DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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OFFICE OF THE ADMINISTRATOR

DATE: August 31, 2021

TO: Sharon Block
Acting Administrator
Office of Information and Regulatory Affairs
Office of Management and Budget

FROM: Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services

SUBJECT: Request for Emergency Clearance of the Paperwork Reduction Act Package for Requirements Related to Surprise Billing: Qualifying Payment Amount, Notice and Consent, Disclosure on Patient Protections Against Balance Billing, and State Law Opt-in

Emergency Justification

The Centers for Medicare & Medicaid Services (CMS) is requesting that an information collection request for some provisions in the Consolidated Appropriations Act of 2021 (Appropriations Act) enacted on December 27, 2020, related to the No Surprises Act be processed in accordance with the implementing regulations of the Paperwork Reduction Act of 1995 (PRA) at 5 CFR 1320.13(a)(2)(i). We believe that public harm will result if the standard, non-emergency clearance procedures are followed. CMS is also requesting waiver of the notice requirement set forth in 5 CFR 1320.13(d).

Specifically, we are requesting emergency approval for the following information collection requirements (ICRs): (i) information to be shared about the qualifying payment amount (45 CFR 149.140(d)); (ii) audits of the qualifying payment amount (45 CFR 149.140(f)); (iii) disclosure for self-insured plans opting in to state law (45 CFR 149.30); (iv) notice and consent to waive balance billing protections, retention of certain documents, and notice to plan or issuer (45 CFR 149.410(b)-(e), 45 CFR 149.420(c) - (i)); (v) provider disclosure on patient protections against balance billing (45 CFR 149.430); and (vi) plan and issuer disclosure on patient protections against balance billing (section 2799A-5(c) of the Public Health Service Act).

The cost-sharing and balance billing requirements on plans, issuers, health care providers, facilities, and providers of air ambulance services in the No Surprises Act apply for plan years (in the individual market, policy years) beginning on or after January 1, 2022. These ICRs contain critical protections for participants, beneficiaries, and enrollees against balance billing. It

is in the public interest that individuals receive the protections under the No Surprises Act on the date on which those protections go into effect. Following the standard PRA process will not provide plans, health insurance issuers, facilities, health care providers, and providers of air ambulance services sufficient time to implement these new requirements.

Background

The No Surprises Act provides federal protections against surprise billing and limits out-of-network cost sharing under many of the circumstances in which surprise medical bills arise most frequently. The 2021 interim final regulations "Requirements Related to Surprise Billing; Part I" (86 FR 36872, 2021 interim final regulations) issued by the Departments of Health and Human Services, the Department of Labor, the Department of Treasury, and the Office of Personnel Management, implement provisions of the No Surprises Act that apply to group health plans, health insurance issuers offering group or individual health insurance coverage, and carriers in the Federal Employees Health Benefits Program that provide protections against balance billing and out-of-network cost sharing with respect to emergency services, non-emergency services furnished by nonparticipating providers at certain participating health care facilities, and air ambulance services furnished by nonparticipating providers of air ambulance services. The 2021 interim final regulations prohibit nonparticipating providers, emergency facilities, and providers of air ambulance services from balance billing participants, beneficiaries, and enrollees in certain situations unless they satisfy certain notice and consent requirements. The No Surprises Act and the 2021 interim final regulations require group health plans and issuers of health insurance coverage to provide information about qualifying payment amounts to nonparticipating providers and facilities and to provide disclosures on patient protections against balance billing to participants, beneficiaries and enrollees. Self-insured plans opting in to state law are required to provide a disclosure to participants. Certain nonparticipating providers and nonparticipating emergency facilities may provide participants, beneficiaries, and enrollees with notice and obtain their consent to waive balance billing protections, provided certain requirements are met. In addition, certain providers and facilities are required to provide disclosures on patient protections against balance billing to participants, beneficiaries and enrollees.