

# FAQS ABOUT AFFORDABLE CARE ACT AND CONSOLIDATED APPROPRIATIONS ACT, 2021 IMPLEMENTATION PART 55

August 19, 2022

Set out below are Frequently Asked Questions (FAQs) regarding implementation of certain provisions of the Affordable Care Act and title I (the No Surprises Act)<sup>1</sup> of Division BB of the Consolidated Appropriations Act, 2021. These FAQs have been prepared jointly by the Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the Departments). Like previously issued FAQs (available at <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs> and <http://www.cms.gov/cciio/resources/fact-sheets-and-faqs/index.html>), these FAQs answer questions from stakeholders to help people understand the law and promote compliance.

## **The No Surprises Act**

Sections 102 and 103 of the No Surprises Act added section 9816 to the Internal Revenue Code (Code), section 716 to the Employee Retirement Income Security Act (ERISA), and section 2799A-1 to the Public Health Service Act (PHS Act). Section 104 of the No Surprises Act added sections 2799B-1 and 2799B-2 to the PHS Act. Section 105 of the No Surprises Act added section 9817 to the Code, section 717 to ERISA, and sections 2799A-2 and 2799B-5 to the PHS Act. These provisions provide protections against surprise medical bills for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services.

Sections 102 and 104 of the No Surprises Act added section 9820(c) to the Code, section 720(c) to ERISA, and sections 2799A-5(c) and 2799B-3 to the PHS Act, generally requiring group health plans, health insurance issuers offering group or individual health insurance coverage, and health care providers and health care facilities to make certain disclosures regarding balance billing protections to the public and to individual participants, beneficiaries, and enrollees.

The Departments issued interim final rules in July 2021 to implement certain of these provisions (July 2021 interim final rules).<sup>2</sup> The July 2021 interim final rules generally prohibit balance billing and limit cost sharing for out-of-network services subject to the surprise billing provisions of the No Surprises Act. Under the No Surprises Act and its implementing regulations, 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:

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<sup>1</sup> The No Surprises Act was enacted as title I of Division BB of the Consolidated Appropriations Act, 2021. Pub. L. 116-260, 134 Stat. 1182 (2020).

<sup>2</sup> 86 FR 36872 (July 13, 2021). The July 2021 interim final rules are generally applicable for plan years (in the individual market, policy years) beginning on or after January 1, 2022. The HHS-only regulations that apply to health care providers, facilities, and providers of air ambulance services are generally applicable with respect to items and services furnished during plan years (in the individual market, policy years) beginning on January 1, 2022.

- (1) an amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act (SSA);
- (2) if there is no such applicable All-Payer Model Agreement, an amount determined by a specified state law; or
- (3) if there is no such applicable All-Payer Model Agreement or specified state law, the lesser of the billed charge or the qualifying payment amount (QPA).

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

The QPA is generally the median of the contracted rates recognized by the plan or issuer on January 31, 2019, for the same or similar item or service that is provided by a provider in the same or similar specialty or facility of the same or similar facility type and provided in the geographic region in which the item or service is furnished, increased for inflation.<sup>3</sup> The median contracted rate is determined with respect to all plans of the plan sponsor (or, if applicable, administering entity) or all coverage offered by the issuer that are offered in the same insurance market. The July 2021 interim final rules establish the methodology for calculating the QPA, including when a plan or issuer lacks sufficient information to calculate a median of contracted rates with participating providers, facilities, or providers of air ambulance services.

#### *Applicability to No-Network and Closed Network Plans*

**Q1: Do the balance billing prohibitions of the No Surprises Act apply to nonparticipating providers, emergency facilities, and providers of air ambulance services when providing emergency services, certain non-emergency services, or air ambulance services to a participant, beneficiary, or enrollee who is covered under a group health plan or group or individual health insurance coverage that does not have a network of providers, such as a plan that utilizes reference-based pricing?**

Yes, with respect to emergency services and air ambulance services. The balance billing prohibitions in sections 2799B-1 and 2799B-5 of the PHS Act, implemented at 45 CFR 149.410 and 149.440, apply to nonparticipating emergency facilities, nonparticipating providers, and nonparticipating providers of air ambulance services, with respect to any participant, beneficiary, or enrollee with benefits under a group health plan or group or individual health insurance coverage offered by a health insurance issuer who is furnished emergency services or air ambulance services (for which benefits are provided under the plan or coverage). A nonparticipating provider is any physician or other health care provider that does not have a contractual relationship directly or indirectly with a group health plan or group or individual health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage, respectively.

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<sup>3</sup> See Rev. Proc. 2022-11, 2022-3 IRB 449, available at <https://www.irs.gov/pub/irs-drop/rp-22-11.pdf>. See also Notice 2022-11, 2022-14 IRB 939, available at <https://www.irs.gov/pub/irs-drop/n-22-11.pdf>.

A nonparticipating emergency facility means an emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to post-stabilization emergency services), that does not have a contractual relationship directly or indirectly with a group health plan or group or individual health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage, respectively. These definitions<sup>4</sup> and the protections afforded to participants, beneficiaries, or enrollees related to emergency services and air ambulance services are not dependent on whether the group health plan or group or individual health insurance coverage has a network of providers.

In contrast, the provisions that prohibit balance billing for non-emergency services apply only to services provided by a nonparticipating provider with respect to a visit to a participating health care facility. A participating health care facility is any health care facility<sup>5</sup> that has a contractual relationship directly or indirectly with a plan or issuer setting forth the terms and conditions upon which the relevant item or service is furnished to the participant, beneficiary, or enrollee under the plan or coverage.<sup>6</sup> Therefore, as stated in the preamble to the July 2021 interim final rules, the prohibitions on balance billing for non-emergency services provided by nonparticipating providers with respect to a visit to certain participating facilities would never be triggered if a plan or coverage does not have a network of participating facilities.<sup>7</sup>

**Q2: Do the surprise billing provisions of the No Surprises Act apply to a group health plan or group or individual health insurance coverage that does not have a network of providers, such as a plan that utilizes reference-based pricing?**

Yes, with respect to emergency services and air ambulance services. The provisions that limit cost sharing for out-of-network emergency services apply if a plan or issuer provides or covers any benefits for emergency services and the services are provided by a nonparticipating provider or nonparticipating emergency facility. Similarly, the provisions that limit cost sharing for out-of-network air ambulance services apply if a plan or issuer provides or covers any benefits for air ambulance services and those services are provided by a nonparticipating provider of air ambulance services. As stated in Q1, the definitions of nonparticipating provider or nonparticipating emergency facility and the protections afforded to participants, beneficiaries, or

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<sup>4</sup> The implementing regulations define “nonparticipating provider” and “nonparticipating emergency facility” but do not include a separate definition of “nonparticipating provider of air ambulance services.” The regulations define “provider of air ambulance services” to mean an entity that is licensed under applicable state and Federal law to provide air ambulance services. 26 CFR 54.9816-3T, 29 CFR 2590.716-3, and 45 CFR 149.30. Similar to the definition of “nonparticipating provider,” the Departments consider a provider of air ambulance services to be a nonparticipating provider of air ambulance services if the provider of air ambulance services does not have a contractual relationship directly or indirectly with a group health plan or group or individual health insurance coverage offered by a health insurance issuer, with respect to the furnishing of air ambulance services under the plan or coverage, respectively.

<sup>5</sup> Under the July 2021 interim final rules, a health care facility is defined, in the context of non-emergency services, as one of the following: (1) a hospital (as defined in section 1861(e) of the SSA), (2) a hospital outpatient department, (3) a critical access hospital (as defined in section 1861(mm)(1) of the SSA), and (4) an ambulatory surgical center described in section 1833(i)(1)(A) of the SSA.

<sup>6</sup> 26 CFR 54.9816-3T, 29 CFR 2590.716-3, and 45 CFR 149.30.

<sup>7</sup> 86 FR 36872, 36904 (July 13, 2021).

enrollees related to emergency services and air ambulance services are not dependent on whether the group health plan or group or individual health insurance coverage has a network of providers.<sup>8</sup>

In contrast, as also noted in Q1, the provisions that limit cost sharing for non-emergency services apply only to services provided by a nonparticipating provider with respect to a visit to a participating health care facility. Therefore, as stated in the preamble to the July 2021 interim final rules, the provisions that limit cost sharing for non-emergency services provided by nonparticipating providers with respect to a visit to certain participating facilities would never be triggered if a plan or coverage does not have a network of participating facilities.<sup>9</sup>

**Q3: How must a group health plan or group or individual health insurance coverage that does not have a network of providers calculate cost sharing for out-of-network items and services that are subject to the surprise billing provisions of the No Surprises Act?**

In general, for emergency services furnished by a nonparticipating provider or a nonparticipating emergency facility, and for non-emergency services furnished by nonparticipating providers with respect to a visit to a participating health care facility, cost sharing is calculated as if the total amount that would have been charged for the services by a participating emergency facility or participating provider were equal to the recognized amount for the services, as defined by the statute and in 26 CFR 54.9816-3T, 29 CFR 2590.716-3, and 45 CFR 149.30.

If an All-Payer Model Agreement or specified state law applies, the plan or issuer must calculate cost sharing for out-of-network services that are subject to the No Surprises Act (other than out-of-network air ambulance services) based on the amount determined by the All-Payer Model Agreement or specified state law.

If an All-Payer Model Agreement or specified state law does not apply (including for all out-of-network air ambulance services subject to the No Surprises Act), cost sharing is determined based on the lesser of the billed charge or the QPA.

