC explains your plan's benefits, costs, and payments.

Consumer: Okay, that's helpful to know.

Coach: Keep in mind that when you get other services throughout the year, the costs for those services will also go toward meeting your deductible and out-of-pocket limit. If you get additional services before the baby arrives, you might meet all or a portion of your deductible and your out-of-pocket limit. All Marketplace health plans must cover certain preventive care for women without charging a copayment or coinsurance—even if a consumer hasn't met her deductible. Here is a list of preventive services for women.

Scenario: Additional Costs

Consumer: Can you give me a quick summary of my costs for medical bills once the baby is born?

Coach: Sure. For a Silver plan, insurance companies typically must cover an average of 70 percent of each Silver plan beneficiary's medical costs. That means consumers can expect to pay around 30 percent, on average, of their medical costs.

If a consumer had $20,000 in medical bills, this means the consumer's personal share of the bills could be around $6,000 in coinsurance amounts if they used in-network medical providers. However, keep in mind that this amount may vary based on the types of services a consumer receives. To calculate a consumer's share of the costs, you can multiply the total costs they expect to owe for medical services by their estimated coinsurance percentage.

If a consumer owed about 30 percent coinsurance for a Silver plan, here's how you could calculate their share of the costs for those $20,000 in medical bills:

0.30 times $20,000 = $6,000

Calculation Tips

To make calculations easy, turn the coinsurance percentage into a decimal by adding a period in front of the number.

Examples:

- 50 percent = 0.50
- 30 percent = 0.30
- 15 percent = 0.15
- 5 percent = 0.05

Note: For percentages lower than 10 percent, be sure to add a 0 before the percentage number.

Scenario: Maximum Cost With Insurance

Lori, even though a consumer would typically owe $6,000 for covered in-network medical services to have a baby in our previous example, keep in mind that your family qualifies for extra savings on additional costs, and you also have an annual out-of-pocket limit. Since you enrolled in a Silver plan with cost-sharing reductions (CSRs), your out-of-pocket limit for your family's Silver plan is $5,400. This means your total costs for the year would be $5,400 plus the monthly premiums to your insurance company. If you get in-network care and services, your insurance company will cover the rest of your costs for essential health benefits (EHB) during the plan year.

Lori, your total health care costs for the year are $2,655.60 for all your monthly premiums (that is, $221.30/month for 12 months) and $5,400 for all your essential health benefit costs after that (your annual out-of-pocket limit). With your insurance, the most you could possibly pay in a year for covered, in-network essential health benefits is $8,055.60.

Key Tip:

Remember, many plans don't start paying for most consumers' medical expenses until they meet their annual deductible. However, all plans must cover certain preventive services at 100 percent (without cost sharing to the consumer) and many plans let consumers pay a fixed, discounted amount (copayment) for certain covered services and prescriptions.

$2,655.60 + $5,400.00 = $8,055.60

Knowledge Check

Consumers may have questions about the total cost of their health care during a plan year. Tony doesn’t qualify for financial assistance through a Marketplace but has enrolled in a Silver plan. If Tony's plan will cover 70 percent (on average) of his medical expenses, what about his costs is true?

Answer: Once Tony meets his deductible, his health insurance company will begin to pay for about 70 percent of the costs of in-network essential health benefits. The most that Tony will pay during the coverage year is the cost of his monthly premiums plus his out-of-pocket limit. Tony is responsible for 30 percent of the cost of covered health care services after he meets his deductible, but his insurance company must cover many preventive care services at 100 percent—even before he meets his deductible.

Scenario: The Gomez Family Addition

Lori Gomez has returned to your office with her newborn baby and would like to add this new family member to her Marketplace plan. Let's review how you can help.

Remember, consumers can report a life change by calling the Federally-facilitated Marketplaces (FFMs) Call Center or by logging into HealthCare.gov and updating their Marketplace account. Let's review the online process. To review the online process of reporting a life change, visit Reporting Life Changes: Types of Qualifying Life Events.

