OMB Control Number: 1210-0169
Expiration Date: 04/30/2022

Appendix 2

Standard Form: "Good Faith Estimate for Health Care Items and Services" Under the No Surprises Act

(For use by health care providers, facilities, and providers of air ambulance services no later than January 1, 2022)

Instructions

Under Section 2799B-6 of the Public Health Service Act and its implementing regulations, health care providers, health care facilities, and providers of air ambulance services are required to provide a good faith estimate of expected charges for items and services to individuals who are not enrolled in a group health plan or group or individual health insurance coverage, or a Federal health care program, or a Federal Employees Health Benefits (FEHB) program health benefits plan (uninsured individuals) or not seeking to file a claim with their group health plan, health insurance coverage, or FEHB health benefits plan (self-pay individuals) **in writing** (and may also provide it orally, if an uninsured (or self-pay) individual requests a good faith estimate in a method other than paper or electronically), upon request **or** at the time of scheduling health care items and services. For ease of reference, for purposes of this document, the term "provider" should be considered to include providers of air ambulance services.

This form may be used by the health care providers and facilities to inform uninsured (or self-pay) individuals of the expected charges for receiving certain health care items and services. A good faith estimate must be provided within 3 business days upon request. Information regarding scheduled items and services must be furnished within 1 business day of scheduling an item or service to be provided in at least 3 business days; and within 3 business days of scheduling an item or service to be provided in at least 10 business days.

To use this model notice, the provider or facility must fill in the blanks with the appropriate information. HHS considers use of the model notice to be good faith compliance with the good faith estimate requirements to inform an individual of expected charges. Use of this model notice is not required and is provided as a means of facilitating compliance with the applicable notice requirements. However, some form of notice, including the provision of certain required information, is necessary to begin the patient-provider dispute resolution process.

NOTE: The information provided in these instructions is intended only to be a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance upon which it is based. Readers should refer to the applicable statutes, regulations, and other interpretive materials for complete and current information, including the HHS interim final rules (IFR) titled *Requirements Related to Surprise Billing; Part II*, published on October 7, 2021.

Health care providers and facilities should not include these instructions with the documents given to patients.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 1210-0169. The time required to complete this information collection is estimated to average 1.3 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

[NAME OF CONVENING PROVIDER OR CONVENING FACILITY]

Good Faith Estimate for Health Care Items and Services

Patient		
Patient First Name	Middle Name	Last Name
Patient Date of Birth: _____/_____/_____		
Patient Identification Number:		
Patient Mailing Address, Phone Number, and Email Address		
Street or PO Box		Apartment
City	State	ZIP Code
Phone		
Email Address		
Patient's Contact Preference: ☐ By mail ☐ By email ☐ By phone		
Patient Diagnosis		
Primary Service or Item Requested/Scheduled		
Patient Primary Diagnosis	Primary Diagnosis Code	
Patient Secondary Diagnosis	Secondary Diagnosis Code	
If scheduled, list the date(s) the Primary Service or Item will be provided: ☐ Check this box if this service or item is not yet scheduled		

Date of Good Faith Estimate: _____/_____/_____	
Summary of Expected Charges (See the itemized estimate attached for more detail.)	
Provider Name	Estimated Total Cost
Provider Name	Estimated Total Cost
Provider Name	Estimated Total Cost
Total Estimated Cost: $	

The following is a detailed list of expected charges for [LIST PRIMARY SERVICE OR ITEM], scheduled for [LIST DATE[S] OF SERVICE, IF SCHEDULED] [[ADD IF ADDITIONAL ITEMS/SERVICES ARE BEING INCLUDED], as well as for items or services reasonably expected to be furnished in conjunction with the primary item or service as part of the period of care]. [Include if items or services are reoccurring, “The estimated costs are valid for 12 months from the date of the Good Faith Estimate.”]

