

APPENDIX

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APPENDIX A

**United States Court of Appeals
for the Fifth Circuit**

No. 24-10561

Guardian Flight, L.L.C.; Med-Trans Corporation,
Plaintiffs — Appellants,
VERSUS

Health Care Service Corporation,
Defendant — Appellee.

United States Court of Appeals
Fifth Circuit
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Appeal from the United States District Court
for the Northern District of Texas

USDC No. 3:23-CV-1861

Before SMITH, CLEMENT, and DUNCAN, *Circuit Judges*.

STUART KYLE DUNCAN, *Circuit Judge*:

Appellants Guardian Flight, LLC, and Med-Trans Corporation, two air ambulance providers (“Providers”), appeal the dismissal of their complaint against Appellee Health Care Service Corporation (“HCSC”) for HCSC’s alleged failure to timely pay dispute resolution awards under the No Surprises Act (“NSA”). Because we agree with the district court that the NSA does not contain a private right of action, and because Providers have failed to allege facts sufficient to state a derivative claim under the Employee Retirement Income Security Act (“ERISA”) or for quantum meruit under Texas law, we affirm.

I

A

Congress enacted the NSA in 2022 to protect patients from surprise medical bills incurred when they receive emergency medical services from out-of-network healthcare providers. *See* 42 U.S.C. §§ 300gg-111, 300gg-112. The NSA achieves this by, *inter alia*, relieving patients from financial liability for surprise bills and creating an Independent Dispute Resolution (“IDR”) process for billing disputes between providers and insurers. *Id.* § 300gg-111(c)(1)–(5); *see generally Tex. Med. Ass’n v. United States Dep’t of Health &*

Hum. Servs., 110 F.4th 762, 767–78 (5th Cir. 2024) (discussing the NSA).¹

Under the IDR provisions, the provider and insurer first try to agree on a price for the services. *Id.* § 300gg-111(c)(1)(A). If the negotiation fails, the provider or payor has four days to initiate IDR proceedings. *Id.* § 300gg-111(c)(1)(B). If the parties pursue IDR, either the parties or the Department of Health and Human Services (“HHS”) selects a certified independent dispute resolution entity (“CIDRE”) to referee. *Id.* § 300gg-111(c)(4).

The CIDRE determines the amount the payor owes the provider. *Id.* § 300gg-111(c)(5). The CIDRE sets that amount via “baseball-style” dispute resolution where the provider and insurer each submit an offer, and the CIDRE selects one party’s offer as the award. *Id.* §§ 300gg-112(b)(5). In selecting which offer to award, the CIDRE must consider the insurer’s “qualifying payment amount,” a heavily regulated rate that reflects the “median of the contracted rates recognized by the plan or issuer . . . for the same or a similar item or service” offered in the same insurance market and geographic area. *Id.* § 300gg-111(a)(3)(E)(i).

In the absence of a fraudulent claim or evidence of a misrepresentation of facts to the CIDRE, the IDR award “shall be binding upon the parties involved,” and payment of the award “shall be made . . . not later than 30 days after the date on which such determination is made.” *Id.* § 300gg- 112(b)(5)(D) (incorporating 42 U.S.C. § 300gg-111(c)(5)(E)); *id.* §

¹ The regulations invalidated by *Texas Medical Association* have no effect on this case.

300gg-112(b)(6). Patients are not involved in open negotiations or the IDR process, and payors are directed to issue any IDR award payments directly to the provider. *See id.* § 300gg-112(b)(1)(A), (b)(5)(B), (b)(6).

The NSA also provides that an IDR award “shall not be subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a)” of the Federal Arbitration Act (“FAA”). *Id.* §§ 300gg-112(b)(5)(D), 300gg-111(c)(5)(E). HHS has the authority to enforce provider and payor non-compliance with the NSA’s provisions. *Id.* § 300gg-22(b)(2)(A) (providing for HHS enforcement against some payors for NSA non-compliance); *id.* § 300gg-134(b) (providing for HHS enforcement against providers for NSA non-compliance).

