

FAQS ABOUT AFFORDABLE CARE ACT AND CONSOLIDATED APPROPRIATIONS ACT, 2021 IMPLEMENTATION PART 63

November 28, 2023

Set out below are Frequently Asked Questions (FAQs) regarding implementation of certain provisions of the Affordable Care Act (ACA) and Title I (the No Surprises Act)¹ 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/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/aca-implementation-faqs> and <https://www.cms.gov/ccio/resources/fact-sheets-and-faqs/index.html>), these FAQs answer questions from stakeholders to help people understand the law and promote compliance.

County Data for Culturally and Linguistically Appropriate Services

Public Health Service (PHS) Act section 2719 and its implementing regulations require non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage to provide certain notices in a culturally and linguistically appropriate manner.² The regulations implementing PHS Act section 2719 require these plans and issuers to provide (1) oral language services (such as a telephone assistance hotline) that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language; (2) notices in any applicable non-English language, upon request; and (3) in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the plan or issuer (referred to as taglines).³ For this purpose, an applicable non-English language, with respect to an address in any United States county to which a notice is sent, is an applicable non-English language if 10 percent or more of the population residing in the county is literate only in the same non-English language, as determined based on American Community Survey (ACS) data published by the United States Census Bureau.⁴

¹ 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).

² Section 2719 of the PHS Act; 26 CFR 54.9815-2719(e); 29 CFR 2590.715-2719(e); and 45 CFR 147.136(e).

³ 26 CFR 54.9815-2719(e), 29 CFR 2590.715-2719(e), and 45 CFR 147.136(e).

⁴ See 45 CFR 26 CFR 54.9815-2719(e)(3); 29 CFR 2590.715-2719(e)(3); and 45 CFR 147.136(e)(3). The Final Rules for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections Under the Affordable Care Act establish that the threshold percentage of people who are literate only in the same non-English language must be determined based on ACS data published by the U.S. Census Bureau, 80 FR 72192, 72208 (Nov. 18, 2015), *available at*

PHS Act section 2715 requires group health plans and health insurance issuers offering group or individual health insurance coverage (including grandfathered health plans) to provide a summary of benefits and coverage (SBC) and uniform glossary in a culturally and linguistically appropriate manner.⁵ The regulations implementing PHS Act section 2715 state that a plan or issuer is considered to provide the SBC in a culturally and linguistically appropriate manner if the thresholds and standards set forth in the PHS Act section 2719 implementing regulations are met as they apply to the SBC.⁶

Contemporaneous with the issuance of these FAQs, the Departments are releasing updated guidance on Culturally and Linguistically Appropriate Services County Data (CLAS County Data). This 2023 CLAS Guidance is available at <https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/clas-county-data-2023.pdf> and <https://www.cms.gov/marketplace/resources/fact-sheets-faqs>.

Q1: What information does the 2023 CLAS Guidance include, and when is it effective for plans and issuers?

The 2023 CLAS Guidance sets forth an updated list of all counties (including counties in U.S. territories)⁷ for which 10 percent or more of the population is literate only in the same non-English language, based on 2016-2020 ACS data published by the United States Census Bureau. This list identifies the language(s) that meet the 10 percent threshold for each county and the percentage of that county's population who are literate only in that language. The 2023 CLAS Guidance also includes sample taglines stating how to access the language services provided by the plan or issuer in each of the languages that meet the 10 percent threshold. Non-grandfathered group health plans and health insurance issuers offering non-grandfathered health insurance coverage are required to provide SBCs as well as claims and appeals notices in a manner that is consistent with the 2023 CLAS Guidance effective for plan years (in the

<https://www.federalregister.gov/d/2015-29294/p-185>. The relevant ACS data set used is the U.S. Census, 2016-2020 American Community Survey 5-Year Estimates, Table B16001, Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over, available at

<https://data.census.gov/table/ACSDT1Y2022.B16001?q=B16001:Language+Spoken+at+Home+by+Ability+to+Speak+English+for+the+Population+5+Years+and+Over>.