[Provider/Facility 1] Estimate

Provider/Facility Name		Provider/Facility Type	
Street Address			
City		State	ZIP Code
Contact Person	Phone	Email	
National Provider Identifier		Taxpayer Identification Number	

Details of Services and Items for [Provider/Facility 1]

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service Code Type: Service Code Number]		
Total Expected Charges from [Provider/Facility 1]				**$**	
Additional Health Care Provider/Facility Notes					

[Provider/Facility 2] Estimate [Delete if not needed]

Provider/Facility Name		Provider/Facility Type	
Street Address			
City		State	ZIP Code
Contact Person	Phone	Email	
National Provider Identifier		Taxpayer Identification Number	

Details of Services and Items for [Provider/Facility 2]

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service Code Type: Service Code Number]		
Total Expected Charges from [Provider/Facility 2]				**$**	
Additional Health Care Provider/Facility Notes					

[Provider/Facility 3] Estimate [Delete if not needed]

Provider/Facility Name		Provider/Facility Type	
Street Address			
City		State	ZIP Code
Contact Person	Phone	Email	
National Provider Identifier		Taxpayer Identification Number	

Details of Services and Items for [Provider/Facility 3]

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service Code Type: Service Code Number]		
Total Expected Charges from [Provider/Facility 3]				**$**	
Additional Health Care Provider/Facility Notes					

Total estimated cost for all services and items: $

Disclaimer

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, and your bill is $400 or more for any provider or facility than your Good Faith Estimate for that provider or facility, federal law allows you to dispute the bill.

If you are billed for more than this Good Faith Estimate, you may have the right to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

If you dispute your bill, the provider or facility cannot move the bill for the disputed item or service into collection or threaten to do so, or if the bill has already moved into collection, the provider or facility has to cease collection efforts. The provider or facility must also suspend the accrual of any late fees on unpaid bill amounts until after the dispute resolution process has concluded. The provider or facility cannot take or threaten to take any retributive action against you for disputing your bill.

There is a $25 fee to use the dispute process. If the Selected Dispute Resolution (SDR) entity reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate, reduced by the $25 fee. If the SDR entity disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises/consumers or call 1-800-985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

PRIVACY ACT STATEMENT: CMS is authorized to collect the information on this form and any supporting documentation under section 2799B-7 of the Public Health Service Act, as added by section 112 of the No Surprises Act, title I of Division BB of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260). We need the information on the form to process your request to initiate a payment dispute, verify the eligibility of your dispute for the PPDR process, and to determine whether any conflict of interest exists with the independent dispute resolution entity selected to decide your dispute. The information may also be used to: (1) support a decision on your dispute; (2) support the ongoing operation and oversight of the PPDR program; (3) evaluate selected IDR entity's compliance with program rules. Providing the requested information is voluntary. But failing to provide it may delay or prevent processing of your dispute, or it could cause your dispute to be decided in favor of the provider or facility.

OMB Control Number: 0938-1401
Expiration Date: 03/31/2022

Model Disclosure Notice Regarding Patient Protections Against Surprise Billing

Instructions for Providers and Facilities
(For use beginning January 1, 2022)

Section 2799B-3 of the Public Health Service Act (PHS Act) requires health care providers and facilities to make publicly available, post on a public website of the provider or facility (if applicable), and provide a one-page notice that includes information in clear and understandable language on:

(1) the restrictions on providers and facilities regarding balance billing in certain circumstances,
(2) any applicable state law protections against balance billing, and
(3) information on contacting appropriate state and federal agencies in the case that an individual believes that a provider or facility has violated the restrictions against balance billing.

Health care providers and facilities may, but aren't required to, use this model notice to meet these disclosure requirements. To use this document properly, the provider or facility should review and complete it in a manner consistent with applicable state and federal law. HHS considers use of this model notice in accordance with these instructions to be good faith compliance with the disclosure requirements of section 2799B-3 of the PHS Act and 45 CFR 149.430, if all other applicable PHS Act requirements are met.