The July 2021 interim final rules establish the methodology for calculating the QPA, including when a plan or issuer lacks sufficient information to calculate a median contracted rate. If a plan or issuer does not have sufficient information to calculate a median contracted rate—including because the plan or issuer does not have a network of participating providers for the item or service involved—the plan or issuer must calculate the QPA using an eligible database, in accordance with the regulations.<sup>10</sup>

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<sup>8</sup> See Q4 regarding the calculation of the out-of-network rate for out-of-network items and services that are subject to the surprise billing provisions of the No Surprises Act.

<sup>9</sup> *Id.*

<sup>10</sup> 26 CFR 54.9816-6T(c)(3), 29 CFR 2590.716-6(c)(3), and 45 CFR 149.140(c)(3). Note that when a plan or issuer has sufficient information to calculate the median of its contracted rates, but payments under its contractual agreements are not on a fee-for-service basis (such as bundled or capitation payments), the plan or issuer is required under the July 2021 interim final rules to calculate the QPA using underlying fee schedule rates or derived amounts. The regulations do not permit a plan or issuer to use underlying fee schedules or derived amounts to calculate the QPA in any other circumstance.

*Example:* Person X is enrolled in a group health plan that does not have a network of providers or facilities. Under the terms of the plan, the plan pays a reference-based amount, based on a fee schedule, for items and services covered under the plan. Participants and beneficiaries generally are responsible for the difference between the provider's or facility's billed charge and the payment amount set under the plan. The plan applies a deductible, after which the plan does not impose cost sharing for covered services. Person X has satisfied the deductible for the current plan year. Person X is taken to a hospital emergency room for emergency services, and the facility sends the plan a bill for \$1,200 for CPT code 99282. There is no All-Payer Model Agreement or specified state law that is applicable with respect to the plan. Under the plan's terms, the plan would pay a reference-based amount of \$800 for CPT code 99282 after the deductible is satisfied.

*Conclusion:* Under the No Surprises Act, the emergency facility is prohibited from billing Person X for an amount that exceeds Person X's cost-sharing requirement. Person X's cost-sharing requirement must be calculated as if the total amount that would have been charged for the services by the nonparticipating emergency facility was equal to the recognized amount for the services. Since neither an All-Payer Model Agreement nor a specified state law applies, the plan must calculate the recognized amount using the QPA. Because the plan does not have a network from which to calculate median contracted rates, the QPA is calculated using an eligible database. Using an eligible database, the plan determines the applicable QPA is \$900. Because Person X's deductible has been satisfied and the plan does not impose other cost-sharing requirements for emergency services, Person X owes no cost sharing and cannot be billed or held liable for the \$400 difference between the amount billed by the facility (\$1,200) and the plan's reference-based amount (\$800).

**Q4: How must a group health plan or group or individual health insurance coverage that does not have a network of providers calculate the out-of-network rate for out-of-network items and services that are subject to the surprise billing provisions of the No Surprises Act?**

If an All-Payer Model Agreement or specified state law applies, the plan or issuer must calculate the out-of-network rate for out-of-network services that are subject to the No Surprises Act based on the amount determined by the All-Payer Model Agreement or specified state law, consistent with the definition of "out-of-network rate" set forth in 26 CFR 54.9816-3T, 29 CFR 2590.716-3, and 45 CFR 149.30.

If an All-Payer Model Agreement or specified state law does not apply, the out-of-network rate is the amount the nonparticipating provider, emergency facility, or provider of air ambulance services and the plan or issuer agree upon as the amount of payment for the item or service (including if the amount agreed upon is the initial payment sent by the plan or issuer or is agreed upon through negotiations with respect to such item or service). However, if the parties enter into the Federal independent dispute resolution (IDR) process and do not agree upon a payment amount before the date on which the certified IDR entity makes a determination with respect to such item or service, then the amount determined by the certified IDR entity is the out-of-

network rate. As a result, a plan or coverage that utilizes a reference-based pricing structure (or a similar network design) and does not have a network of providers may be required to make a total payment that is different than the plan's or issuer's reference-based amount for items and services that are subject to the surprise billing provisions of the No Surprises Act.

**Q5: How do the maximum-out-of-pocket requirements of section 2707(b) of the PHS Act apply to items and services subject to the No Surprises Act for a non-grandfathered large group market plan, or self-insured group health plan, that does not have a network of providers?**

In October 2014, the Departments issued FAQs Part XXI, which provide guidance on the maximum-out-of-pocket (MOOP) requirements under section 2707(b) of the PHS Act. The FAQs state that the Departments would not consider a non-grandfathered large group market plan or self-insured group health plan that utilizes reference-based pricing (or a similar network design) as failing to comply with the MOOP requirements of section 2707(b) of the PHS Act if the plan treats providers that accept the reference amount as the only in-network providers for purposes of section 2707(b) of the PHS Act, as long as the plan or issuer uses a reasonable method to ensure that it offers adequate access to quality providers at the reference-based price.<sup>11</sup> FAQs Part XXI set forth the specific factors the Departments will consider when evaluating whether such a plan is using a reasonable method. One of those factors is the type of service. Those FAQs state that a plan or issuer that uses reference-based pricing and treats providers that accept the reference amount as the only in-network providers for purposes of the MOOP requirements should apply only to those services for which the period between identification of the need for care and provision of the care is long enough for consumers to make an informed choice of provider. Those FAQs also state that limiting or excluding out-of-pocket spending from counting toward the MOOP with respect to providers that do not accept the reference-based price would not be considered reasonable with respect to emergency services.<sup>12</sup>

Note that the term “emergency services” was previously defined under section 2719A of the PHS Act and its implementing regulations, and that provision was sunset and recodified by the No Surprises Act. “Emergency services” are now defined in 26 CFR 54.9816-4T(c)(2), 29 CFR 2590.716-4(c)(2), and 45 CFR 149.110(c)(2) to include certain items and services furnished after

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<sup>11</sup> The Departments previously stated that if a plan includes a network of providers, the plan may, but is not required to, count an individual's out-of-pocket spending for out-of-network items and services toward the plan's annual out-of-pocket maximum. See FAQs about Affordable Care Act Implementation (Part XVIII) and Mental Health Parity Implementation, Q4 (Jan. 9, 2014), available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-xviii.pdf> and [http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca\\_implementation\\_faqs18.html](http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs18.html); and FAQs about Affordable Care Act Implementation (Part XIX), Q2 (May 2, 2014), available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-xix.pdf> and [http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca\\_implementation\\_faqs19.html](http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs19.html).

<sup>12</sup> See FAQs about Affordable Care Act Implementation (Part XXI) (Oct. 10, 2014), available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-xxi.pdf> and [https://www.cms.gov/sites/default/files/repo-new/61/Reference\\_Pricing\\_FAQ\\_10.10.14.pdf](https://www.cms.gov/sites/default/files/repo-new/61/Reference_Pricing_FAQ_10.10.14.pdf). As stated in FAQs Part XXI, compliance with section 2707(b) of the PHS Act is not determinative of compliance with any other provision of law, including section 2713 of the PHS Act (relating to coverage of preventive services). This also applies to sections 9816 and 9817 of the Code, sections 716 and 717 of ERISA, or sections 2799A-1 and 2799A-2 of the PHS Act (relating to surprise billing protections).

the patient is stabilized. Additionally, post-stabilization services are excluded from the definition of “emergency services” under the No Surprises Act if all conditions under 45 CFR 149.410(b) are met.<sup>13</sup> The new definition of “emergency services” reflects that, when patients receive these post-stabilization services, they may not have an opportunity in the time between identification of the need for care and provision of the care to seek a participating provider (and be protected from out-of-network cost sharing and balance billing). Therefore, consistent with the Departments’ prior guidance in FAQs Part XXI, limiting or excluding out-of-pocket spending from counting toward the MOOP with respect to providers that do not accept the reference-based price would not be considered reasonable with respect to post-stabilization services that are included in the definition of “emergency services.”

**Q6: Do the surprise billing provisions of the No Surprises Act apply in the case of a group health plan or group or individual health insurance coverage that generally does not provide out-of-network coverage?**

Yes. The No Surprises Act’s protections regarding emergency services, non-emergency services furnished by a nonparticipating provider with respect to a visit to a participating facility, and air ambulance services apply if those services are otherwise covered under the plan or coverage, even if the plan or coverage otherwise does not provide coverage for out-of-network items or services.

Note that, under section 9816(a) of the Code, section 716(a) of ERISA, and section 2799A-1(a) of the PHS Act, if a plan or issuer provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department, the plan or issuer must cover emergency services, including on an out-of-network basis, in accordance with the No Surprises Act and its implementing regulations.<sup>14</sup> Similarly, under section 9816(b) of the Code, section 716(b) of ERISA, section 2799A-1(b) of the PHS Act, if a plan or issuer provides or covers benefits with respect to non-emergency items and services, the plan or issuer must cover the items and services furnished to a participant, beneficiary, or enrollee of the plan or coverage by a nonparticipating provider with respect to a visit at a participating health care facility in accordance with requirements set forth in 26 CFR 54.9816-5T(c), 29 CFR 2590.716-5(c), and 45 CFR 149.120(c) related to cost sharing, payment amounts, and procedural requirements related to billing disputes. Finally, under section 9817(a) of the Code, section 717(a) of ERISA, and section 2799A-2(a) of the PHS Act, if a plan or issuer provides or covers any benefits for air ambulance services, the plan or issuer must cover such services from a nonparticipating provider of air ambulance services in accordance with requirements set forth in 26 CFR 54.9817-1T(b), 29 CFR 2590.717-1(b), and 45 CFR 149.130(b) related to cost sharing, payment amounts, and procedural requirements related

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<sup>13</sup> Under 45 CFR 149.410(b), post-stabilization services are emergency services unless all of the following conditions are met: (1) the attending emergency physician or treating provider determines that the participant, beneficiary, or enrollee is able to travel using nonmedical transportation or nonemergency medical transportation to an available participating provider or facility located within a reasonable travel distance, taking into account the individual’s medical condition; (2) the provider or facility furnishing such additional items and services satisfies the notice and consent criteria of 45 CFR 149.420(c) through (g); (3) the participant, beneficiary, or enrollee (or their authorized representative) is in a condition to receive notice and provide consent; and (4) the provider or facility satisfies any additional requirements or prohibitions under state law.