⁵ Section 2715 of the PHS Act; 26 CFR 54.9815-2715, 29 CFR 2590.715-2715, and 45 CFR 147.200.

⁶ 26 CFR 54.9815-2715(a)(5), 29 CFR 2590.715-2715(a)(5), and 45 CFR 147.200(a)(5).

⁷ The Departments note that this guidance is also applicable to group health plans, including non-Federal governmental plans, (whether insured or self-insured) offering coverage in the U.S. Territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands, and that are subject to the language access standards in PHS Act section 2719. However, HHS determined that certain PHS Act requirements enacted in the Affordable Care Act are appropriately governed by the definition of "state" at ACA section 1304(d) and therefore will not apply to health insurance issuers in the U.S. Territories. See the 2016 Payment Notice final rule, 80 FR at 10757, 10781, 10862, and 10863 (amending the definition of "State" in 45 C.F.R. §§ 144.103 and 154.102).⁷ This analysis applies only to health insurance governed by the PHS Act. Therefore, as a practical matter, PHS Act, ERISA, and Code requirements applicable to group health plans, including non-Federal governmental plans, such as the language access requirements in PHS Act section 2719, continue to apply to such coverage in the U.S. Territories. Issuers selling policies to both private sector and public sector employers in the U.S. Territories will want to make certain that their products comply with relevant federal requirements applicable to group health plans since their customers are still subject to those provisions.

individual market, policy years) beginning on or after January 1, 2025. The 2023 CLAS Guidance will be applicable until the next version of this guidance is issued and effective.

The Departments intend to update the following documents in the future to reflect the updates in the 2023 CLAS Guidance:

- SBC template and sample completed SBCs in English (with updated taglines in applicable non-English languages);
- Additional translated versions of the SBC and Uniform Glossary; and
- Model notices for internal claims and appeals and external review (with updated taglines in applicable non-English languages).

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 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 participants, beneficiaries, and enrollees in a group health plan or group or individual health insurance coverage offered by a health insurance issuer with respect to certain out-of-network items or services. These provisions also direct the Departments to establish a Federal Independent Dispute Resolution (“IDR”) process for resolving disputes between plans or issuers and providers, facilities, or providers of air ambulance services about the out-of-network rate for out-of-network items or services subject to the No Surprises Act in cases where a specified State law or an applicable All-Payer Model Agreement does not provide a method for determining the total amount payable (qualified IDR items and services).⁸ The Departments and the Office of Personnel Management (OPM) implemented regulations governing the Federal IDR process, which may be used by group health plans and health insurance issuers offering group or individual health insurance coverage and nonparticipating providers, facilities, and providers of air ambulance services to determine the out-of-network rate for certain items and services, in the October 2021 interim final rules.^{9,10} On August 26, 2022 the Departments published a rule finalizing certain provisions related to the Federal IDR process.¹¹

⁸ Code section 9816(c)(2)(A), ERISA section 716(c)(2)(A), and PHS Act section 2799A-1(c)(2)(A).

⁹ 86 FR 55980 (Oct. 7, 2021).

¹⁰ OPM regulation of FEHB carriers is set forth at 5 CFR 890.114.

¹¹ 87 FR 52618. However, in *Tex. Med. Ass’n, et. Al. v. U.S. Dep’t of Health and Human Servs.*, Case No. 6:22-cv-372 (E.D. Tex. February 06, 2023), the District Court issued a memorandum opinion and order that vacated portions of the August 2022 final rules related to the certified IDR entity's consideration of the statutory factors when making a payment determination. Specifically, the district court vacated the following: (1) the requirement that certified IDR entities consider the QPA and then the additional statutory factors under 26 CFR 54.9816-8(c)(4)(iii)(B)(1)-(5) and 54.9817-2(b)(3), 29 CFR 2590.716-8(c)(4)(iii)(B)(1)-(5) and 2590.717-2(b)(3), and 45 CFR 149.510(c)(4)(iii)(B)(1)-(5) and 149.520(b)(3); (2) the provision that a certified IDR entity should evaluate whether