If a state develops model language for its disclosure notice that is consistent with section 2799B-3 of the PHS Act, HHS will consider a provider or facility that makes good faith use of the state-developed model language to be compliant with the federal requirement to include information about state law protections.

Public Disclosure Requirements
The disclosure notice must be publicly available, and (if applicable) posted on a provider's or facility's public website.

- **To satisfy the public disclosure requirement**, providers and facilities must prominently display a sign with the required disclosure information in a location of the provider or facility, such as, where individuals schedule care, check-in for appointments, or pay bills, unless the provider doesn't have a publicly accessible location.

- **To satisfy the separate requirement to post the disclosure on a public website**, the disclosure or a link to the disclosure must appear on a searchable homepage of the provider's or facility's public website.

Who should get this notice
In general, providers and facilities must give the disclosure notice to individuals who are participants, beneficiaries, or enrollees of a group health plan or group or individual health insurance coverage offered by a health insurance issuer, including covered individuals in a health benefits plan under the Federal Employees Health Benefits Program, and to whom they furnish items or services, and then only if such items or services are furnished at a health care facility, or in connection with a visit at a health care facility.

Provision of the notice
Providers and facilities must provide the notice in-person, by mail, or via email, as selected by the individual. The disclosure notice must be limited to one-page (double-sided) and must use a font size of 12-points or larger.

Providers and facilities must issue the disclosure notice no later than the date and time on which they request payment from the individual (including requests for copayment or coinsurance made at the time of a visit to the provider or facility). If the provider or facility doesn't request payment from the individual, the notice must be provided no later than the date on which the provider or facility submits a claim for payment to the plan or issuer.

Language access

Use of Plain Language
Health care providers, facilities, plans, and issuers are encouraged to use plain language in the disclosure notice and test the notice for clarity and usability when possible.

Plain language, accessibility, and language access resources:
- Plainlanguage.gov/guidelines
- Section508.gov
- LEP.gov

Compliance with Federal Civil Rights Laws
Entities that receive federal financial assistance must comply with federal civil rights laws that prohibit discrimination. These laws include section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, and section 504 of the Rehabilitation Act of 1973. Section 1557 and title VI require covered entities to take reasonable steps to ensure meaningful access to individuals with limited English proficiency, which may include offering language assistance services such as translation of written content into languages other than English.

Section 1557 and section 504 require covered entities to take appropriate steps to ensure effective communication with individuals with disabilities, including provision of appropriate auxiliary aids and services. Auxiliary aids and services may include interpreters, large print materials, accessible information and communication technology, open and closed captioning, and other aids or services for persons who are blind or have low vision, or who are deaf or hard of hearing. Information provided through information and communication technology also must be accessible to individuals with disabilities, unless certain exceptions apply. Providers and facilities are reminded that the disclosure notice must comply with applicable state or federal language-access standards.

NOTE: The information provided in these instructions is intended to be only a general summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance on which it is based. Refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

Do not include these instructions with the disclosure notice provided to patients.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-XXXX. The time required to complete this information collection is estimated to average 3.5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Instructions for Group Health Plans and Health Insurance Issuers
(For use for plan years beginning on or after January 1, 2022)

Federal law requires group health plans and health insurance issuers offering group or individual health insurance coverage to 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 Internal Revenue Code (the Code), section 716 of the Employee Retirement Income Security Act (ERISA), and section 2799A-1 of the Public Health Service Act (PHS Act) apply, information in plain language on:

(1) the restrictions on balance billing in certain circumstances,
(2) any applicable state law protections against balance billing,
(3) the requirements under Code section 9816, ERISA section 716, and PHS Act section 2799A-1, and
(4) information on contacting appropriate state and federal agencies in the case that an individual believes that a provider or facility has violated the restrictions against balance billing.[1]

Plans and issuers may, but aren't required to, use this model notice to meet these disclosure requirements. To use this document properly, the plan or issuer should review and complete it in a manner consistent with applicable state and federal law. The Departments of Health and Human Services, Labor, and the Treasury (the Departments) will consider use of this model notice in accordance with these 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.