<sup>14</sup> See 26 CFR 54.9816-4T, 29 CFR 2590.716-4, and 45 CFR 149.110.

to billing disputes.<sup>15</sup> These requirements may result in a plan or coverage providing benefits for out-of-network items and services subject to the surprise billing provisions, even if the plan or coverage otherwise would not provide coverage for these items or services on an out-of-network basis.

#### *Applicability to Air Ambulance Services*

**Q7: If a plan or issuer covers air ambulance services only for emergencies, is the plan or issuer required under the No Surprises Act to cover non-emergent air ambulance services (such as non-emergent inter-facility transports) provided by a nonparticipating provider of air ambulance services?**

No. Under 26 CFR 54.9817-1T, 29 CFR 2590.717-1, and 45 CFR 149.130, if a plan or issuer provides or covers any benefits for air ambulance services, the plan or issuer must cover “such services” from a nonparticipating provider of air ambulance services in accordance with the implementing regulations. The Departments in this instance interpret “such services” to mean air ambulance services the plan or issuer provides or covers, as opposed to all air ambulance services. Therefore, if non-emergent air ambulance services are not covered under the terms of a plan or coverage, neither the No Surprises Act<sup>16</sup> nor its implementing regulations require the plan or issuer to cover those services or limit the amount a participant, beneficiary, or enrollee may be charged for those services.<sup>17</sup>

**Q8: Do the protections against surprise medical bills in the No Surprises Act apply to air ambulance services furnished by a nonparticipating provider of air ambulance services when the point of pick-up is in a jurisdiction outside of the United States?**

Yes. The requirements in 26 CFR 54.9817-1T, 29 CFR 2590.717-1, and 45 CFR 149.130 and 45 CFR 149.440 prohibiting surprise medical bills for air ambulance services apply to air ambulance services (for which benefits are available under the plan or coverage) furnished by a nonparticipating provider of air ambulance services that is licensed under applicable state and federal law to provide air ambulance services, and that therefore meets the definition of a provider of air ambulance services set forth in 26 CFR 54.9816-3T, 29 CFR 2590.716-3, and 45 CFR 149.30, even if the point of pick-up is in a jurisdiction outside of the United States.

**Q9: How should a plan or issuer identify the geographic region used to calculate the QPA for air ambulance services when the point of pick-up is outside of the United States?**

Under 26 CFR 54.9816-6T(a)(7)(ii), 29 CFR 2590.716-6(a)(7)(ii), and 45 CFR 149.140(a)(7)(ii), the geographic region in which air ambulance services are furnished is based on the point of pick-up, which is defined under 42 CFR 414.605 as the location of the individual at the time the

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<sup>15</sup> See Q7 for further detail about the coverage requirements applicable to air ambulance services.

<sup>16</sup> Section 9817 of the Code, section 717 of ERISA, and section 2799A-2 of the PHS Act.

<sup>17</sup> In contrast, and as noted in Q6, if a plan or issuer provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department, the plan or issuer must cover all emergency services, as defined in the No Surprises Act and its implementing regulations. 26 CFR 54.9816-4T, 29 CFR 2590.716-4, and 45 CFR 149.110.



individual is placed on board the ambulance. For air ambulance services, a “geographic region” generally is defined as one region consisting of all metropolitan statistical areas (MSAs) in the state, and one region consisting of all other portions of the state, determined based on the point of pick-up.<sup>18</sup>

If a plan or issuer does not have sufficient information, as defined under 26 CFR 54.9816-6T(a)(15), 29 CFR 2590.716-6(a)(15), and 45 CFR 149.140(a)(15), to calculate the median contracted rate based on this primary definition, the “geographic region” is one region consisting of all MSAs in each Census division and one region consisting of all other portions of the Census division, determined based on the point of pick-up. In cases in which a plan or issuer does not have sufficient information using its own contracted rates to calculate the median contracted rate using either definition, the plan or issuer must determine the QPA using the same definitions of “geographic region” based on data from an eligible database, pursuant to 26 CFR 54.9816-6T(c)(3), 29 CFR 2590.716-6(c)(3), and 45 CFR 149.140(c)(3).

The Departments recognize that the July 2021 interim final rules do not currently provide for geographic regions outside of the United States. Therefore, the methodology for calculating the QPA for air ambulance services, either based on a plan’s or issuer’s contracted rates or using an eligible database, does not currently account for air ambulance services that are subject to the surprise billing protections of the No Surprises Act when the point of pick-up is outside of the United States.

In future rulemaking, the Departments intend to address the geographic region to be used to calculate the QPA for air ambulance services when the point of pick-up is in a jurisdiction outside of the United States. Until that rulemaking is finalized and effective, plans and issuers are expected to use a reasonable method to determine which geographic region under the interim final regulations applies for purposes of calculating the QPA for air ambulance services for which the point of pick-up is outside of the United States. For example, the Departments will consider a plan or issuer to have used a reasonable method if the plan or issuer identifies the relevant geographic region based on the border point of entry to the United States following patient pick-up.<sup>19</sup>

*Example:* A nonparticipating provider of air ambulance services is dispatched from Florida to pick up an individual experiencing a medical emergency in the Bahamas, and transports the individual back to a hospital in the United States, entering the United States through the Miami-Fort Lauderdale-West Palm Beach MSA. The nonparticipating provider of air ambulance services submits a claim to the individual’s plan or issuer for the services. The plan or issuer determines that the air ambulance services are a covered benefit under the terms of the individual’s coverage. The plan or issuer could reasonably

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<sup>18</sup> The Departments consulted with the National Association of Insurance Commissioners, as required by the No Surprises Act, to establish the geographic regions to be used in the methodology for calculating the QPA set forth in the July 2021 interim final rules.

<sup>19</sup> This method is generally consistent with the approach used in Medicare for air ambulance transports from areas outside of the United States to the United States for covered claims. See Medicare Claims Payment Manual, Chapter 15, Section 20.1.5D (Rev. 11365, 04-28-22), available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c15.pdf>.

calculate the QPA for the air ambulance services using the geographic region that corresponds to the United States border point of entry, which in this case would be the region consisting of all MSAs in Florida, provided the plan or issuer has sufficient information to calculate a median contracted rate for that region.

### *Applicability to Emergency Services Furnished in a Behavioral Health Crisis Facility*

The surprise billing protections set forth in the No Surprises Act and its implementing regulations apply to emergency services<sup>20</sup> (with respect to an emergency medical condition) that are furnished with respect to a visit to a hospital emergency department (defined to include a hospital outpatient department that provides emergency services) or an independent freestanding emergency department,<sup>21</sup> including ancillary services routinely available to the emergency department to evaluate that emergency medical condition, as well as pre- and post-stabilization services (regardless of the department of the hospital in which the services are furnished). The term “emergency medical condition” means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in section 1867(e)(1)(A)(i)-(iii) of the SSA, as added by the Emergency Medical Treatment and Labor Act (EMTALA), referring to placing the health of the individual (or, with respect to a pregnant person, the health of the person or their unborn child) in serious jeopardy, serious impairment to bodily functions, and serious dysfunction of any bodily organ or part.

Under the July 2021 interim final rules, as noted above, the term “emergency department of a hospital” includes a hospital outpatient department that provides emergency services. The July 2021 interim final rules also define “independent freestanding emergency department” to mean a health care facility (not limited to those described in the definition of “health care facility” in the July 2021 interim final rules) that provides emergency services, and is geographically separate and distinct from a hospital and separately licensed as such by a state.<sup>22</sup> The preamble to the July 2021 interim final rules states that the definition of “independent freestanding emergency department” is intended to include any health care facility that is geographically separate and

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<sup>20</sup> For the definition of emergency services, see 26 CFR 54.9816-4T(c)(2), 29 CFR 2590.716-4(c)(2), and 45 CFR 149.110(c)(2).

<sup>21</sup> For the definitions of emergency department of a hospital and independent freestanding emergency department, see 26 CFR 54.9816-3T, 29 CFR 2590.716-3, and 45 CFR 149.30.

<sup>22</sup> 26 CFR 54.9816-3T, 29 CFR 2590.716-3, and 45 CFR 149.30.

distinct from a hospital, and licensed by a state to provide emergency services (as defined in the July 2021 interim final rules), with respect to an emergency medical condition.<sup>23</sup>

**Q10: How do the surprise billing provisions of the No Surprises Act and its implementing regulations apply to emergency services furnished with respect to a visit to a behavioral health crisis facility?**

The July 2021 interim final rules made clear that the definition of emergency medical condition includes mental health conditions and substance use disorders that satisfy that definition.<sup>24</sup> The Departments recognize that individuals experiencing behavioral health emergencies may be served most effectively in settings outside of hospital emergency departments and that states, localities, and health care systems are actively exploring alternatives to hospital-based care to respond to behavioral health emergencies, including through services provided in specialized facilities that are staffed by behavioral health providers trained to provide crisis services.

