FAQS ABOUT CONSOLIDATED APPROPRIATIONS ACT, 2021 IMPLEMENTATION PART 62

October 6, 2023

Set out below are Frequently Asked Questions (FAQs) regarding implementation of certain provisions of Title I (the No Surprises Act)[1] of Division BB of the Consolidated Appropriations Act, 2021, in light of the August 24, 2023 decision in *Texas Medical Association et al. v. United States Department of Health and Human Services et al*., Case No. 6:22-cv-450-JDK (E.D. Tex.) (*TMA III*). These FAQs have been prepared jointly by the Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the Departments), along with the Office of Personnel Management (OPM). 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 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 out-of-network services subject to the No Surprises Act.[2]

In July 2021, the Departments and OPM issued interim final rules implementing several of these statutory provisions (July 2021 interim final rules).[3] The Departments have also previously issued guidance on various No Surprises Act implementation issues, including FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 55 (FAQs Part 55).[4]

The No Surprises Act and the July 2021 interim final rules generally prohibit balance billing and limit cost sharing for emergency services provided by nonparticipating providers and

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[1] Pub. L. 116-260, 134 Stat. 1182 (2020).

[2] No Surprises Act section 102(d)(1) added 5 U.S.C. 8902(p) to require that Federal Employees Health Benefits Program (FEHB) carriers provide these protections to their enrollees. OPM regulations are set forth at 5 CFR 890.114. For purposes of this document, the term "plans and issuers" includes FEHB carriers to the extent consistent with 5 CFR 890.114.

[3] 86 FR 36872 (July 13, 2021). The Departments published final rules on August 26, 2022, that finalized certain provisions of the July 2021 interim final rules. 87 FR 52618 (Aug. 26, 2022).

[4] FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 55 (Aug. 19, 2022), available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-55.pdf and https://www.cms.gov/files/document/faqs-part-55.pdf.

nonparticipating emergency facilities, non-emergency services provided by nonparticipating providers with respect to a visit to a participating health care facility,[5] and air ambulance services provided by nonparticipating providers of air ambulance services. However, if patients are provided notice and give consent to waive surprise billing protections, consistent with applicable requirements, nonparticipating providers and nonparticipating emergency facilities may balance bill for certain post-stabilization services, and for certain non-emergency services furnished with respect to a visit to a participating health care facility, in limited circumstances.[6]

Patient Cost Sharing

Under the No Surprises Act and the July 2021 interim final rules, cost-sharing requirements for out-of-network emergency services and applicable non-emergency items and services cannot be greater than the requirements that would apply if the services were provided by a participating provider or participating emergency facility and must be calculated based on the "recognized amount," which is:

> (1) an amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
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> (2) if there is no such applicable All-Payer Model Agreement, an amount determined by a specified State law; or
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> (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).[7]

Cost-sharing requirements for out-of-network air ambulance services must be the same requirements that would apply if the services were provided by a participating provider of air ambulance services and 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. Under the July 2021 interim final rules, the median contracted rate was determined with respect to all plans of the plan sponsor (or, if applicable, administering entity) or all coverage offered by the issuer

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[5] A health care facility, in the context of non-emergency services, is defined as (1) a hospital (as defined in section 1861(e) of the Social Security Act), (2) a hospital outpatient department, (3) a critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act), or (4) an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act. Code section 9816(b)(2)(A)(ii), ERISA section 716(b)(2)(A)(ii), and PHS Act section 2799A–1(b)(2)(A)(ii); 26 CFR 54.9816-3T, 29 CFR 2590.716-3, and 45 CFR 149.30.

[6] 26 CFR 54.9816-4T(c)(2)(ii)(B) and 54.9816-5T(b); 29 CFR 2590.716-4(c)(2)(ii)(B) and 2590.716-5(b); and 45 CFR 149.110(c)(2)(ii)(B) and 149.120(b); 86 FR 36872, 36906 (July 13, 2021) (providing that individuals are allowed to waive their balance billing protections "only after receiving a written notice that includes detailed information designed to ensure that individuals knowingly accept out-of-pocket charges (including charges associated with balance bills) for care received from a nonparticipating provider or nonparticipating emergency facility").