Scenario: Report a Life Change

Coach: Lori, to get started, log in to your HealthCare.gov account. From there navigate to your user profile section and select the Go to applications button.

On the application screen, select your current-year application. Once your application opens, you'll land on the Application Status screen. While on this screen, you will select the Report a life change link on the menu to the left.

This page contains a lot of information about reporting a life change and some examples of changes to report.

Once you have reviewed this information, select the Report a life change button.

Here are some examples of the different types of life changes you can report.

Since your family size and income will be changing, you should select the first radio button option: Report a change in my household's income, size, address, or other information, then select the Continue button.

Scenario: Savings Setup Screen

Coach: On the “Savings setup” screen, indicate whether you would like your application set up to check your household’s eligibility for savings. You can select “Help me decide” to answer questions to determine if your household is likely to qualify for savings.

On the “Decide if you’d like to check for savings” screen, indicate how many people you will report on your tax return, including yourself. Then indicate your estimated household income range.

Next, Lori can review and update her application information.

Scenario: Add a Person Screen

Coach: After reconfirming your own information from the original application, including your home and mailing address, preferred language, and contact preferences, you will come to the “Who needs health coverage” screen where you can add your newborn child’s information.

Note that the “Middle name” and “Suffix” fields are optional. However, providing this information is a best practice to make sure your application is accurate and complete.

Scenario: Updating Family and Household Information

After Lori adds her new baby to the household, she will need to proceed through the remainder of the application, provide any additional information as needed, and resubmit it.

The Marketplace will generate a new eligibility determination notice for the Gomez family. Lori should select View Results to review her new notice and confirm that the baby appears in her household's updated "Eligibility Overview" section.

Note that any time a consumer reports a life change, the consumer's notice will indicate whether they're eligible for a Special Enrollment Period (SEP) — even if the consumer reported the change during Open Enrollment.

Scenario: Eligibility Results

Finally, Lori should select Continue to Enrollment to choose a plan. If the Gomez family remains eligible for advance payments of the premium tax credit (APTC), Lori should set the amount she'd like to use. She should also report whether anyone in the household uses tobacco before viewing available plans and prices. Remember, Lori can use Marketplace tools to get an estimate of her family's yearly costs based on whether she thinks the family will use high, medium, or low amounts of health care. She can also find out if available plans cover her family's doctors, hospitals, and prescription drugs.

Keep in mind that you should always advise consumers to pay their first month's premium (binder payment) after they have enrolled to be sure their enrollment is complete.

Additional Information for Lori

Remind Lori to complete all items on the "To-Do List," including selecting and confirming a plan.

The plan selection will show only people who applied and were found eligible to enroll in a Marketplace plan. Anyone who is or may be eligible for Medicaid or Children's Health Insurance Program (CHIP) or who is no longer applying for Marketplace coverage won't appear in the plan selection. Anyone continuing Marketplace coverage must select and confirm enrollment in a Marketplace plan for the coverage changes to take effect. Anyone eligible for an SEP can select a new plan if they desire, if applicable.

Key Points

- When consumers experience a life change, they should report it using their Marketplace account at HealthCare.gov.
- After consumers add new information to their Marketplace account, consumers should review and update their entire application.
- The Marketplaces will provide an eligibility notice containing information about an SEP, if appropriate.

Conclusion

Good work!

You should now have a good understanding of Coverage to Care and how to help consumers report a life change.

Even if consumers keep their Marketplace plan from one year to the next, it's important to point out that certain aspects of the plan like copayments, coinsurance, and provider networks may change. As you meet with consumers who are re-enrolling in plans, be sure to review this information with them and be sure they understand the basic aspects of their plan. This will ensure that consumers continue to select plans that meet their needs and help them continue to access the coverage each year.

You've finished the learning portion of this course. Select **Exit Course** to leave the course and take the *Coverage to Care Assistance* exam or to close the course and return to the exam later.

If you choose to take the exam, the code to access this exam is: 356810.