B

In this case, Providers initiated IDR under the NSA to resolve their billing disputes with HCSC. After IDR concluded, Providers sued HCSC alleging it (1) failed to timely pay Providers thirty-three IDR awards in violation of the NSA; (2) improperly denied benefits to HCSC’s beneficiaries in violation of ERISA by failing to pay Providers; and (3) was unjustly enriched because Providers conferred a benefit on HCSC that HCSC has never paid.

The district court granted HCSC’s motion to dismiss the complaint under Rule 12(b)(1) and 12(b)(6). It dismissed the NSA claim after concluding that the NSA contains no private right of action. The court dismissed the ERISA claim for lack of standing because Providers, as assignees of HCSC’s individual plan beneficiaries, did not show the beneficiaries

suffered injury given that the NSA shields them from liability and removes them from the IDR process. Finally, the court dismissed Providers’ quantum meruit claim because they did not perform their air ambulance services for HCSC’s benefit. The district court also ruled that granting Providers leave to amend would be futile. Providers timely appealed.

II

We review *de novo* a district court’s “dismissal for lack of subject matter jurisdiction pursuant to Rule 12(b)(1) or for failure to state a claim pursuant to Rule 12(b)(6).” *Ctr. for Biological Diversity, Inc. v. BP Am. Prod. Co.*, 704 F.3d 413, 421 (5th Cir. 2013). “Legal questions relating to standing and mootness are also reviewed *de novo*,” *ibid.*, as are questions of statutory interpretation. *Seago v. O’Malley*, 91 F.4th 386, 389 (5th Cir. 2024).

III

Providers argue that the district court erred in dismissing their NSA, ERISA, and quantum meruit claims. We address each claim in turn.

A

The district court correctly dismissed Providers’ claim against HCSC for its failure to timely pay dispute resolution awards obtained under the NSA because the NSA provides no private right of action.

First, as the district court correctly observed, the NSA contains no express right of action to enforce or confirm an IDR award. The only right of action provided derives from the incorporated vacatur sections of Section 10(a) of the FAA—none of which applies to this dispute, as Providers concede. So, we

begin with the presumption that Congress did not intend to create any private cause of action. *Sigmon v. Sw. Airlines Co.*, 110 F.3d 1200, 1205 (5th Cir. 1997).

To overcome this presumption, Providers must show “that Congress affirmatively contemplated private enforcement when it passed the relevant statute.” *Ibid.* (cleaned up); *see also Casas v. Am. Airlines, Inc.*, 304 F.3d 517, 521–22 (5th Cir. 2002) (noting plaintiffs’ “heavy burden” to “overcome the familiar presumption that Congress did not intend to create a private right of action”); *see also* Anthony J. Bellia, Jr., *Justice Scalia, Implied Rights of Action, and Historical Practice*, 92 NOTRE DAME L. REV. 2077, 2090 (2017) (“[H]istorically federal courts did not supply private rights of action for federal statutory violations independently of congressional authority.”).

Providers do not carry their heavy burden of showing Congress contemplated a private right of action in the NSA. Indeed, the NSA’s text and structure point in the opposite direction. The NSA expressly *bars* judicial review of IDR awards *except* as to the specific provisions borrowed from the FAA (sections which, again, Providers concede are inapplicable). *See* 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II) (IDR awards “*shall not be subject to judicial review, except in a case described*” in 9 U.S.C. § 10(a) (emphasis added)); *id.* § 300gg-112(b)(5)(D) (incorporating the same).² The district court correctly

² Those provisions authorize a court to vacate an arbitral award:
 (1) where the award was procured by corruption, fraud, or undue means;

(2) where there was evident partiality or corruption in the arbitrators, or either of them;

reasoned that this bar on judicial review strongly suggests Congress did not insert a private right of action into the statute.