[7] The term "recognized amount" is defined at 26 CFR 54.9816-3T, 29 CFR 2590.716-3, and 45 CFR 149.30.

that are offered in the same insurance market. The Departments established the methodology for calculating the QPA in the July 2021 interim final rules, including the methodology to apply when a plan or issuer lacks sufficient information to calculate a median contracted rate.[8]

Initial Payment or Notice of Denial of Payment

The No Surprises Act and the July 2021 interim final rules establish several procedural requirements to help ensure that payment disputes under the No Surprises Act are resolved in a timely manner. The No Surprises Act and the July 2021 interim final rules require plans and issuers to determine whether services are covered under the plan or coverage and, if the services are covered, to send an initial payment or notice of denial of payment to a nonparticipating provider, facility, or provider of air ambulance services not later than 30 calendar days after the provider, facility, or provider of air ambulance services submits a bill related to items and services that are within the scope of the surprise billing protections.[9] Under the July 2021 interim final rules, the 30-calendar-day period began on the date the plan or issuer received the information necessary to decide a claim for payment for such services, commonly known as a "clean claim."[10]

As stated in the preamble to the July 2021 interim final rules, an initial payment under the No Surprises Act 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. In cases where the provider, facility, or provider of air ambulance services is willing to accept the cost-sharing amount plus the initial payment (or the patient cost-sharing amount alone, in cases where a denial of payment is sent) as payment in full, this amount will be treated as the out-of-network rate.[11]

For this purpose, 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 health care 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 the denial.[12] 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),[13] which may be disputed through a plan's or issuer's claims and appeals process.

[8] 26 CFR 54.9816-6T, 29 CFR 2590.716-6, and 45 CFR 149.140.
[9] Code sections 9816(a)(1)(C)(iv)(I) and 9817(a)(3)(A), ERISA sections 716(a)(1)(C)(iv)(I) and 717(a)(3)(A), and PHS Act sections 2799A-1(a)(1)(C)(iv)(I) and 2799A-2(a)(3)(A); 26 CFR 54.9816-4T(b)(3)(iv)(A), 54.9816-5T(c)(3), and 54.9817-1T(b)(4)(i), 29 CFR 2590.716-4(b)(3)(iv)(A), 2590.716-5(c)(3), and 2590.717-1(b)(4)(i), and 45 CFR 149.110(b)(3)(iv)(A), 149.120(c)(3), and 149.130(b)(4)(i).
[10] 86 FR 36872, 36900 (July 13, 2021).
[11] *Id.* at 36900-36901.
[12] 26 CFR 54.9816-3T, 29 CFR 2590.716-3, and 45 CFR 149.30.
[13] *Id*.

The District Court's Decision in *TMA III*

On August 24, 2023, the United States District Court for the Eastern District of Texas (district court) issued an opinion and order in *TMA III* vacating certain provisions of the July 2021 interim final rules as well as certain portions of several No Surprises Act guidance documents issued by the Departments. The district court in *TMA III* held that several provisions of the regulations and guidance are unlawful and vacated and remanded them for further consideration.

Of relevance to these FAQs, the district court vacated:

- A number of provisions related to the QPA methodology, including the inclusion of contracted rates for items and services "regardless of the number of claims paid at that contracted rate," the use of contracted rates of all self-insured group health plans administered by the same entity, rules governing calculation of the QPA for providers "in the same or similar specialty," the exclusion of bonus, incentive, and risk-sharing payments, and the exclusion of single case agreements.[14]

- The provision starting the 30-calendar-day timeframe for a plan or issuer to send an initial payment or notice of denial of payment for air ambulance services when the plan or issuer receives the information necessary to decide a claim for payment.[15]

- OPM regulations at 5 CFR 890.114(a), insofar as they require compliance with the vacated regulations and guidance.

The district court upheld other challenged provisions of the Departments' regulations that require disclosure of information about the QPA and that define geographic regions based on census divisions for purposes of calculating the QPA for air ambulance services. The district court's decision did not vacate any other provisions of the July 2021 interim final rules, including the patient protections against surprise billing.