Resources

Note: There are some references and links to nongovernmental third-party websites in this section. CMS offers these links for informational purposes only, and inclusion of these websites shouldn't be construed as an endorsement of any third-party organization's programs or activities.

Module 2 — Coverage to Care (C2C)

Coverage to Care: A resource whether you're an individual managing coverage for you and your family or a provider or organization helping those in your community manage their care.

CMS.gov/priorities/health-equity/c2c

Coverage to Care: Enrollment Toolkit for community partners, Assisters, and other people who help consumers enroll in coverage or change plans:

CMS.gov/files/document/c2c-enrollment-toolkit-2021.pdf

Coverage to Care: Enrollment Toolkit (Spanish language/Español):

CMS.gov/files/document/c2c-enrollment-toolkit-spanish.pdf

Getting Coverage: How to get coverage through a Health Insurance Marketplace®. Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.

Healthcare.gov/apply-and-enroll/how-to-apply/

Coverage to Care: 5 ways to make the most of your health coverage.

CMS.gov/About-CMS/Agency-Information/OMH/Downloads/5-Ways-to-Make-the-Most-of-Your-Coverage.pdf

Coverage to Care: Roadmap to better care.

CMS.gov/files/document/c2c-roadmap-better-care.pdf

Glossary of Health Coverage and Medical Terms:

Healthcare.gov/sbc-glossary/

Module 3 — Coverage to Care Assistance

Office of Minority Health: Resource center to help health care professionals, researchers, consumers, and community partners improve health outcomes and address health disparities.

CMS.gov/priorities/health-equity/minority-health/resource-center

Savings Estimator Tool: Provides consumers with a quick view of income levels that qualify for savings in 2024.

Healthcare.gov/lower-costs/

Using Your Health Insurance Coverage: Finding a doctor in your plan.

Healthcare.gov/using-marketplace-coverage/getting-medical-care/

Consumer Authorization and Personally Identifiable Information (PII): Obtaining Consumer Authorization and Handling Consumers' PII in the FFM.

CMS.gov/marketplace/technical-assistance-resources/consumer-authorization-and-handling-pii.pdf

Model Authorization Form for Navigators in a Federally-facilitated Marketplace:

CMS.gov/marketplace/technical-assistance-resources/draft-authorization-form-navigators.pdf

Office for Civil Rights (OCR) website: Official website of HHS OCR, which contains information about federal laws on discrimination, privacy, and conscience and religious freedom.

HHS.gov/ocr/index.html

Office for Civil Rights (OCR): How to File a Civil Rights Complaint: Consumers who believe they have been discriminated against on the basis of race, color, national origin, sex, age, disability, or religion may file a complaint with OCR.

HHS.gov/civil-rights/filing-a-complaint/complaint-process/index.html

Module 4 — Consumer Protections in the No Surprises Act

No Surprises Act: Consumer Webpage to learn more about their protections under the No Surprises Act

CMS.gov/medical-bill-rights

No Surprises Act Consumer Advocate Toolkit: More information on the consumer consent form and notice, the good faith estimate, and protections against unexpected medical bills.

CMS.gov/nosurprises/consumer-advocate-toolkit

Module 5 — Coverage Costs and Life Insurance

How much will health insurance cost? Health Insurance Marketplace Calculator.

KFF.org/interactive/subsidy-calculator/

What plans are available in my area: You can browse plans and estimated prices here any time.

Healthcare.gov/see-plans/#/

Using your health insurance coverage: Improving and keeping up with your health.

Healthcare.gov/using-marketplace-coverage/

MyHealthfinder: See which preventive services you may need.

Health.gov/myhealthfinder

Finding a Provider: Reviews and ratings of local providers

Healthgrades.com/

Preventive Care Benefits for Women: These services are free only when delivered by a doctor or other provider in your plan's network.

Healthcare.gov/preventive-care-women/

Reporting Life Changes: Types of Qualifying Life Events.

CMS.gov/marketplace/technical-assistance-resources/qualifying-life-events.pdf