Code section 9816(c)(3), ERISA section 716(c)(3), and PHS Act section 2799A-1(c)(3) also direct the Departments to specify criteria under which multiple qualified IDR items and services may be considered jointly as part of one payment determination (batching). Under the October 2021 interim final rules, multiple claims for qualified IDR items and services may be submitted and considered jointly as part of one payment determination by a certified IDR entity only if certain conditions are met:

- The qualified IDR items and services are billed by the same provider, group of providers, facility, or provider of air ambulance services. Items and services are billed by the same provider or group of providers, the same facility, or the same provider of air ambulance services if the items or services are billed with the same National Provider Identifier or Taxpayer Identification Number;
- Payment for the items and services would be made by the same group health plan or health insurance issuer;
- The qualified IDR items and services are the same or similar items or services. The qualified IDR items and services are considered to be the same or similar items or services if each is billed under the same service code, or a comparable code under a different procedural code system, such as Current Procedural Terminology (CPT) codes with modifiers, if applicable, Healthcare Common Procedure Coding System (HCPCS) with modifiers, if applicable, or Diagnosis-Related Group (DRG) codes with modifiers, if applicable;¹² and
- All the qualified IDR items and services were furnished within the same 30-business-day period (or are items or services for which the open negotiation period expired during the same 90-calendar day cooling-off period).¹³

The District Court's Decisions in *TMA IV* and *TMA III*

On August 3, 2023, the United States District Court for the Eastern District of Texas (District Court) issued an opinion and order¹⁴ that vacated certain provisions of the October 2021 interim final rules setting forth the batching criteria under which multiple IDR items or services may be considered jointly as part of a single IDR proceeding. Specifically, the District Court vacated the requirement under 26 CFR 54.9816-8T(c)(3)(i)(C), 29 CFR 2590.716-8(c)(3)(i)(C), and 45 CFR

the information submitted under 26 CFR 54.9816-8(c)(4)(iii)(B)-(D) and 54.9817-2(b)(3), 29 CFR 2590.716-8(c)(4)(iii)(B)-(D) and 2590.717-2(b)(3), and 45 CFR 149.510(c)(4)(iii)(B)-(D) and 149.520(b)(3) is credible and relates to the offer submitted by either party for the payment amount for the qualified IDR item or service that is the subject of the payment determination, and the certified IDR entity should not give weight to information to the extent it is not credible, it does not relate to either party's offer for the payment amount for the qualified IDR item or service, or it is already accounted for by the QPA or another factor; (3) the dispute resolution examples; and (4) the requirement that, if the certified IDR entity relies on additional information in selecting an offer, its written decision must include an explanation of why the certified IDR entity concluded that this information was not already reflected in the QPA.

¹² As discussed below, this requirement, set forth at 26 CFR 54.9816-8T(c)(3)(i)(C), 29 CFR 2590.716-8(c)(3)(i)(C), and 45 CFR 149.510(c)(3)(i)(C), was vacated by the U.S. District Court for the Eastern District of Texas in *Tex. Med. Ass'n v. U.S. Dep't of Health & Hum. Servs.* ("*TMA IV*"), No. 6:23-cv-59-JDK, 2023 WL 4977746 (E.D. Tex. Aug. 3, 2023).

¹³ 26 CFR 54.9816-8T(c)(3)(i), 29 CFR 2590.716-8(c)(3)(i), and 45 CFR 149.510(c)(3)(i).

¹⁴ *TMA IV*.

149.510(c)(3)(i)(C) that for qualified IDR items and services to be batched together, the qualified IDR items or services must be “the same or similar items and services,” defined as those items or services billed under the same service code or a comparable code under a different procedural code system, such as CPT codes with modifiers, if applicable, HCPCS with modifiers, if applicable, or DRG codes with modifiers, if applicable.¹⁵

Subsequently, of relevance to these FAQs, on August 24, 2023, the District Court issued an opinion and order¹⁶ that vacated the portion of the August 2022 Technical Guidance for Certified IDR Entities (August Technical Guidance)¹⁷ that had provided that the two service codes for a single air ambulance transport (one representing a lift off code, or base rate, and the other representing a per mileage code) could not be batched in a single IDR dispute.¹⁸

Q2: In light of the *TMA IV* and *TMA III* opinions and orders, how do the batching requirements of the No Surprises Act apply to qualified IDR items and services for disputes eligible for initiation of the Federal IDR process on or after August 3, 2023?