If a state develops model language for its disclosure notice that is consistent with section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, the Departments will consider a plan or issuer that makes good faith use of the state-developed model language to be compliant with the federal requirement to include information about state law protections.

Language access

Use of Plain Language

Plans and issuers are encouraged to use plain language in the disclosure notice and test the notice for clarity and usability when possible.

Plain language, accessibility, and language access resources:

[1] Section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act.

- Plainlanguage.gov/guidelines
- Section508.gov
- LEP.gov

Compliance with Federal Civil Rights Laws

Entities that receive federal financial assistance must comply with federal civil rights laws that prohibit discrimination. These laws include section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, and section 504 of the Rehabilitation Act of 1973. Section 1557 and title VI require covered entities to take reasonable steps to ensure meaningful access to individuals with limited English proficiency, which may include offering language assistance services such as translation of written content into languages other than English.

Section 1557 and section 504 require covered entities to take appropriate steps to ensure effective communication with individuals with disabilities, including provision of appropriate auxiliary aids and services. Auxiliary aids and services may include interpreters, large print materials, accessible information and communication technology, open and closed captioning, and other aids or services for persons who are blind or have low vision, or who are deaf or hard of hearing. Information provided through information and communication technology also must be accessible to individuals with disabilities, unless certain exceptions apply. Plans and issuers are reminded that the disclosure notice must comply with applicable state or federal language-access standards.

NOTE: The information provided in these instructions is intended to be only a general summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance on which it is based. Refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

Do not include these instructions with the disclosure notice provided to participants, beneficiaries, or enrollees.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1401. The time required to complete this information collection is estimated to average 3.5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed model language as appropriate*]

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed model language regarding applicable state law requirements as appropriate*]

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact [*applicable contact information for entity responsible for enforcing the federal and/or state balance or surprise billing protection laws*].

Visit [*website*] for more information about your rights under federal law.
[*If applicable, insert:* Visit [*website*] for more information about your rights under [state laws].]

On September 30, 2021, the Department of Health and Human Services (HHS), the Department of Labor, and the Department of the Treasury (collectively, the Departments), along with the Office of Personnel Management (OPM), released an interim final rule with comment period, entitled "Requirements Related to Surprise Billing; Part II." This rule is related to Title I (the No Surprises Act) of Division BB of the Consolidated Appropriations Act, 2021, and establishes new protections from surprise billing and excessive cost sharing for consumers receiving health care items/services. It implements additional protections against surprise medical bills under the No Surprises Act, including provisions related to the independent dispute resolution process, good faith estimates for uninsured (or self-pay) individuals, the patient-provider dispute resolution process, and expanded rights to external review.

In conjunction with the release of this interim final rule, the Departments and OPM launched a website focused primarily on providing general information about No Surprises Act provisions. It will include a federal portal for organizations to apply to become certified independent dispute resolution entities and for providers and payers to participate in the federal independent dispute resolution process. The Departments and OPM intend to post additional information over the next several months, including information about how to initiate an independent dispute resolution process in the federal portal, and plan to highlight different provisions as they become more relevant to different stakeholders and audiences.

Background – Surprise Billing and the Need for Greater Protections

Most group health plans and health insurance issuers that offer group or individual health insurance coverage have a network of providers and health care facilities (in-network providers) that agree to accept a specific payment amount for their services. Providers and facilities that are not part of a plan or issuer network (out-of-network or "OON" providers) usually charge higher amounts than the contracted rates the plans or issuers pay to in-network providers.

When a person with health coverage gets care from an OON provider, their health plan or issuer usually does not cover the entire OON cost, leaving the person with higher costs than if they had been seen by an in-network provider. In many cases, the OON provider may bill the individual for the difference between the charge and the amount paid by their plan or insurance, unless prohibited by state law. This is known as "balance billing."