To the extent that services provided in response to a behavioral health crisis meet the definition of “emergency services,” and are provided with respect to a visit to a facility that meets the definition of an “emergency department of a hospital” or an “independent freestanding emergency department,” as those terms are defined under the July 2021 interim final rules, these services are subject to the surprise billing protections in the No Surprises Act and its implementing regulations applicable to emergency services.<sup>25</sup> This is true regardless of whether the license issued to the facility uses the term “hospital emergency department” or “independent freestanding emergency department” and regardless of whether the license issued to the facility uses the term “emergency services” to describe the services the facility is licensed to provide. For example, if under state licensure laws, a facility that provides behavioral health crisis response services is permitted to provide emergency services as described in 26 CFR 54.9816-4T(c)(2), 29 CFR 2590.716-4(c)(2), and 45 CFR 149.110(c)(2), and is geographically separate and distinct from a hospital, then such a facility would fall within the definition of “independent freestanding emergency department” under the July 2021 interim final regulations, and the surprise billing protections would apply with respect to emergency services provided with respect to a visit to the facility.

*General Disclosure for Protections Against Balance Billing*

Section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, as added by the No Surprises Act, require plans and issuers to make certain disclosures regarding balance billing protections to participants, beneficiaries, and enrollees that are similar to disclosure requirements applicable to providers and facilities under section 2799B-3 of the PHS Act, as implemented in 45 CFR 149.430.

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<sup>23</sup> 86 FR 36872, 36879 (Jul. 13, 2021).

<sup>24</sup> 26 CFR 54.9816-4T(c)(1), 29 CFR 2590.716-4(c)(1), and 45 CFR 149.110(c)(1).

<sup>25</sup> In addition, to the extent that a medical screening examination and stabilizing treatment provided in response to a behavioral health crisis meet the definition of “emergency services,” and are provided in an outpatient department of a hospital, these services are also subject to the surprise billing protections applicable to emergency services.

In general, plans and issuers must make publicly available, post on a public website of the plan or issuer, and include on each explanation of benefits for an item or service with respect to which the requirements under section 9816 of the Code, section 716 of ERISA, and section 2799A-1 of the PHS Act apply, information on:

- (1) the requirements under those sections, as applicable;
- (2) the requirements and prohibitions applied under sections 2799B-1 and 2799B-2 of the PHS Act (relating to the prohibitions against balance billing for emergency and non-emergency services in certain circumstances);
- (3) other applicable state laws on out-of-network balance billing; and
- (4) contacting appropriate state and Federal agencies if an individual believes the provider or facility has violated the prohibition against balance billing.

These disclosure requirements are applicable for plan years (in the individual market, policy years) beginning on or after January 1, 2022.

To reduce burden and facilitate compliance with these disclosure requirements, the Departments issued a model disclosure notice that may be used to satisfy the disclosure requirements regarding balance billing protections.<sup>26</sup> The Departments consider use of the model notice in accordance with the accompanying instructions to be good faith compliance with the disclosure requirements of section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, if all other applicable requirements are met.

**Q11: May a group health plan that does not have its own website satisfy the disclosure requirements of section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, with respect to posting the required information on a public website of the plan, if the plan’s service provider posts the required information on its public website on behalf of the group health plan?**

Yes. If a group health plan does not have a website, the plan may satisfy the requirements to post on its public website the information required by section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, by entering into a written agreement under which a plan’s health insurance issuer or third-party administrator (TPA), as applicable, posts the information on its public website where information is normally made available to participants, beneficiaries, and enrollees, on the plan’s behalf. To the extent a health insurance issuer or TPA posts the required information on its public website on behalf of a plan, the plan satisfies the requirements with respect to posting the information on the plan’s public website if the health insurance issuer or TPA makes the information available in the required manner. The Departments note this guidance applies in instances in which the plan sponsor (for example, an

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<sup>26</sup> See Q13, which explains which versions of the standard notice and consent form and model disclosure notice providers, facilities, plans, and issuers may use.

employer) may maintain a public website, but the group health plan sponsored by the employer does not.

Notwithstanding the preceding paragraph, if a plan enters into a written agreement under which a health insurance issuer or TPA agrees to post the required information on its public website on behalf of the plan, and the health insurance issuer or TPA fails to do so, the plan violates the disclosure requirements of section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act.

**Q12: Are plans and issuers required under section 9820(c)(1)(B) of the Code, section 720(c)(1)(B) of ERISA, and section 2799A-5(c)(1)(B) of the PHS Act to provide information on all state laws regarding balance billing?**

No. The statute requires plans and issuers to provide information only on “applicable” state laws regarding out-of-network balance billing. The Departments will consider a plan or issuer to be in compliance with the requirements in section 9820(c)(1)(B) of the Code, section 720(c)(1)(B) of ERISA, and section 2799A-5(c)(1)(B) of the PHS Act if the plan’s or issuer’s disclosure includes information on state laws applicable to balance billing that apply with respect to participants, beneficiaries, and enrollees in such coverage.

The Departments do not expect a plan or issuer to provide information on state laws that do not apply to a particular participant, beneficiary, or enrollee that is enrolled in the plan or coverage. The Departments note that many state laws regarding balance billing and other surprise billing protections such as limits on cost sharing do not apply with respect to participants, beneficiaries, and enrollees who are enrolled in coverage provided by a self-insured group health plan or out-of-state issuer.

The Departments note that, prior to the enactment of the No Surprises Act, some states adopted laws that apply to providers and facilities within the state with respect to participants, beneficiaries, and enrollees who are enrolled in coverage over which the state does not have jurisdiction, such as coverage provided by a self-insured ERISA plan (that did not or could not voluntarily opt in to the state law) or by an out-of-state health insurance issuer. These state laws do not establish requirements that apply to self-insured group health plans or, generally, coverage provided by out-of-state health insurance issuers. The Departments will not consider a plan or out-of-state issuer to violate the requirements in section 9820(c)(1)(B) of the Code, section 720(c)(1)(B) of ERISA, and section 2799A-5(c)(1)(B) of the PHS Act if the plan’s or issuer’s disclosure does not include information on state laws that would not apply to claims arising under the relevant plan or policy regarding out-of-network balance billing. However, if a self-insured plan has voluntarily opted into a state law that provides such protections, the plan is required to disclose information on any such state law.

*Standard Notice and Consent Form and Model Disclosure Notice Regarding Patient Protections Against Balance Billing*

Section 2799B-2 of the PHS Act, as implemented in 45 CFR 149.410 and 149.420, allows nonparticipating providers and facilities to seek consent from an individual to waive the

individual's balance billing and cost-sharing protections in certain situations. In order to seek that consent, the nonparticipating provider or facility must provide written notice to participants, beneficiaries, or enrollees in accordance with guidance issued by HHS, and in the form and manner specified in guidance. HHS issued standard notice and consent documents that nonparticipating providers and facilities must use in order to meet the requirements of the notice and consent exception. HHS considers use of these documents in accordance with their accompanying instructions to be good faith compliance with the notice and consent requirements of section 2799B-2(d) of the PHS Act, provided that all other requirements are met. To the extent a state develops notice and consent documents that otherwise meet the statutory and regulatory requirements under section 2799B-2(d) of the PHS Act and 45 CFR 149.410 and 149.420, the state-developed documents will meet the Secretary of HHS's specifications regarding the form and manner of the notice and consent documents.

In addition, section 2799B-3 of the PHS Act, as implemented in 45 CFR 149.430, requires certain providers and facilities to provide disclosures regarding patient protections against balance billing to participants, beneficiaries, and enrollees. In general, those providers and facilities must make publicly available, post on a public website of the provider or facility (if applicable), and provide to participants, beneficiaries, and enrollees a one-page notice in clear and understandable language containing information on:

- (1) the requirements and prohibitions applicable to such provider or facility under sections 2799B-1 and 2799B-2 of the PHS Act (relating to prohibitions on balance billing for emergency and non-emergency services in certain circumstances);
- (2) any applicable state requirements; and
- (3) contacting appropriate state and federal agencies if the individual believes the provider or facility has violated the restrictions against balance billing.

HHS issued a model disclosure notice that may be used to satisfy these disclosure requirements regarding these balance billing protections, and the parallel disclosure requirements on plans and issuers in section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, which are described in more detail in Q11 and Q12. For providers and facilities, HHS considers use of the model notice in accordance with their accompanying instructions to be good faith compliance with the disclosure requirements under section 2799B-3 of the PHS Act, as implemented in 45 CFR 149.430, provided that all other requirements are met. In addition, for plans and issuers, the Departments consider use of the model notice in accordance with the accompanying instructions to be good faith compliance with the disclosure requirements set forth in section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, provided that all other requirements are met.

**Q13: Which versions of the standard notice and consent form and model disclosure notice may providers, facilities, plans, and issuers use?**

HHS previously published and obtained emergency approval from the Office of Management and Budget (OMB) for a standard notice and consent form that providers and facilities must use

when providing notice and seeking consent from individuals to waive their protections against surprise bills (unless a state develops notice and consent documents that otherwise meet the statutory and regulatory requirements under section 2799B-2(d) of the PHS Act and 45 CFR 149.410 and 149.420) and a model disclosure notice that providers, facilities, plans, and issuers may use to notify individuals of their protections against balance billing.

Based on public comments, HHS has revised these documents and obtained OMB approval for the revised versions.<sup>27</sup>

Providers and facilities may use either the initial version of the standard notice and consent form (Appendix II) or the revised version (Appendix IV) for items and services furnished during calendar year 2022. However, providers and facilities may use only the revised version of the standard notice and consent form (Appendix IV) for items and services furnished on or after January 1, 2023. Providers and facilities may use either the initial version of the model disclosure notice (Appendix I) or the revised version (Appendix III) for making disclosures during calendar year 2022. However, HHS will consider providers' and facilities' use of only the revised version of the model disclosure notice (Appendix III) to be good faith compliance for disclosures made on or after January 1, 2023.