Q1: How should plans and issuers calculate a QPA for purposes of patient cost sharing, disclosures with an initial payment or notice of denial of payment, and disclosures and submissions required under the Federal IDR process following the decision in *TMA III*?

The decision in *TMA III* requires certain changes to the methodology that is used to calculate a QPA. The Departments and OPM disagree with this decision and the Department of Justice intends to appeal. However, the district court's decision is currently in effect. Therefore, plans and issuers are required to calculate QPAs in a manner consistent with the statutes and regulations that remain in effect after the *TMA III* vacatur. The Departments and OPM generally do not intend to issue interim guidance (other than as outlined in these FAQs) addressing the QPA methodology in response to *TMA III*. Accordingly, plans and issuers are expected to calculate QPAs using a good faith, reasonable interpretation of the applicable statutes and regulations that remain in effect after the *TMA III* decision.

[14] *See Texas Med. Ass'n et al. v. U.S. Dep't of Health and Human Servs. et al.*, No. 6:22-cv-450-JDK, at *44-45 (E.D. Tex. Aug. 24, 2023).
[15] 26 CFR 54.9817-1T(b)(4)(i), 29 CFR 2590.717-1(b)(4)(i), and 45 CFR 149.130(b)(4)(i).

Plans and issuers have expressed concern to the Departments and OPM that the *TMA III* decision will require them to review millions of existing QPAs and calculate a very substantial number of new QPAs, which will require significant resources and take many months, if not longer. Plans and issuers have indicated that calculating the QPA in accordance with the *TMA III* decision may be more complicated and resource intensive than the initial calculation of the QPA under the July 2021 interim final rules.

The Departments and OPM are cognizant of the impact on QPAs and the significant challenges associated with recalculation. Moreover, for many recent and future dates of service, the Departments and OPM recognize that, as a matter of practical necessity, plans and issuers will need to take certain actions, such as calculating patient cost sharing for items and services subject to the No Surprises Act's surprise billing protections, well before a new QPA can be calculated. Therefore, the Departments and OPM will exercise their enforcement discretion under the relevant No Surprises Act provisions for any plan or issuer, or party to a payment dispute in the Federal IDR process, that uses a QPA calculated in accordance with the methodology under the July 2021 interim final rules and guidance in effect immediately before the decision in *TMA III*, for items and services furnished before May 1, 2024, the first day of the calendar month that is 6 months after the issuance of these FAQs. This exercise of enforcement discretion applies to QPAs for purposes of patient cost sharing, providing required disclosures with an initial payment or notice of denial of payment, and providing required disclosures and submissions under the Federal IDR process.

HHS will similarly exercise enforcement discretion under the relevant No Surprises Act provisions for a provider, facility, or provider of air ambulance services that bills, or holds liable, a participant, beneficiary, or enrollee for a cost-sharing amount based on a QPA calculated using a method described above.

HHS encourages States that are the primary enforcers of the relevant No Surprises Act provisions with respect to issuers, providers, facilities, or providers of air ambulance services to adopt a similar approach to enforcement. HHS will not consider a State to be failing to substantially enforce these provisions because the State adopts such an approach.

If necessary, the Departments and OPM will timely reevaluate whether it is necessary to provide additional time for the enforcement relief allowing QPAs to be calculated in accordance with the methodology under the July 2021 interim final rules and guidance in effect immediately before the decision in *TMA III* as plans and issuers take reasonable steps to come into compliance. The Departments and OPM do not currently expect any such additional time would extend beyond November 1, 2024, the first day of the calendar month that is 12 months after the issuance of these FAQs, but will reassess the status of QPA recalculations and provide additional guidance as appropriate.

Q2: What is the Departments' and OPM's general approach to implementation of the No Surprises Act with respect to the methodology for calculating a QPA following the decision in *TMA III*?