A "balance bill" may come as a surprise for many people. A surprise bill is an unexpected bill from a health care provider or facility. This can happen when a person with health insurance unknowingly gets medical care from a provider, facility, or provider of air ambulance services outside their health plan's network. Surprise billing happens in both emergency and non-emergency care settings.

In an emergency, an individual usually gets care at the nearest emergency department. Even if they go to an in-network hospital for emergency care, they might get care from OON providers at that facility. For non-emergency care, an individual might choose an in-network facility or an in-network provider, but not know that a provider involved in their care (for example, an anesthesiologist or radiologist) is an OON provider. In some of these instances, a person can receive a surprise bill from an OON provider that is higher than the amount they would otherwise pay or had planned for their in-network care. The No Surprises Act protects these individuals from large and unexpected surprise bills.

When individuals do not have an opportunity to select in-network providers or are given care by an OON provider involved in their in-network care, their health care costs go up overall. Surprise billing is often used as leverage by providers to get higher in-network payments, which result in higher premiums, higher cost sharing for consumers, and increased health care spending overall.[1] Studies

have shown that surprise bills can be expensive for the patient, their employer, and the health care system.

- A recent study found that payments made to providers/facilities by people who got a surprise bill for emergency care were more than ten times higher than those made by other individuals for the same care.[2]
- OON cost sharing and surprise bills usually do not count toward a person's deductible and maximum out-of-pocket limit. Individuals with surprise bills may have to spend more out-of-pocket because they have to pay their OON cost sharing and surprise billing amounts regardless of whether they've met their deductible and maximum out-of-pocket limits.
- Studies have shown that in the period from 2010-2016, more than 39% of emergency department visits to in-network hospitals resulted in surprise bills, increasing to 42.8% in 2016. During the same period, the average amount of a surprise medical bill also increased from $220 to $628.[3]
- Although some states have enacted laws to reduce or eliminate balance billing, these efforts do not provide comprehensive consumer protections.[4] Even in a state that has enacted protections, they typically do not apply to individuals enrolled in self-insured health coverage, as federal law generally preempts state laws that regulate self-insured group health plans sponsored by private employers. In addition, states have limited power to address surprise bills that involve an out-of-state provider and providers of air ambulance services.
- The No Surprises Act supplements state balance billing laws and All-Payer Model Agreements. In cases where a state has an All-Payer Model Agreement or where a state law applies, the state law or All-Payer Model Agreement generally determines an individual's cost-sharing amount and the OON payment rate.

In addition to protecting consumers, the balance billing provisions in the No Surprises Act have the potential to decrease health care spending, despite administrative burdens. When the rules become effective, they will provide patients immediate protection against balance bills, reducing their exposure to out-of-pocket medical expenses. The Congressional Budget Office has projected that the No Surprises Act will reduce private health plan premiums by 0.5%-1% on average, and reduce the federal deficit by $17 billion over 10 years.[5]

Prior Rulemaking

On July 13, 2021, the Departments and OPM issued "Requirements Related to Surprise Billing; Part I,"[6] a rule that will restrict excessive out-of-pocket costs to consumers resulting from surprise billing and balance billing. This rule goes into effect for health care providers and facilities, and providers of air ambulance services on January 1, 2022, and for plan, policy, or contract years starting on or after January 1, 2022, for group health plans, health insurance issuers, and Federal Employees Health Benefits (FEHB) program carriers. The rule:

- Bans balance billing for emergency services. Cost-sharing for emergency services must be determined on an in-network basis.
- Requires that patient cost-sharing, such as copayments, co-insurance, or a deductible, for emergency services and certain non-emergency services provided at an in-network facility cannot be higher than if such services were provided by an in-network provider, and any cost-sharing obligation must be based on in-network provider rates.
- Prohibits OON charges for items or services provided by an OON provider at an in-network facility, unless certain notice and consent is given. Providers and facilities must provide patients with a plain-language consumer notice explaining that patient consent is required to receive care on an OON basis before that provider can bill the patient more than in-network cost-sharing rates.