Similarly, the Departments will consider plans' and issuers' use of either the initial (Appendix I) or revised (Appendix III) version of the model disclosure notice in accordance with its accompanying instructions to be good faith compliance for making disclosures with respect to plan or policy years beginning on or after January 1, 2022, and before January 1, 2023. However, the Departments will consider plans' and issuers' use of only the revised version of the model disclosure notice (Appendix IV) to be good faith compliance for disclosures with respect to plan or policy years beginning on or after January 1, 2023.

#### *Methodology for Calculating Qualifying Payment Amounts*

In general, under section 9816(a)(3)(E) of the Code, section 716(a)(3)(E) of ERISA, and section 2799A-1(a)(3)(E) of the PHS Act, for a given item or service, the QPA is the median of the contracted rates recognized by the plan or issuer on January 31, 2019, for the same or similar item or service that is provided by a provider in the same or similar specialty and provided in a geographic region in which the item or service is furnished, increased for inflation. The median contracted rate is determined with respect to all group health plans of the plan sponsor, or all group or individual health insurance coverage offered by the health insurance issuer in the same insurance market. The No Surprises Act and the July 2021 interim final rules establish the

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<sup>27</sup> The initial and revised versions of the model disclosure notice and standard notice and consent form are available at <https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets>. The information collection is approved under OMB control number 0938-1401 (CMS-10780, Requirements Related to Surprise Billing: Qualifying Payment Amount, Notice and Consent, Disclosure on Patient Protections Against Balance Billing, and State Law Opt-in), and currently has an expiration date of May 31, 2025.

methodology that plans and issuers must use to calculate the median of contracted rates to determine the QPA.

After the July 2021 interim final rules were issued, stakeholders brought to the Departments' attention certain contractual arrangements in which providers accept contracted rates established by plans or issuers for service codes that they are not likely to bill or that are not utilized by their specific provider specialty. Stakeholders raised concerns that the inclusion of these rates in the calculation of QPAs may artificially lower the QPA, as these providers have little incentive to negotiate fair reimbursement rates for these service codes, with some even accepting \$0 as their rate for codes they do not utilize.

The No Surprises Act and its implementing regulations place the responsibility for monitoring the accuracy of plans' and issuers' QPA calculation methodologies with the Departments (and applicable state authorities) by requiring audits of plans' and issuers' QPA calculation methodologies.<sup>28</sup> It is not the responsibility of a provider, facility, provider of air ambulance services, or certified IDR entity to verify a QPA's accuracy, and plans and issuers are not obligated to demonstrate that a QPA was calculated in accordance with the requirements of 26 CFR 54.9816-6T(c), 29 CFR 2590.716-6(c), and 45 CFR 149.140(c) unless required to do so by an applicable regulator. Providers, facilities, and providers of air ambulance services with concerns about a plan's or issuer's compliance with the requirements of 26 CFR 54.9816-6T, 26 CFR 54.9816-6, 29 CFR 2590.716-6, and 45 CFR 149.140 may contact the No Surprises Help Desk at 1-800-985-3059, submit a complaint at <https://www.cms.gov/nosurprises/policies-and-resources/providers-submit-a-billing-complaint>, or contact the applicable state authority.

**Q14: Under the No Surprises Act and its implementing regulations, are plans and issuers required to calculate a median contracted rate separately for each provider specialty, if the plan's or issuer's contracted rates for service codes vary based on provider specialty (as a result of the plan's or issuer's contracting process)?**

Yes. Under 26 CFR 54.9816-6T(b)(3), 29 CFR 2590.716-6(b)(3), and 45 CFR 149.140(b)(3), if a plan or issuer has contracted rates that vary based on provider specialty for a service code, the median contracted rate (and consequently the QPA) must be calculated separately for each provider specialty, as applicable. Plans and issuers are required to calculate separate median contracted rates by provider specialty both in instances where their contracting process purposefully sets different rates for different specialties and in instances where the contracting process otherwise results in different rates for different specialties.

The Departments have been informed that some plans and issuers establish contracted rates by offering most providers the same fee schedule for all covered services, and then it is up to the providers to negotiate increases to the rates for the services that they are most likely to bill. After the negotiation process, the entire fee schedule may be included in the provider contract, with contracted rate modifications made only to certain service codes based on the negotiations. For example, an anesthesiologist's contract may include rates for anesthesia services that are a result of negotiations between the plan or issuer and the provider and that are materially different from

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<sup>28</sup> 86 FR 36872, 36899 (July 13, 2021).



the contracted rates the plan or issuer has for the same anesthesia services with other providers in specialties that do not bill for those services. Similarly, an anesthesiologist's contract may also include contracted rates for other services the anesthesiologist does not provide (for example, dermatology services) that are identical to the contracted rates the plan or issuer has with other providers in specialties who similarly do not bill for those services.<sup>29</sup>

To the extent contracted rates for a service code vary based on only certain provider specialty types, the plan or issuer must calculate a separate median contracted rate for each provider specialty for which the rates differ. For example, if a plan's or issuer's contracted rates for a given anesthesia service are clustered at one rate for anesthesiologists and at another rate for all other provider specialties because those providers do not provide and bill for anesthesia services, the plan or issuer must calculate one median contracted rate for the anesthesia service code for anesthesiologists, and one separate median contracted rate for the same anesthesia service code for all other provider specialties. In this example, the plan or issuer would not be expected to calculate separate median contracted rates for the anesthesia service code for each of the other specialties, such as psychiatry or cardiology, because the plan or issuer does not have contracted rates for anesthesia services that vary based on those provider specialties.

The Departments understand that some natural variation in contracted rates is likely to occur as part of the contracting process. A plan or issuer may have established contracted rates for service codes that vary across providers for reasons that are not based on provider specialty. For the purpose of identifying provider specialties for which QPAs must be separately calculated, a plan's or issuer's contracted rates for an item or service are considered to vary based on provider specialty if there is a material difference in the median contracted rates for a service code between providers of different specialties, after accounting for variables other than provider specialty. Plans and issuers whose median contracted rates for a service code are not materially different between providers of different specialties are not required to calculate median contracted rates separately for each provider specialty when determining the QPA. For this purpose, whether a material difference exists depends on all the relevant facts and circumstances.

The Departments recognize that plans and issuers (reasonably and in good faith) may have not understood the July 2021 interim final rules to require the calculation of separate median contracted rates when the plan's or issuer's contracting process unintentionally results in contracted rates that vary based on provider specialty. Accordingly, the Departments will not require a plan or issuer (to the extent not already in compliance) to calculate a QPA as described in this guidance with respect to items and services furnished prior to the date that is 90 days after publication of these FAQs. HHS encourages states to take a similar approach to enforcement and will not consider a state to be failing to substantially enforce the requirements relating to the calculation of a QPA because the state takes such an approach. The Departments will monitor plans' and issuers' compliance with the July 2021 interim final rules, as interpreted in this guidance, and are continuing to monitor contracting practices that affect the calculation of the QPA, to determine whether additional guidance is needed.

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<sup>29</sup> The Departments have been informed that some plans and issuers enter \$0 in their fee schedule for covered items and services that a provider or facility is not equipped to furnish. In the Departments' view, \$0 does not represent a contracted rate in these cases. Therefore, plans and issuers should not include \$0 amounts in calculating median contracted rates.

**Q15: How may a self-insured group health plan calculate a QPA if it offers multiple benefit package options administered by different TPAs?**

Under 26 CFR 54.9816-6T(b), 29 CFR 2590.716-6(b), and 45 CFR 149.140(b), the median contracted rate used to determine the QPA for an item or service is determined with respect to all group health plans of the plan sponsor or all coverage offered by a health insurance issuer that are offered in the same insurance market. In the case of a self-insured group health plan, an “insurance market” generally means all self-insured group health plans (other than account-based plans and plans that consist solely of excepted benefits) of the plan sponsor. However, to reduce burden on self-insured group health plans, the July 2021 interim final rules provide that sponsors of self-insured group health plans may allow their TPAs to determine the QPA on behalf of the sponsor by calculating the median contracted rate using the contracted rates recognized by all self-insured group health plans administered by the TPA, as opposed to only those of the particular plan sponsor.

Consistent with the approach set forth in the July 2021 interim final rules, if a single self-insured group health plan offers multiple benefit package options administered by different TPAs, the plan may allow each TPA acting on behalf of the plan to calculate a median contracted rate separately for those benefit package options administered by the TPA. In other words, contracted rates would not have to be aggregated across multiple mutually-exclusive benefit package options administered by different TPAs to calculate a median contracted rate. Instead, the relevant QPA in a particular case would be the QPA specific to the particular item or service under the benefit package option elected by the participant or beneficiary.

For example, if a self-insured plan offers participants a choice of two benefit packages, Option A administered by TPA “A” and Option B administered by TPA “B,” the QPA for an item or service may be calculated separately for Option A and Option B, determined with respect to all self-insured group health plans administered by the same TPA (including from other plan sponsors). In this case, if a participant is enrolled in coverage under Option A, the plan would use the QPA for Option A for claims arising under that participant’s coverage, as calculated by TPA “A” for all self-insured group health plans administered by TPA “A.”