The Departments and OPM recognize that changes to No Surprises Act requirements resulting from *TMA III* and other No Surprises Act-related court decisions have added uncertainty, complexity, and unanticipated burdens for entities that must comply with the No Surprises Act, including those involved in the Federal IDR process.[16] The Departments' and OPM's approach to implementation of the No Surprises Act with respect to provisions of the QPA methodology that were affected by *TMA III* will be marked by an emphasis on assisting (rather than imposing penalties on) regulated entities that are working diligently and in good faith to recalculate QPAs and comply with the applicable statutes and regulations that remain in effect after the *TMA III* decision.

Q3: Must plans and issuers continue to make disclosures about the QPA to nonparticipating providers, facilities, and providers or air ambulance services with an initial payment or notice of denial of payment, and in a timely manner upon request of the provider or facility?

Yes. Plans and issuers must continue to comply with the requirements related to disclosure of information about the QPA.[17] These disclosure provisions were not vacated by *TMA III*. This includes the requirement to include a statement certifying that the QPA applies for purposes of the recognized amount (or, in the case of air ambulance services, for calculating the participant's, beneficiary's, or enrollee's cost sharing) and that each QPA was determined in compliance with 26 CFR 54.9816-6T, 29 CFR 2590.716-6, and 45 CFR 149.140, as applicable.

For purposes of the statement that each QPA was determined in compliance with applicable regulatory requirements, a plan or issuer may certify that a QPA was determined in compliance with applicable rules where the QPA was calculated using a good faith, reasonable interpretation of the applicable statutes and regulations that remain in effect after the *TMA III* decision, as described in Q1.

Further, the Departments and OPM will exercise enforcement discretion for disclosures regarding a QPA provided with an initial payment or notice of denial of payment, consistent with the exercise of enforcement discretion outlined in Q1. Specifically, for items and services furnished before May 1, 2024, the Departments and OPM will exercise enforcement discretion with respect to these disclosures where a plan or issuer certifies that a QPA was determined in compliance with applicable rules using the methodology under the July 2021 interim final rules and guidance in effect immediately before the decision in *TMA III*, provided that the plan or issuer, in a timely manner upon request of the provider, facility, or provider of air ambulance services, discloses that it is using a QPA calculated in such a manner.

[16] In the past, the Departments and OPM have attempted to mitigate the burden on affected parties by providing disputing parties additional time to come into compliance with changes to the Federal IDR process, such as extensions to submit disputes to the Federal IDR process that would have expired during periods in which the Federal IDR process functions were temporarily suspended, or the ability to resubmit incorrectly batched disputes.
[17] 26 CFR 54.9816-6T(d), 26 CFR 54.9816-6(d), 29 CFR 2590.716-6(d), and 45 CFR 149.140(d).

HHS encourages States that are the primary enforcers of the relevant No Surprises Act provisions with respect to issuers to adopt a similar approach to enforcement. HHS will not consider a State to be failing to substantially enforce these provisions because the State adopts such an approach.

Q4: In light of the district court's decision in *TMA III*, how can certified IDR entities proceed in considering a QPA submitted to a Federal IDR payment dispute?

Certified IDR entities can consider the QPA submitted in light of the *TMA III* decision among any other factors and additional information (other than prohibited information) in determining which party's offer best represents the value of the qualified IDR item or service as the out-of-network rate, consistent with 26 CFR 54.9816-8(c)(4)(ii)(A), 29 CFR 2590.716-8(c)(4)(ii)(A), and 45 CFR 149.510(c)(4)(ii)(A). Certified IDR entities may request, and disputing parties may provide, additional information relevant to the submitted QPA. Certified IDR entities can consider such information when determining the appropriate payment amount for an item or service, to the extent such information does not include the prohibited factors identified in 26 CFR 54.9816-8T(c)(4)(v), 29 CFR 2590.716-8(c)(4)(v), and 45 CFR 149.510(c)(4)(v).

Q5: In light of the district court's decision in *TMA III*, how should a plan or issuer proceed when the plan or issuer does not have the information necessary to decide a claim for payment within 30 calendar days after a bill for air ambulance services is transmitted by a nonparticipating provider of air ambulance services?