To protect patients from surprise bills and remove them from payment disputes between providers, facilities, or providers of air ambulance services and plans or issuers, the July 13, 2021 rule

established that, for emergency services and certain non-emergency services furnished by OON providers at certain in-network facilities, the patient pays a cost-sharing rate similar to that imposed in-network. The rate for this cost sharing is calculated based on a state All-Payer Model Agreement, specified state law, or, if neither of these apply, the qualifying payment amount (QPA). The QPA is generally the plan or issuer's median contracted rate for the same or similar service in the specific geographic area. The balance of the bill to be paid by the plan or issuer following patient cost sharing and any initial payment from the plan or issuer is determined between the provider, facility, provider of air ambulance services, and the plan or issuer through an open negotiation period and, if the parties cannot agree on a payment amount, the federal independent dispute resolution process described below.

Review the Requirements Related to Surprise Billing; Part I Interim Final Rule with Comment Period fact sheet for more information on this earlier rule.

On September 10, 2021, the Departments and OPM released a notice of proposed rulemaking (NPRM) to implement certain provisions of the No Surprises Act, entitled "Reporting Requirements Regarding Air Ambulance Services, Agent and Broker Disclosure Requirements and HHS Enforcement." If finalized, this proposed rule would establish:

- New reporting requirements regarding air ambulance services;
- New disclosures and reporting requirements regarding agent and broker compensation;
- New procedures for enforcement of Public Health Service Act (PHS Act) provisions against providers, health care facilities, and providers of air ambulance services;
- New disclosure and reporting requirements applicable to issuers of individual health insurance coverage and short-term, limited-duration insurance regarding agent and broker compensation; and
- Revisions to existing PHS Act enforcement procedures for plans and issuers.

Review the Air Ambulance NPRM – Fact Sheet for more information.

Summary of the September 30, 2021 Rule

The "Requirements Related to Surprise Billing; Part II" rule builds on the July 1, 2021 rule and the September 10, 2021 NPRM to continue implementing the No Surprises Act. The rule issued on September 30, 2021, outlines the federal independent dispute resolution process, good faith estimate requirements for uninsured (or self-pay) individuals, patient-provider dispute resolution processes for uninsured (or self-pay) individuals, and external review provisions of the No Surprises Act.

Independent Dispute Resolution

The September 30, 2021 rule establishes the federal independent dispute resolution process that OON providers, facilities, providers of air ambulance services, plans, and issuers in the group and individual markets may use to determine the OON rate for applicable items or services after an unsuccessful open negotiation. Not all items and services are eligible for the federal independent dispute resolution process. This process applies only to those services for which balance billing was prohibited under the "Requirements Related to Surprise Billing; Part I" rule.

Before initiating the federal independent dispute resolution process, disputing parties must initiate a 30-day "open negotiation" period to determine a payment rate. In the case of a failed open negotiation period, either party may initiate the federal independent dispute resolution process. The parties then may jointly select a certified independent dispute resolution entity to resolve the dispute. The certified independent dispute resolution entity and personnel of the entity assigned to the case must attest that

they have no conflicts of interest with either party. If the parties cannot jointly select a certified independent dispute resolution entity or if the selected certified independent dispute resolution entity has a conflict of interest, the Departments will select a certified independent dispute resolution entity. After a certified independent dispute resolution entity is selected, the parties will submit their offers for payment along with supporting documentation. The certified independent dispute resolution entity will then issue a binding determination selecting one of the parties' offers as the OON payment amount. Both parties must pay an administrative fee ($50 each for 2022), and the non-prevailing party is responsible for the certified independent dispute resolution entity fee for the use of this process. To learn more about the 2022 administrative fee and allowable independent dispute resolution entity fee ranges for 2022, see Calendar Year 2022 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act. Details on important open negotiation and independent dispute resolution deadlines can be found in the table below.