*Requirements for Initial Payments or Notices of Denial of Payment, Related Disclosures, and Initiation of Open Negotiation Periods and Federal IDR Process*

The No Surprises Act and its implementing regulations, including the July 2021 interim final rules, a second set of interim final rules issued in October 2021 (October 2021 interim final rules),<sup>30</sup> and the final rules issued concurrently with these FAQs establish requirements to help ensure that billing disputes related to items and services subject to the balance billing protections in the No Surprises Act are resolved in a timely fashion. Among other requirements, these include timeframes within which a plan or issuer must make an initial payment or send a notice

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<sup>30</sup> 86 FR 55980 (Oct. 7, 2021).

of denial of payment for items and services subject to surprise billing protections;<sup>31</sup> disclosures a plan or issuer must furnish to a provider, facility, or provider of air ambulance services with an initial payment or notice of denial of payment;<sup>32</sup> and a process for initiating an open negotiation period that must precede any initiation of the Federal IDR process.<sup>33</sup>

**Q16: Under the No Surprises Act and its implementing regulations, when must a plan or issuer send an initial payment or notice of denial of payment to a nonparticipating provider, facility, or provider of air ambulance services for items and services subject to the surprise billing protections?**

Sections 9816(a)(1)(C)(iv)(I) and 9817(a)(3)(A) of the Code, sections 716(a)(1)(C)(iv)(I) and 717(a)(3)(A) of ERISA, and sections 2799A-1(a)(1)(C)(iv)(I) and 2799A-2(a)(3)(A) of the PHS Act, as added by the No Surprises Act, require plans and issuers to send an initial payment or notice of denial of payment<sup>34</sup> not later than 30 calendar days after a nonparticipating provider, facility, or provider of air ambulance services submits a bill related to the items and services that fall within the scope of the surprise billing protections for emergency services, non-emergency services performed by nonparticipating providers related to a visit to a participating facility, and air ambulance services furnished by nonparticipating providers of air ambulance services. The 30-calendar-day period begins on the date the plan or issuer receives the information necessary to decide a claim for payment for such services, commonly known as a “clean claim.”<sup>35</sup>

The Departments will generally enforce the applicable provisions of the No Surprises Act in conjunction with states where applicable. Providers, facilities, and providers of air ambulance services with concerns about a plan’s or issuer’s compliance with the 30-calendar-day requirement to send an initial payment or notice of denial of payment may contact the No Surprises Help Desk at 1-800-985-3059 or submit a complaint at <https://www.cms.gov/nosurprises/policies-and-resources/providers-submit-a-billing-complaint>.

**Q17: May a provider, facility, or provider of air ambulance services initiate open negotiation prior to receiving an initial payment or notice of denial of payment for items and services subject to the surprise billing protections?**

No. In general, providers, facilities, and providers of air ambulance services have 30 business days from the day they receive an initial payment or a notice of denial of payment from the plan

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<sup>31</sup> 26 CFR 54.9816-4T(b)(3)(iv)(A), 29 CFR 2590.716-4(b)(3)(iv)(A), and 45 CFR 149.110(b)(3)(iv)(A); 26 CFR 54.9816-5T(c)(3), 29 CFR 2590.716-5(c)(3), and 45 CFR 149.120(c)(3); and 26 CFR 54.9817-1T(b)(4)(i), 29 CFR 2590.717-1(b)(4)(i), and 45 CFR 149.130(b)(4)(i).

<sup>32</sup> 26 CFR 54.9816-6T(d)(1), 26 CFR 54.9816-6(d)(1), 29 CFR 2590.716-6(d)(1), and 45 CFR 149.140(d)(1).

<sup>33</sup> 26 CFR 54.9816-8T(b)(1), 29 CFR 2590.716-8(b)(1), and 45 CFR 149.510(b)(1).

<sup>34</sup> The Departments note that a plan or issuer must send an initial payment or notice of denial of payment directly to the provider, facility, or provider of air ambulance services, as applicable. 26 CFR 54.9816-4T(b)(3)(iv)(A), 54.9816-5T(c)(3), and 54.9817(b)(4)(i); 29 CFR 2590.716-4(b)(3)(iv)(A), 2590.716-5(c)(3), and 2590.717-1(b)(4)(i); or 45 CFR 149.110(b)(3)(iv)(A), 149.120(c)(3), and 149.130(b)(4)(i). A plan or issuer does not satisfy its obligation under the statute and regulations if the plan or issuer sends an initial payment or notice of denial of payment to a participant, beneficiary, or enrollee that was furnished items or services by a nonparticipating provider, facility, or provider of air ambulance services.

<sup>35</sup> 86 FR 36872, 36900 (July 13, 2021).

or issuer regarding an item or service that falls within the scope of the surprise billing provisions to initiate open negotiation with respect to that item or service. If a plan or issuer fails to send an initial payment or notice of denial of payment not later than 30 calendar days after the plan or issuer receives a bill related to such an item or service from a nonparticipating provider, facility, or provider of air ambulance services that includes the information necessary to decide a claim for payment (*i.e.*, a “clean claim”), the 30-business-day timeline to initiate open negotiations will not begin until an initial payment or notice of denial of payment is made.

Providers, facilities, and providers of air ambulance services with concerns about a plan’s or issuer’s compliance with the requirements to timely make an initial payment or provide notice of denial of payment may contact the No Surprises Help Desk at 1-800-985-3059 or submit a complaint at <https://www.cms.gov/nosurprises/policies-and-resources/providers-submit-a-billing-complaint>. The Departments will generally enforce the applicable provisions of the No Surprises Act, in conjunction with states where applicable.

**Q18: Under the No Surprises Act and its implementing regulations, what constitutes an “initial payment” or a “notice of denial of payment” to a nonparticipating provider, facility, or provider of air ambulance services for items and services that are subject to the surprise billing protections?**

As stated in the preamble to the July 2021 interim final rules, the initial payment should be an amount that the plan or issuer reasonably intends to be payment in full based on the relevant facts and circumstances and as required under the terms of the plan or coverage, prior to the beginning of any open negotiation period or initiation of the Federal IDR process.<sup>36</sup> The initial payment is not required to be equivalent to the QPA (or the QPA less the individual’s cost-sharing amount), but as noted in Q19, the plan or issuer must include the QPA for each item or service with the initial payment or notice of denial of payment, as well as a statement certifying that the QPA applies for the purposes of the recognized amount, among other required information.

A notice of denial of payment means, with respect to an item or service for which benefits subject to the surprise billing protections are provided or covered, a written notice from the plan or issuer to the provider, facility, or provider of air ambulance services that states that payment for the item or service will not be made by the plan or coverage and explains the reason for denial.<sup>37</sup> For example, a notice of denial of payment could be provided if the item or service is covered but is subject to a deductible greater than the recognized amount.

The term “notice of denial of payment” does not include a notice of benefit denial due to an “adverse benefit determination” as defined in 29 CFR 2560.503-1(m)(4), as explained in the July 2021 interim final rules. There is a significant distinction between an adverse benefit determination, which may be disputed through a plan’s or issuer’s claims and appeals process, and a notice of denial of payment or an initial payment that is less than the billed amount under the July 2021 interim final rules, which may be disputed through open negotiation and, after that,

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<sup>36</sup> *Id.*

<sup>37</sup> 26 CFR 54.9816-3T, 29 CFR 2590.716-3, and 45 CFR 149.30.

through the Federal IDR process. In general, when adjudication of a claim results in a participant, beneficiary, or enrollee being personally liable for payment to a provider or facility, this determination may be an adverse benefit determination that can be disputed through a plan's or issuer's typical claims and appeals process. Conversely, when: (1) the adjudication of a claim results in a decision that does not affect the amount the participant, beneficiary, or enrollee owes; (2) the dispute involves only payment amounts due from the plan or issuer to the provider, facility, or provider of air ambulance services; and (3) the provider, facility, or provider of air ambulance services has no recourse against the participant, beneficiary, or enrollee, the decision is not an adverse benefit determination and the payment dispute may be resolved through open negotiation and, if necessary, the Federal IDR process.

**Q19: A plan or issuer receives a claim for emergency services from a nonparticipating provider, under which the recognized amount with respect to the item or service furnished by the nonparticipating provider is the QPA. After reviewing the claim, the plan or issuer provides an initial payment with an explanation of benefits that includes only a general statement that the claim was processed according to applicable state or Federal law and directs the nonparticipating provider to a website for more information. Does this satisfy the requirements of the regulations with respect to the information to be shared with an initial payment or notice of denial of payment?**

No. Under 26 CFR 54.9816-6T(d)(1), 26 CFR 54.9816-6(d)(1), 29 CFR 2590.716-6(d)(1), and 45 CFR 149.140(d)(1), in cases in which the recognized amount (or, in the case of air ambulance services, the amount on which cost sharing is based) with respect to an item or service furnished by the provider or facility is the QPA, plans and issuers are required to provide in writing, in paper or electronic form, certain information to nonparticipating providers, nonparticipating emergency facilities, and nonparticipating providers of air ambulance services regarding the QPA and how to dispute an initial payment or notice of denial of payment.