Providers counter that they seek only judicial *enforcement* of an IDR award, not judicial *review* of one. That is a distinction without a difference. The term “judicial review” is broad enough to include a court’s order to enforce an IDR award. “Review” includes “[p]lenary power *to direct and instruct an agent or subordinate*, including the right to remand, modify, or vacate any action by the agent or subordinate, or to act directly in place of the agent or subordinate.” *Review*, BLACK’S LAW DICTIONARY (12th ed. 2024) (emphasis added).³

(3) where the arbitrators were guilty of misconduct in refusing to postpone the hearing, upon sufficient cause shown, or in refusing to hear evidence pertinent and material to the controversy; or of any other misbehavior by which the rights of any party have been prejudiced; or

(4) where the arbitrators exceeded their powers, or so imperfectly executed them that a mutual, final, and definite award upon the subject matter submitted was not made.

9 U.S.C. § 10(a)(1)–(4).

³ It follows that judicial review also encompasses the power to *vacate* IDR determinations. See *Hall St. Assocs., L.L.C. v. Mattel, Inc.*, 552 U.S. 576, 578 (2008) (“The Federal Arbitration Act . . . provides for expedited judicial review to confirm, vacate, or modify arbitration awards.”). That disposes of the slightly different argument made in the other NSA case we decide today. See *Guardian Flight, L.L.C. v. Med. Evaluators of Tex. ASO, L.L.C.*, No. 24-20051, — F.4th — (5th Cir. _____, 2025). As we explain in that case, the provider there asserts that the NSA’s bar on judicial review does not touch a court’s power to declare an IDR determination *void*. We reject that argument for the same

Furthermore, courts interpreting other statutes, including the FAA, have held that “judicial review” includes actions that seek to confirm or enforce a dispute resolution award. *See, e.g., Concrete Pipe & Prods. of Cal., Inc. v. Constr. Laborers Pension Trust*, 508 U.S. 602, 611 (1993) (explaining ERISA “provides for judicial *review* of the arbitrator’s decision by an action in the district court to *enforce*, vacate, or modify the award” (emphases added)).⁴ And Congress uses the term “judicial review” when referring to private causes of action. *See, e.g.,* 33 U.S.C. § 2236(b)(2) (creating private right of “action to seek judicial review”); 42 U.S.C. § 10139(c) (referring to a “civil action for judicial review”).

In sum, Providers’ enforcement action depends on the availability of a private right of action not present in the NSA. As a result, the NSA’s plain text bars this suit. We will not find an implied right of action where Congress expressly forecloses it. *See Sigmon*, 110 F.3d at 1206 (holding a statute’s “express bar” on lawsuits “compel[led] the conclusion that Congress did not intend to provide a private remedy”).

Congress could have done otherwise. Section 9 of the FAA empowers courts to confirm or enforce arbitration awards, *see* 9 U.S.C. § 9, but Congress chose not to incorporate § 9 into the NSA. It

reason we reject the Providers’ argument here: it artificially narrows the term “judicial review” that Congress used in the NSA.

⁴ *See also Hall St. Assocs.*, 552 U.S. at 578 (interpreting “judicial review” in the FAA to include “confirm[ing]” an arbitral award); *Mid Atl. Cap. Corp. v. Bien*, 956 F.3d 1182, 1194 (10th Cir. 2020) (same); *Med. Shoppe Int’l, Inc. v. Turner Invs., Inc.*, 614 F.3d 485, 488 (8th Cir. 2010) (same).

incorporated only parts of § 10. *See* 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II). By contrast, in other statutes, Congress *has* incorporated § 9 to create a private right of action. *See* 5 U.S.C. § 580(c) (“A final award is binding on the parties to the arbitration proceeding, and may be enforced pursuant to *sections 9 through 13* of” the FAA (emphasis added)).⁵ So, Congress knew how to create a private right of action in the NSA—and has done so elsewhere—but declined to do so. *Howard Univ. Hosp. v. D.C. Dep’t of Emp. Servs.*, 952 A.2d 168, 174 (D.C. 2008) (“Where a statute, with reference to one subject, contains a given provision, the omission of such [a] provision from a similar statute concerning a related subject . . . is significant to show [that] a different intention existed.” (alterations in original) (quoting *Smith v. D.C. Dep’t of Emp. Servs.*, 548 A.2d 95, 100 n.13 (D.C. 1988))); *Turtle Island Restoration Network v. Evans*, 284 F.3d 1282, 1296 (Fed. Cir. 2002) (“When Congress omits from a statute a provision found in similar statutes, the