When making a payment determination, certified independent dispute resolution entities must begin with the presumption that the QPA is the appropriate OON amount. If a party submits additional information that is allowed under the statute, then the certified independent dispute resolution entity must consider this information if it is credible. For the independent dispute resolution entity to deviate from the offer closest to the QPA, any information submitted must clearly demonstrate that the value of the item or service is materially different from the QPA.

The rule also describes the independent dispute resolution entity certification process and the information independent dispute resolution entities must submit to be certified as federal independent dispute resolution entities. The rule provides a process by which members of the public, including providers, facilities, providers of air ambulance services, and plans or issuers, can petition for the denial or revocation of certification of an independent dispute resolution entity.

To ensure transparency in the independent dispute resolution process, the rule establishes monthly reporting requirements for certified independent dispute resolution entities to inform quarterly public reports on payment determinations.

The Departments will certify independent dispute resolution entities on a rolling basis. Entities that would like to be certified by January 1, 2022, should submit their application by November 1, 2021.

Learn more about the independent dispute resolution entity certification process or apply to be a certified independent dispute resolution entity at the federal portal.

To stay up to date with the federal independent dispute resolution process, sign up or access your subscriber preferences at the No Surprises Act Dispute Resolution" email list.

Important Open Negotiation and Independent Dispute Resolution Deadlines

Independent Dispute Resolution Action	Timeline
Initiate 30-business-day open negotiation period	30 business days, starting on the day of initial payment or notice of denial of payment
Initiate independent dispute resolution	4 business days, starting the

process following failed open negotiation	business day after the open negotiation period ends
Mutual agreement on certified independent dispute resolution entity selection	3 business days after the independent dispute resolution initiation date
Departments select certified independent dispute resolution entity in the case of no conflict-free selection by parties	6 business days after the independent dispute resolution initiation date
Submit payment offers and additional information to certified independent dispute resolution entity	10 business days after the date of certified independent dispute resolution entity selection
Payment determination made	30 business days after the date of certified independent dispute resolution entity selection
Payment submitted to the applicable party	30 business days after the payment determination

Good Faith Estimates for Uninsured (or Self-pay) Individuals – Requirements for Providers and Facilities

When scheduling an item or service, or if requested by an individual, providers and facilities are required to inquire about the individual's health insurance status or whether an individual is seeking to have a claim submitted to their health insurance coverage for the care they are seeking. The provider or facility must provide a good faith estimate of expected charges for items and services to an uninsured (or self-pay) individual, meaning an individual that:

- Does not have benefits for an item or service under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, federal health care program (as defined in section 1128B(f) of the Social Security Act), or a health benefits plan under chapter 89 of title 5, United States Code[7],[8]; or
- Has benefits for such items/services under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, or a health benefits plan under chapter 89 of title 5, United States Code, but does not seek to have a claim submitted to their plan, issuer, or carrier for the item or service.

The good faith estimate must include expected charges for the items or services that are reasonably expected to be provided together with the primary item or service, including items or services that may be provided by other providers and facilities. For example, for a surgery, the good faith estimate might

include the cost of the surgery, any labs or tests, and the anesthesia that might be used during the operation. If an item or service is something that isn't scheduled separately from the surgery itself, it will generally be included in the good faith estimate. Other items or services related to the surgery that might be scheduled separately, like pre-surgery appointments or physical therapy in the weeks after the surgery, won't be included in the good faith estimate.

HHS understands that it may take time for providers and facilities to develop systems and processes for providing and receiving the required information from others. Therefore, for good faith estimates provided to uninsured (or self-pay) individuals from January 1, 2022, through December 31, 2022, HHS will exercise its enforcement discretion in situations where a good faith estimate provided to an uninsured (or self-pay) individual does not include expected charges from other providers and facilities that are involved in the individual's care.