Specifically, when the recognized amount is the QPA, plans and issuers must provide the following information with an initial payment or notice of denial of payment:

- (1) the QPA for each item or service involved;
- (2) if the QPA is based on a downcoded service code or modifier, a statement from the plan or issuer explaining that the service code or modifier billed by the provider, facility, or provider of air ambulance services was downcoded; an explanation of why the claim was downcoded, including a description of which service codes or modifiers were altered, added, or removed, if any; and the amount that would have been the QPA had the service code or modifier not been downcoded;<sup>38</sup>
- (3) a statement to certify that the plan or issuer has determined that the QPA applies for the purposes of the recognized amount (or, in the case of air ambulance services, for

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<sup>38</sup> These requirements related to downcoding were finalized in final rules issued concurrently with these FAQs and are applicable with respect to items or services provided or furnished on or after the date that is 60 days after the date of publication of the final rules in the Federal Register for plan years (in the individual market, policy years) beginning on or after January 1, 2022.

calculating the participant's, beneficiary's, or enrollee's cost sharing), and that each QPA was determined in compliance with the methodology established in the July 2021 interim final rules

(4) a statement that if the provider or facility, as applicable, wishes to initiate a 30-business-day open negotiation period for purposes of determining the amount of total payment, the provider or facility may contact the appropriate person or office to initiate open negotiation, and that if the 30-business-day open negotiation period does not result in a determination, generally, the provider or facility may initiate the Federal IDR process within 4 days after the end of the open negotiation period; and

(5) contact information, including a telephone number and email address, for the appropriate person or office to initiate open negotiations for purposes of determining an amount of payment (including cost sharing) for such item or service.<sup>39</sup>

In this case, because the plan or issuer provides an explanation of benefits with only a general statement about the processing of the claim and directs the provider to a website for more information, the plan or issuer has failed to provide all the information required to be provided when making an initial payment or sending a notice of denial of payment and has therefore failed to satisfy the requirements of the July 2021 interim final rules.<sup>40</sup>

It is important to note that plans and issuers are not required to provide a QPA in all circumstances. For example, plans and issuers are not required to provide the QPA when the recognized amount for the item or service is calculated based on an amount determined by an All-Payer Model Agreement or under a specified state law, or when the item or service is not covered under the terms of the plan or coverage.

The Departments recognize that the requirements related to when a plan or issuer must provide a QPA, particularly in instances in which a plan or issuer has provided a recognized amount that is not the QPA, have caused confusion for some providers and facilities as to whether claims for which no QPA is provided are being properly processed by plans and issuers. Remittance Advice Remark Codes (RARCs) related to the No Surprises Act were approved and made effective as of March 1, 2022.<sup>41</sup> Although plans and issuers are not required to use the RARCs under the No Surprises Act and its implementing regulations, the Departments strongly encourage plans and issuers to use the RARCs, subject to state law, as these codes can facilitate communication with providers and facilities regarding how claims subject to the No Surprises Act were calculated. For example, in certain instances in which the recognized amount is not the QPA, a plan or

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<sup>39</sup> Certain additional information must be provided in a timely manner upon request from a nonparticipating provider, facility, or provider of air ambulance services. *See* 26 CFR 54.9816-6T(d)(2), 29 CFR 2590.716-6(d)(2), and 45 CFR 149.140(d)(2).

<sup>40</sup> Although plans and issuers are not required to include the requisite information on an explanation of benefits, the July 2021 interim final rules require disclosure of the information and assume that issuers and TPAs will automate the process of preparing and providing the information in a format similar to an explanation of benefits. *See* 86 FR 36872, 36933.

<sup>41</sup> *See* Remittance Advice Remark Codes Related to the No Surprises Act (March 1, 2022), available at: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/CAA-NSA-RARC-Codes.pdf>.

issuer can use RARC N867 to communicate that cost sharing was calculated based on a specified state law, in accordance with the No Surprises Act.

**Q20: If a plan or issuer has failed to disclose the information it is required to provide when making an initial payment or sending a notice of denial of payment, may a provider, facility, or provider of air ambulance services initiate an open negotiation period and then proceed to the Federal IDR process?**

Yes. In general, providers, facilities, and providers of air ambulance services have 30 business days from the day they receive an initial payment or a notice of denial of payment from the plan or issuer regarding an item or service to initiate open negotiation with respect to that item or service, including in cases in which information required to be provided is missing. However, a plan's or issuer's failure to satisfy the disclosure requirements in 26 CFR 54.9816-6T(d)(1) or (2), 26 CFR 54.9816-6(d)(1), 29 CFR 2590.716-6(d)(1) or (2), and 45 CFR 149.140(d)(1) or (2) could adversely affect a provider's, facility's, or provider of air ambulance services' ability to meaningfully participate in negotiations during the open negotiation period and Federal IDR process.

In these cases, when a plan or issuer fails to comply with the disclosure requirements in 26 CFR 54.9816-6T(d)(1) or (2), 26 CFR 54.9816-6(d)(1), 29 CFR 2590.716-6(d)(1) or (2), and 45 CFR 149.140(d)(1) or (2), providers, facilities, or providers of air ambulance services retain the right to initiate the open negotiation period within 30 business days of receiving the initial payment or notice of denial of payment. In initiating the open negotiation period, the provider, facility, or provider of air ambulance services, must provide the standard open negotiation notice<sup>42</sup> to the plan or issuer, as required in 26 CFR 54.9816-8T(b), 29 CFR 2590.716-8(b), and 45 CFR 149.140(b).<sup>43, 44</sup> After the 30-business-day open negotiation period has lapsed, the provider, facility, or provider of air ambulance services may initiate the Federal IDR process in accordance with the normal timelines.

Alternatively, in cases in which a plan or issuer fails to comply with the disclosure requirements in 26 CFR 54.9816-6T(d)(1) or (2), 26 CFR 54.9816-6(d)(1), 29 CFR 2590.716-6(d)(1) or (2), and 45 CFR 149.140(d)(1) or (2), providers, facilities, or providers of air ambulance services may request an extension to initiate the Federal IDR process,<sup>45</sup> and provide applicable attestations, by emailing a request for extension due to extenuating circumstances to

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<sup>42</sup> <https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/surprise-billing-part-ii-information-collection-documents-attachment-2.pdf>.

<sup>43</sup> Note that plans and issuers are prohibited from initiating open negotiation periods or the Federal IDR process before satisfying the requirements in 26 CFR 54.9816-6T(d)(1) and (2), 26 CFR 54.9816-6(d)(1), 29 CFR 2590.716-6(d)(1) and (2), and 45 CFR 149.140(d)(1) and (2), as applicable.

<sup>44</sup> The Departments expect that a party initiating open negotiation will be able to demonstrate the steps it has taken to comply with the notice requirements. Examples of steps taken to comply with the notice requirement include emailing or otherwise submitting the standard open negotiation notice to the contact or web portal address based on information provided with the initial payment or notice of denial of payment, or any contact associated with the plan or issuer if (and only if) contact information was not included with the initial payment or notice of denial of payment.

<sup>45</sup> 26 CFR 54.9816-8T(g); 29 CFR 2590.716-8(g); 45 CFR 149.510(g).

[FederalIDRQuestions@cms.hhs.gov](mailto:FederalIDRQuestions@cms.hhs.gov), including the time period(s) for which they are seeking an extension.

Failure by either party to supply information that is required to be submitted to the certified IDR entity (for example, failure to provide the QPA) may lead to a finding by the certified IDR entity that does not take into consideration the absent information, or may lead to the certified IDR entity drawing an inference about the absent information that is adverse to that party.

Providers, facilities, and providers of air ambulance services with concerns about a plan's or issuer's compliance with the requirements of 26 CFR 54.9816-6T(d)(1), 26 CFR 54.9816-6(d)(1), 29 CFR 2590.716-6(d)(1), and 45 CFR 149.140(d)(1), including concerns that a plan or issuer is not acting in good faith with respect to this requirement, may contact the No Surprises Help Desk at 1-800-985-3059 or submit a complaint at <https://www.cms.gov/nosurprises/policies-and-resources/providers-submit-a-billing-complaint>. The Departments will generally enforce the applicable provisions of the No Surprises Act, in conjunction with states where applicable.

**Q21: A plan or issuer establishes an online portal for nonparticipating providers, facilities, and providers of air ambulance services to submit the information necessary to initiate the open negotiation period. However, the portal does not accept uploads of the standard open negotiation form issued by the Departments, and the plan or issuer does not otherwise accept delivery of the standard open negotiation form. Instead, the plan or issuer requires that nonparticipating providers, facilities, and providers of air ambulance services manually enter information for each claim separately in a manner prescribed by the plan or issuer through the portal before the plan or issuer will engage in any open negotiation with the nonparticipating provider. Is this permissible?**

No. The October 2021 interim final rules at 26 CFR 54.9816-8T(b)(1)(ii)(B), 29 CFR 2590.716-8(b)(1)(ii)(B), and 45 CFR 149.510(b)(1)(ii)(B) state that the initiating party may initiate the open negotiation period by sending an open negotiation notice to the other party electronically (such as by email) if the following conditions are satisfied:

- (1) the initiating party has a good faith belief that the electronic method is readily accessible by the other party; and
- (2) the notice is provided in paper form free of charge upon request.

The Departments have developed a standard open negotiation form<sup>46</sup> that an initiating party must use to initiate the open negotiation period. The October 2021 interim final rules do not prohibit a plan or issuer from encouraging the use of an online portal for nonparticipating providers, facilities, and providers of air ambulance services to submit the information necessary to initiate the open negotiation period, or from seeking additional information to inform good faith open negotiations, such as through use of a supplemental open negotiation form. However, because

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<sup>46</sup> See Open Negotiation Notice and Instructions, available at: <https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/surprise-billing-part-ii-information-collection-documents-attachment-2.pdf>.



the initiating party (in this case, a nonparticipating provider) is required to use the standard open negotiation form, the other party must accept the standard open negotiation form sent by the initiating party to the contact information provided by the non-initiating party even when the initiating party does not use the plan's or issuer's portal or supplemental form, provided that the notice was sent in a manner that complies with the delivery requirements discussed above.