⁵ In a 28(j) letter, Providers point out that a federal district court recently found an implied private right of action in the NSA, reasoning it would be absurd to interpret the statute otherwise. *See Guardian Flight LLC v. Aetna Life Ins. Co.*, No. 3:24-cv-680-MPS, 2025 WL 1399145, at *8–9 (D. Conn. May 14, 2025). The court also tried to explain Congress’s decision to omit the FAA’s express private right of action from the NSA: Unlike “binding” IDR awards, FAA arbitration awards are not self-enforcing, so an express private right of action is necessary to confirm them. *Id.* at *8. We are unconvinced. We follow the NSA’s plain text and structure in concluding Congress created no general private right of action in the NSA. *See* 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II). We are likewise unpersuaded by the district court’s ERISA analysis; like Providers, the court relied on precedent that predates the NSA’s enactment. *See infra* Section III.B; *N. Cypress Med. Ctr. Operating Co. v. Cigna Healthcare*, 781 F.3d 182 (5th Cir. 2015).

omission is typically thought deliberate.” (citing *I.N.S. v. Phinpathya*, 464 U.S. 183, 190 (1984))); 2B NORMAN SINGER & SHAMBIE SINGER, SUTHERLAND STATUTORY CONSTRUCTION § 51:2 (7th ed. 2024) (“[C]ourts presume a different intent when a legislature omits words used in a prior statute on a similar subject.”).

Instead, Congress took a different tack: it empowered HHS to assess penalties against insurers for failure to comply with the NSA. *See* 42 U.S.C. § 300gg-22(b)(2)(A); 45 C.F.R. § 150.301 *et seq.* The Centers for Medicare and Medicaid Services (CMS), an agency within HHS, has acted on that authority by soliciting provider complaints and compelling payors to pay IDR awards where appropriate.⁶ CMS maintains an online portal through which providers may submit complaints regarding the IDR process. *See No Surprises Complaint Form*, CMS, <https://perma.cc/HHD2-8HW7>.

The inference from the NSA’s broader structure, then, is plain. The “express provision of one method of enforcing a substantive rule suggests that Congress intended to preclude others.” *Alexander v. Sandoval*, 532 U.S. 275, 290 (2001); *Sigmon*, 110 F.3d at 1206 (holding the “existence of [an] administrative scheme of enforcement is strong evidence that Congress intended the administrative remedy to be exclusive” (quotations omitted)). The NSA’s structure conveys Congress’s policy choice to enforce the statute through administrative penalties, not a private right of action.

⁶ *See* U.S. GOV’T ACCOUNTABILITY OFF., GAO-24-106335, PRIVATE HEALTH INSURANCE: ROLL OUT OF INDEPENDENT DISPUTE RESOLUTION PROCESS FOR OUT-OF-NETWORK CLAIMS HAS BEEN CHALLENGING 35 (2023).

Providers insist that without a private right of action, “not only would the purpose of the NSA be frustrated, the very structure of the NSA would fall apart.” But our interpretation is compelled by the NSA’s text and structure, both of which exclude a general private right of action. Nor does that interpretation obviously “frustrate” the NSA’s purpose. Congress may have had good reasons to provide only a general administrative remedy, together with a strictly limited form of judicial review.