The July 2021 interim final rules continue to provide that, not later than 30 calendar days after a bill for air ambulance services is transmitted by a nonparticipating provider of air ambulance services, the plan or issuer must determine whether the services are covered, and if the services are covered, send the provider an initial payment or notice of denial of payment.[18] This requirement was not vacated by *TMA III*. The Departments and OPM therefore expect plans and issuers to make reasonable efforts to determine coverage and provide initial payments or notices of denial of payment where applicable under the plan or coverage within the 30-calendar-day timeframe.

Generally, the ERISA claims procedure regulation and the Affordable Care Act internal claims and appeals regulations require plans and issuers to communicate with claimants and their authorized representatives (which may include a provider of air ambulance services), so as to facilitate full and fair review of benefit claims and provide a reasonable claims procedure, as required under ERISA section 503.[19] The ERISA claims procedure regulation at 29 CFR 2560.503-1 generally provides that if a plan or issuer[20] did not receive sufficient information to

[18] 26 CFR 54.9817-1T(b)(4)(i), 29 CFR 2590.717-1(b)(4)(i), and 45 CFR 149.130(b)(4)(i).
[19] 26 CFR 54.9815-2719, 29 CFR 2590.715-2719, and 45 CFR 147.136.
[20] Under PHS Act section 2719, non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage are generally required to comply with the internal claims and appeals processes set forth in the ERISA claims procedure regulation, along with additional standards added by the Affordable Care Act. *See* 26 CFR 54.9815-2719(b), 29 CFR 2590.715-2719(b), and 45 CFR 147.136(b).

make a claim determination, it may notify the claimant[21] of the specific information necessary to complete the claim. The Departments remind plans and issuers of their obligations to comply with these and related internal claims and appeals requirements, which should allow providers to submit bills with sufficient information for the plan or issuer to decide a claim for payment within the 30-calendar-day timeframe, as required under the No Surprises Act.

Accordingly, before denying a claim that may be subject to the No Surprises Act because the provider did not submit sufficient information, plans and issuers should communicate with providers to obtain the information the plan or issuer needs to provide a full and fair review within the 30-calendar-day timeframe to determine whether the services are covered services (and therefore to determine whether the services are subject to the protections of the No Surprises Act), and if covered under the No Surprises Act, to send an initial payment or notice of denial of payment. If a plan or issuer cannot determine coverage in that timeframe, the plan or issuer should issue a notice of *benefit* denial due to an adverse benefit determination, as defined in 29 CFR 2560.503-1, and should communicate the basis for the denial in a manner that does not incorrectly suggest that the furnished service has been determined not to be a covered service.

The Departments and OPM note that similar provisions of the July 2021 interim final rules applicable to emergency services and certain non-emergency items and services – beginning the 30-calendar-day period for sending an initial payment or notice of denial of payment when the plan or issuer "receives the information necessary to decide a claim for payment" for the services – were not vacated by *TMA III* and remain in effect.

Q6: Does the No Surprises Act continue to prohibit balance billing for air ambulance services provided by a nonparticipating provider of air ambulance services?

Yes. The No Surprises Act prohibits nonparticipating providers of air ambulance services from balance billing a participant, beneficiary, or enrollee with benefits under a group health plan or group or individual health insurance coverage offered by a health insurance issuer for air ambulance services for which benefits are available under such plan or coverage. Specifically, a nonparticipating provider of air ambulance services is prohibited from billing or holding liable such individual for a payment amount for the service that is more than the cost-sharing amount as determined in accordance with Code section 9817(a)(1) and (2), ERISA section 717(a)(1) and (2), or PHS Act section 2799A–2(a)(1) and (2), as applicable.[22] The district court's decision in *TMA III* does not change this statutory requirement.

[21] The claimant can be a health care professional, or in this case a provider of air ambulance services, if it is an authorized representative. In the case of a claim involving urgent care, a health care professional, with knowledge of a claimant's medical condition, is permitted to act as an authorized representative of the claimant and therefore may be required to communicate with plans and issuers to facilitate the review of the benefit claim. *See* 29 CFR 2560.503-1(b)(4); *see also* 26 CFR 54.9815-2719(a)(2)(iii), 29 CFR 2590.715-2719(a)(2)(iii), and 45 CFR 147.136(a)(2)(iii). The term "health care professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services. *See* 29 CFR 2560.503-1(m)(7).