The October 2021 interim final rules permit the initiating party to send the open negotiation notice to the opposing party electronically if the party sending the notice has a good faith belief that the electronic method is readily accessible to the other party. For example, if a provider sends an open negotiation notice to the email address identified by the plan or issuer with the initial payment or notice of denial of payment, this electronic delivery would satisfy the delivery requirements of the October 2021 interim final rules (so long as the provider also provides the notice in paper form free of charge upon request).<sup>47</sup> Conversely, if a plan or issuer is in compliance with the requirement to disclose contact information with the initial payment or notice of denial of payment,<sup>48</sup> a provider, facility, or provider of air ambulance services generally would not have a good faith belief that sending an open negotiation notice to a general email address (that was not identified with the initial payment or notice of denial of payment) of the plan or issuer is a readily accessible electronic method under the October 2021 interim final rules.

In the preamble to the October 2021 interim final rules, the Departments encouraged plans, issuers, providers, facilities, and providers of air ambulance services to engage in good faith open negotiations. The Departments are aware of instances in which plans and issuers are not responding to or not acknowledging receipt of the notice of initiation of open negotiation, as well as instances in which providers are failing to provide information to plans and issuers in addition to what is included on the standard notice of initiation of open negotiation form, to assist the plan or issuer in identifying the claim under dispute. The Departments are of the view that these actions may hinder a party's ability to meaningfully participate in an open negotiation. The Departments consider good faith negotiations to include a dialogue between parties; at minimum, during the open negotiation period, parties should communicate to identify the claims under dispute, the type of plan or coverage responsible for the claims, and other information to help identify whether the claims qualify for the Federal IDR process. If a plan, issuer, provider, facility, or provider of air ambulance services timely sends the notice of initiation of open negotiation, and the other party does not respond during the 30-business-day open negotiation period, the initiating party may initiate the Federal IDR process during the 4-business-day period beginning on the 31<sup>st</sup> business day after the start of the open negotiation period if the item or service is a qualified IDR item or service.<sup>49</sup>

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<sup>47</sup> 86 FR 55980, 55990 (Oct. 7, 2021).

<sup>48</sup> Plans and issuers are required to provide contact information, including a telephone number and email address, for the appropriate person or office to initiate open negotiations. 26 CFR 54.9816-6T(d)(1)(v), 29 CFR 2590.716-6(d)(1)(v), and 45 CFR 149.140(d)(1)(v).

<sup>49</sup> For the definition of qualified IDR item or service, see 26 CFR 54.9816-8T(a)(2)(xii), 29 CFR 2590.716-8(a)(2)(xii), and 45 CFR 149.510(a)(2)(xii).

The Departments will continue to monitor whether and how the parties to a payment dispute interact during the open negotiation period and will consider whether additional guidance is needed.

### **Transparency in Coverage Machine-Readable Files**

The Transparency in Coverage Final Rules (the TiC Final Rules) require non-grandfathered plans and issuers offering non-grandfathered coverage in the group and individual markets to disclose, on a public website, information regarding in-network rates for covered items and services, out-of-network allowed amounts and billed charges for covered items and services, and negotiated rates and historical net prices for covered prescription drugs in separate machine-readable files.<sup>50</sup>

The machine-readable file requirements of the TiC Final Rules are applicable for plan years (in the individual market, policy years) beginning on or after January 1, 2022. The Departments previously announced that they will defer enforcement of the requirements related to machine-readable files disclosing in-network and out-of-network data until July 1, 2022.<sup>51</sup> The Departments also previously announced that they will defer enforcement of the requirement that plans and issuers publish a machine-readable file related to prescription drugs while the Departments consider, through notice-and-comment rulemaking, whether this requirement remains appropriate.<sup>52</sup>

Additionally, the TiC Final Rules require plans and issuers to make price comparison information available to participants, beneficiaries, and enrollees through an internet-based self-service tool and in paper form, upon request.<sup>53</sup> This information must be available for plan years (in the individual market, policy years) beginning on or after January 1, 2023, with respect to the 500 items and services identified by the Departments in Table 1 in the preamble to the TiC Final Rules,<sup>54</sup> and with respect to all covered items and services, for plan or policy years beginning on or after January 1, 2024.<sup>55</sup>

**Q22: May a group health plan that does not have its own website satisfy the requirements of the TiC Final Rules with respect to posting the machine-readable files on a public website, if the plan's service provider posts the machine-readable files on its public website on behalf of the group health plan?**

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<sup>50</sup> 26 CFR 54.9815-2715A3; 29 CFR 2590.715-2715A3; and 45 CFR 147.212; 85 FR 72158 (Nov. 12, 2020).

<sup>51</sup> See FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49, Q2 (Aug. 20, 2021), available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf> and <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf>. For 2022 plan years and policy years beginning after July 1, 2022, plans and issuers should post the machine-readable files beginning in the month in which the plan year (in the individual market, policy year) begins, consistent with the applicability provision of the TiC Final Rules.

<sup>52</sup> See id. at Q1.

<sup>53</sup> 26 CFR 54.9815-2715A2(b); 29 CFR 2590.715-2715A2(b); and 45 CFR 147.211(b).

<sup>54</sup> 85 FR 72158, 72182 (Nov. 12, 2020).

<sup>55</sup> 26 CFR 54.9815-2715A2(c)(1); 29 CFR 2590.715-2715A2(c)(1); and 45 CFR 147.211(c)(1).

Yes. If a group health plan does not have its own public website, nothing in the TiC Final Rules requires the plan to create its own website for the purposes of providing a link to a location where the machine-readable files are publicly available. The Departments note this guidance applies in instances in which the plan sponsor (for example, the employer) maintains a public website, but the group health plan sponsored by the employer does not.

Instead, a plan may satisfy the requirements of 26 CFR 54.9815-2715A3(b), 29 CFR 2590.715-2715A3(b), and 45 CFR 147.212(b) by entering into a written agreement under which a service provider (such as a TPA) posts the machine-readable files on its public website on behalf of the plan.

To the extent a service provider posts the required information on its public website on behalf of a plan, the plan satisfies the requirements with respect to posting the information on a public website if the service provider makes the information available in the required manner, regardless of whether the group health plan has a public website.<sup>56</sup> In the case of aggregated Allowed Amounts files, however, the plan must post a link to the file hosted by the service provider on the plan's own website, if the plan maintains a public website, per the requirements of 26 CFR 54.9815-2715A3(b)(4)(iii), 29 CFR 2590.715-2715A3(b)(4)(iii), and 45 CFR 147.212(b)(4)(iii).

Notwithstanding the preceding paragraph, if a plan enters into an agreement under which a service provider agrees to post the machine-readable files on its public website on behalf of the plan, and the service provider fails to do so, the plan violates the disclosure requirements of 26 CFR 54.9815-2715A3(b), 29 CFR 2590.715-2715A3(b), and 45 CFR 147.212(b).

**Q23: With regard to the internet-based self-service tool as required by the TiC Final Rules, will the list of codes for the 500 items and services required in the self-service tool for plan years (in the individual market, policy years) beginning on or after January 1, 2023 be updated when an item or service code is no longer valid?**

The list of 500 items and services that must be included in the first phase of implementation of the internet-based self-service tool can be found on the TiC Website at [www.cms.gov/healthplan-price-transparency/resources/500-items-services](http://www.cms.gov/healthplan-price-transparency/resources/500-items-services). The Departments will update this list quarterly to reflect the retirement of any codes that were included in Table 1 in the preamble to the TiC Final Rules list and will provide a reasonable period of time for plans and issuers to update their internet-based self-service tools to reflect the current codes. Plans and issuers should refer to this webpage for the most up-to-date list of codes to comply with the requirements regarding the self-service tool for plan years (in the individual market, policy years) beginning on or after January 1, 2023 and prior to January 1, 2024.

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<sup>56</sup> 26 CFR 54.9815-2715A3(b)(4)(ii); 29 CFR 2590.715-2715A3(b)(4)(ii); and 45 CFR 147.212(b)(4)(ii).

## APPENDICES:

### Initial forms

**Appendix I: Model Disclosure Notice Regarding Patient Protections Against Surprise Billing:** for use by providers and facilities under section 2799B-3 of the PHS Act for disclosures during calendar year 2022, and for use by group health plans and health insurance issuers under section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act for disclosures with respect to plan years beginning on or after January 1, 2022, and before January 1, 2023

Available at: <https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf> (see “Version 1”)

**Appendix II: Standard Notice and Consent Documents Under the No Surprises Act:** for use by nonparticipating providers and nonparticipating emergency facilities under section 2799B-2 of the PHS Act for items and services furnished during calendar year 2022 only

Available at: <https://www.cms.gov/files/document/standard-notice-consent-forms-nonparticipating-providers-emergency-facilities-regarding-consumer.pdf> (see “Version 1”)

### Revised forms

**Appendix III: Model Disclosure Notice Regarding Patient Protections Against Surprise Billing:** for use by providers and facilities under section 2799B-3 of the PHS Act for disclosures during calendar year 2022 and on or after January 1, 2023, and for use by group health plans and health insurance issuers under section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act for disclosures with respect to plan years beginning on or after January 1, 2022

Available at: <https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf> (see “Version 2”)

**Appendix IV: Standard Notice and Consent Documents Under the No Surprises Act:** for use by nonparticipating providers and nonparticipating emergency facilities under section 2799B-2 of the PHS Act for items and services furnished during calendar year 2022 and on or after January 1, 2023

Available at: <https://www.cms.gov/files/document/standard-notice-consent-forms-nonparticipating-providers-emergency-facilities-regarding-consumer.pdf> (see “Version 2”)