For example, in the first calendar year the NSA was operational, providers filed more than *thirty times* the number of IDR disputes HHS anticipated. *See* Brief for America’s Health Insurance Plans as Amicus Curiae Supporting Appellee at 5–7, *Guardian Flight, L.L.C. v. Health Care Serv. Corp.*, No. 24-10561 (5th Cir. argued Feb. 24, 2025). By 2023, providers had initiated nearly 680,000 disputes. *Ibid.* Congress may have judged it better to have an administrative enforcement mechanism handle most award disputes instead of throwing open the floodgates of litigation. Understandably, Providers would prefer a different mechanism for resolving provider-insurer disputes. But the wisdom of Congress’s policy choice is beyond our judicial ken.⁷

⁷ Amici American Hospital Association, *et al.*, suggest that declining to find an implied private right of action in the NSA “raises the question whether it is constitutional to wholly abrogate a core common-law right without providing a reasonable alternative remedy.” But amici fail to present any authority that directly addresses this concern beyond mere suggestion, and, in any case, neither amici nor HCSC has explained why the NSA’s administrative remedy is so inadequate as to violate the Constitution.

In sum, Providers have not shown that, despite the NSA’s express bar on judicial review in cases like this, Congress “affirmatively contemplated” a private right of action to enforce IDR awards.

B

We turn next to Providers’ ERISA claim, which the district court dismissed for lack of standing.

To demonstrate standing for a derivative ERISA claim as healthcare providers, Providers must first obtain an assignment of benefits from individual plan beneficiaries. *See N. Cypress Med. Ctr. Operating Co.*, 781 F.3d at 191–92. Providers satisfy this requirement, as several HCSC beneficiaries assigned their rights to Appellants.

Providers must also show, however, that the individual plan beneficiaries for whom they are assignees suffered a concrete injury, had those beneficiaries brought the claim themselves. *See Quality Infusion Care, Inc. v. Health Care Serv. Corp.*, 628 F.3d 725, 729 (5th Cir. 2010) (“[A]n assignee . . . stands in the same position as its assignor stood.” (ellipses in original) (quoting *Houk v. Comm’r of Internal Revenue*, 173 F.2d 821, 825 (5th Cir. 1949))); *see also Thole v. U.S. Bank N.A.*, 590 U.S. 538, 547 (2020) (“There is no ERISA exception to Article III.”).

Providers claim the beneficiaries suffered concrete injuries when HCSC refused to provide them with out-of-network coverage benefits under the parties’ contracts. We disagree. The NSA shields the beneficiaries from liability for any out-of-network coverage costs, so the beneficiaries have not suffered—and could not suffer—any concrete injury from HCSC’s failure to cover medical bills that fall within

the scope of the NSA.⁸ Further, the beneficiaries had nothing to gain or lose in the IDR proceedings between Appellants and HCSC. That process exists entirely outside and independent of ERISA.

Providers argue the injury to beneficiaries is nonetheless cognizable because the beneficiaries have suffered a breach of contract and so have been denied a benefit of their bargain with HCSC. We disagree. This technical violation, if it amounts to one, does no actual harm to the beneficiaries and is consequently an abstract theory insufficient for Article III injury. *See TransUnion LLC v. Ramirez*, 594 U.S. 413, 427 (2021) (“Article III grants federal courts the power to redress harms that defendants cause plaintiffs, not a freewheeling power to hold defendants accountable for legal infractions.” (quoting *Casillas v. Madison Ave. Assocs.*, 926 F.3d 329, 332 (7th Cir. 2019)); *Thole*, 590 U.S. at 541 (“If [plaintiffs] were to *win* this lawsuit, they would still receive the exact same monthly benefits that they are already slated to receive, not a penny more. The plaintiffs therefore have no concrete stake in this lawsuit.”)).

In short, because the beneficiaries would lack Article III standing if they brought an ERISA claim on their own, Providers lack standing to bring a derivative ERISA claim as their assignees. *See Thole*, 590 U.S. at 547.⁹

⁸ See 42 U.S.C. § 300gg-135 (non-participating air ambulance providers “shall not bill, and shall not hold liable, [the] participant, beneficiary, or enrollee for a payment amount for such service furnished by such provider” beyond the patient’s cost-sharing for the service).