Patient-Provider Dispute Resolution

In a situation where an uninsured (or self-pay) individual receives a good faith estimate and then is billed for an amount substantially in excess of the good faith estimate, HHS establishes in the September 30, 2021 rule a patient-provider dispute resolution process to determine a payment amount. The September 30, 2021 rule provides eligibility details for this dispute resolution process, a definition of "substantially in excess," and further information on the selection process for select dispute resolution (SDR) entities that will resolve disputes through the patient-provider dispute resolution process.

A patient's bill will be determined eligible for the patient-provider dispute resolution process if the patient received a good faith estimate, if the process is initiated within 120 calendar days of the patient receiving the bill, and if the bill is substantially in excess of the good faith estimate. HHS has defined "substantially in excess" as the billed charges being at least $400 more than the good faith estimate for any provider or facility listed on the good faith estimate.

SDR entities will make payment determinations as part of the patient-provider dispute resolution process. The patient-provider dispute resolution process has timelines for documentation submission and payment determination, and participating individuals will be charged an administrative fee. To ensure the administrative fee does not act as a barrier for consumers accessing dispute resolution, the fee will be set at $25 in the first year and will be updated through sub-regulatory guidance in future years.

External Review

The September 30, 2021 rule amends final rules issued by the Departments in 2015 related to external review. The September 30, 2021 rule expands the scope of adverse benefit determinations eligible for external review to include determinations that involve whether a plan or issuer is complying with the surprise billing and cost-sharing protections under the No Surprises Act and its implementing regulations. In addition, under these interim final rules, grandfathered plans that are not otherwise subject to external review requirements will be subject to external review requirements for coverage decisions that involve whether a plan or issuer is complying with the surprise billing and cost-sharing protections under the No Surprises Act.

Applicability Date and Comment Period

The regulations in the rule are generally applicable to group health plans and health insurance issuers for plan and 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 applicable beginning on January 1, 2022. The OPM-only regulations that apply to carriers under the FEHB program are

applicable to contract years beginning on or after January 1, 2022. The rules regarding the certification of independent dispute resolution entities and SDR entities are effective from the date the rule is published in the Federal Register.

Written comments on the rule issued on September 30, 2021, must be received by 60 days after the rule is published in the Federal Register to be considered.

Visit the Federal Register to read more about the interim final rule with comment period.

This communication was printed, published, or produced and disseminated at U.S. taxpayer expense.

###

---

[1] Cooper, Z. et al., Surprise! Out-of-Network Billing for Emergency Care in the United States, NBER Working Paper 23623, 20173623; Duffy, E. et al., Policies to Address Surprise Billing Can Affect Health Insurance Premiums. The American Journal of Managed Care 26.9 (2020): 401-404; and Brown E.C.F., et al., The Unfinished Business of Air Ambulance Bills, Health Affairs Blog (March 26, 2021),

doi: 10.1377/hblog20210323.911379, available at https://www.healthaffairs.org/do/10.1377/hblog20210323.911379/full/.

[2] Biener, A. et al., Emergency Physicians Recover a Higher Share of Charges from Out-of-network Care than from In-network Care, Health Affairs 40.4 (2021): 622-628.

[3] Sun, E.C., et al. “Assessment of Out-of-Network Billing for Privately Insured Patients Receiving Care in In-network Hospitals.” *JAMA Internal Medicine*, 179.11 (2019): 1543-1550. Doi:10.1001/jamainternmed.2019.3451.

[4] States that have enacted balance billing protections include Arizona, Colorado, Delaware, Indiana, Iowa, Maine, Massachusetts, Minnesota, Mississippi, Missouri, New Mexico, North Carolina, Pennsylvania, Rhode Island, Texas, Vermont, and Washington.

[5] https://www.cbo.gov/system/files/2021-01/PL_116-260_div%20O-FF.pdf.

[6] https://www.govinfo.gov/content/pkg/FR-2021-07-13/pdf/2021-14379.pdf

[7] A health benefits plan offered under chapter 89 of title 5, United States Code is also known as a Federal Employees Health Benefits plan.

[8] The rules do not apply to people with coverage through programs such as Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE. Each of these programs already has other protections against high medical bills.