[22] PHS Act section 2799B-5; 45 CFR 149.440.

Q7: May nonparticipating providers of air ambulance services balance bill participants, beneficiaries, and enrollees if a claim for air ambulance services is denied for lack of sufficient information (in other words, because it is not a "clean claim")?

No, nonparticipating providers of air ambulance services may not balance bill a participant, beneficiary, or enrollee if a claim for air ambulance services is denied for lack of sufficient information unless and until the services are determined to not be covered services under the plan or coverage.

The Departments and OPM are concerned that, as a result of the district court's decision in *TMA III*, plans and issuers may deny claims for otherwise covered air ambulance services because they do not have the information necessary within the 30-calendar-day timeframe to determine whether services are covered, and that, in turn, nonparticipating providers of air ambulance services may mistakenly believe that they are permitted to bill their patients directly for services in excess of the applicable cost-sharing amount allowed to be charged under the No Surprises Act. As discussed in Q6, this would violate the No Surprises Act. The Departments and OPM expect plans, issuers, and providers of air ambulance services to take steps to ensure that no bills are sent to patients in violation of the statutory prohibition.

In light of the district court's decision in *TMA III*, HHS reminds providers of air ambulance services that the statute authorizes HHS to impose civil monetary penalties for violations of the No Surprises Act in States where HHS is directly enforcing the balance billing provisions with respect to providers of air ambulance services.[23] As stated in the preamble to the July 2021 interim final rules, providers of air ambulance services "should take steps necessary to ensure compliance by, among other actions, determining whether a given item or service is being furnished under circumstances that would trigger the surprise billing protections."[24] For example, nonparticipating providers of air ambulance services should refrain from billing an individual in excess of the applicable cost-sharing amount allowed to be charged under the No Surprises Act, unless and until the provider has determined that the services are not a covered benefit under the plan or coverage (and therefore not subject to the No Surprises Act's surprise billing protections). This includes refraining from billing the individual in excess of the applicable cost-sharing amount in instances where the nonparticipating provider of air ambulance services has received a notice of *benefit* denial due to an adverse benefit determination, as defined in 29 CFR 2560.503-1, from the plan or issuer due to insufficient information, but the services are in fact covered services. Nonparticipating providers of air ambulance services may need to resubmit or appeal a claim to the plan or issuer instead of billing the participant, beneficiary, or enrollee in excess of the applicable cost-sharing amount. Otherwise, the provider risks violating the No Surprises Act and the July 2021 interim final rules by billing individuals for services that are ultimately subject to the balance billing protections.[25]

[23] PHS Act section 2799B-4(b).

[24] 86 FR 36872, 36905 (July 13, 2021).

[25] The Consumer Financial Protection Bureau (CFPB) also issued guidance in the wake of the No Surprises Act's enactment reminding debt collectors, information furnishers, and credit bureaus that they must comply with applicable laws and regulations. Specifically, the CFPB reminded debt collectors that the Fair Debt Collection Practices Act's prohibition on misrepresentations includes misrepresenting that a consumer must pay a debt stemming from a charge that exceeds the amount permitted by the No Surprises Act, and reminded furnishers and

HHS encourages providers of air ambulance services to communicate timely with plans and issuers to ensure the balance billing and cost-sharing protections are applied appropriately and consistently with the statute, and to ensure that plans and issuers have sufficient information to make coverage determinations within the 30-calendar-day timeframe.

credit reporting agencies that the accuracy and dispute obligations imposed by the Fair Credit Reporting Act apply with respect to debts stemming from charges that exceed the amount permitted by the No Surprises Act. CFBP Bulletin 2022-01: Medical Debt Collection and Consumer Reporting Requirements in Connection with the No Surprises Act (Jan. 13, 2022), available at https://www.consumerfinance.gov/compliance/supervisory-guidance/cfpb-bulletin-2022-01-medical-debt-collection-consumer-reporting-requirements-in-connection-with-no-surprises-act/#:~:text=The%20Bureau%20of%20Consumer%20Financial,unconscionable%20practices%2C%20and%20to%20remind.