As a result of the *TMA IV* and *TMA III* opinions and orders, Code section 9816(c)(3)(A)(iii), ERISA section 716(c)(3)(A)(iii), and PHS Act section 2799A–1(c)(3)(A)(iii), in conjunction with the remaining non-vacated regulations, provide the effective standard for determining whether qualified IDR items and services may appropriately be batched together. That statutory text provides that items and services may be considered jointly as part of a single determination only if they are “related to the treatment of a similar condition.” Therefore, until the Departments and OPM engage in notice and comment rulemaking on the circumstances under which items and services will be considered “related to the treatment of a similar condition,” disputes eligible for initiation of the Federal IDR process on or after August 3, 2023, should be submitted in a manner that is consistent with the statutes and regulations that remain in effect after the *TMA IV* and *TMA III* vacatur. The District Court’s order in *TMA IV* does not impact the batching provisions set forth at 26 CFR 54.9816-8T(c)(3)(i)(A), (B), or (D), 29 CFR 2590.716-8(c)(3)(i)(A), (B), or (D), and 45 CFR 149.510(c)(3)(i)(A), (B), or (D) and those provisions

¹⁵ The *TMA IV* order also vacated the \$350 administrative fee per party established by the Amendment to the Calendar Year 2023 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act: Change in Administrative Fee issued on December 23, 2022, available at <https://www.cms.gov/ccio/resources/regulations-and-guidance/downloads/amended-cy2023-fee-guidance-federal-independent-dispute-resolution-process-nsa.pdf>. The Departments previously issued guidance to clarify the administrative fee amount for 2023 following *TMA IV*. See Centers for Medicare & Medicaid Services (Aug. 11, 2023). *Federal Independent Dispute Resolution (IDR) Process Administrative Fee FAQs*, available at <https://www.cms.gov/ccio/resources/regulations-and-guidance/downloads/no-surprises-act-independent-dispute-resolution-administrative-fee-frequently-asked-questions.pdf>.

¹⁶ Memorandum Opinion and Order, *Tex. Med. Ass’n v. U.S. Dep’t of Health & Hum. Servs.* (“*TMA III*”), No. 6:22-cv-450-JDK, 2023 WL 5489028 (E.D. Tex. Aug. 24, 2023).

¹⁷ *Technical Guidance for Certified IDR Entities* at 2-3 (Aug. 18, 2022), available at <https://www.cms.gov/files/document/TA-certified-independent-dispute-resolution-entities-August-2022.pdf>.

¹⁸ The opinion and order in *TMA III* also vacated provisions of the July 2021 interim final rules and other guidance documents relating to the QPA methodology, among other things. *TMA III*, 2023 WL 5489028, at *19-20. The Departments issued FAQs About Consolidated Appropriations Act, 2021 Implementation Part 62 (Oct. 6, 2023), available at <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-62> and <https://www.cms.gov/files/document/faqs-part-62.pdf> to provide guidance on those other aspects of the *TMA III* decision.

remain in effect. Certified IDR entities have the sole responsibility for determining whether the items and services submitted as part of a batched dispute meet the statutory and remaining regulatory standards for a batched dispute.

Q3: May disputes for air ambulance services for a single air ambulance transport that are initiated on or after August 3, 2023, be submitted as a batched dispute?

As a result of the *TMA III* order, air ambulance services for a single air ambulance transport, including an air ambulance mileage code and base rate code, may be submitted as a batched dispute, so long as all provisions of the batching regulations are satisfied, in accordance with Q2 of these FAQs. Nothing in this guidance or the *TMA III* opinion and order precludes an air ambulance mileage code or base rate code from being submitted separately as a single dispute.