⁹ Providers contend that every circuit to consider this ERISA

C

Finally, the district court correctly dismissed Providers' quantum-meruit claim because they failed to allege that they provided a direct benefit to HCSC. Providers admit that Texas courts have held in other contexts that because healthcare services are undertaken for the patient's benefit, not the insurer's, the patient is the proper target of a healthcare provider's quantum-meruit claim. *See Tex. Med. Res., LLP v. Molina Healthcare of Texas, Inc.*, 659 S.W.3d 424, 437 (Tex. 2023). Providers merely argue that this is "a debatable proposition," and that the district court was "too hasty" in dismissing their quantum-meruit claim because it leaves them without a judicial remedy.

The district court was right. Providers did not render any services for HCSC's benefit. Instead they provided "air ambulance transports for [HCSC's] beneficiaries." Those beneficiaries are not plaintiffs in this case, so Providers plainly fail to allege facts that could satisfy the elements of a quantum-meruit claim under Texas law. *See Tex. Med. Res., LLP*, 659 S.W.3d at 436 ("[I]t is not enough to show that [the plaintiff's] efforts benefited [the defendant]. Rather, the plaintiff's efforts must have been undertaken *for* the person sought to be charged." (cleaned up) (emphasis and second and third alterations in original) (quoting

issue, including this court, has determined that the beneficiary suffered a concrete injury. Not so. Each of Providers' cited cases predates the NSA and is therefore inapposite. *See, e.g., Springer v. Cleveland Clinic Emp. Health Plan Total Care*, 900 F.3d 284 (6th Cir. 2018).

Bashara v. Baptist Mem'l Hosp. Sys., 685 S.W.2d 307, 310 (Tex. 1985))).¹⁰

IV

The district court's judgment is AFFIRMED.

¹⁰ The district court did not abuse its discretion in denying Providers' request for leave to amend. Providers have no cause of action under the NSA and do not explain which facts they could allege in an amended complaint to satisfy the elements of their ERISA or quantum-meruit claims. See *Porretto v. City of Galveston Park Bd. of Trs.*, 113 F.4th 469, 491 (5th Cir. 2024) ("[A] 'bare bones' request to amend pleadings 'remains futile when it 'fail[s] to apprise the district court of the facts that [the plaintiff] would plead in an amended complaint.'"" (quoting *Edionwe v. Bailey*, 860 F.3d 287, 295 (5th Cir. 2017))).

APPENDIX B

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

GUARDIAN FLIGHT LLC and
MED-TRANS CORPORATION,

Plaintiffs,
v.

HEALTH CARE SERVICE
CORPORATION,

Defendant.

CIVIL ACTION NO.
3:23-CV-1861-B

MEMORANDUM OPINION AND ORDER

Before the Court is Defendant Health Care Service Corporation (“HCSC”)’s Motion to Dismiss (Doc. 11). For the following reasons, the Court **GRANTS** HCSC’s Motion and **DISMISSES** Plaintiffs Guardian Flight LLC and Med-Trans Corporation (collectively, “Plaintiffs”)’s claims. A final judgment will follow.

I.

BACKGROUND¹

This case is about air ambulances. Air ambulances serve the important role of transporting people experiencing severe health crises to hospitals that provide emergency care. Doc. 1, Compl., ¶ 7. Until recently, most air ambulance providers were out-of-network health care providers, meaning that they had no affiliation with any health insurance company, and had not negotiated the prices for their services with health insurance companies. *See* H.R. REP. No. 116-615(I), at 52 (2020). This meant that air ambulance providers could charge one price for their services, while health insurance companies would only cover a different (i.e., lower) price. *Id.* at 51–52. This, in turn, led to “balance billing,” meaning that patients were responsible for the difference between the provider’s price and the amount covered by the health insurers. *See id.* at 48. For example, if an out-of-network provider charged \$30,000, but a patient’s health plan covered only \$5,000, the patient typically owed the out-of-network provider \$25,000.

These circumstances led to enactment of the No Surprises Act (“NSA”) in 2022. *See id.* at 47–49. The

¹ The Court derives the factual background from Plaintiffs’ Complaint and the Congressional Record of the No Surprises Act. “[A] court ruling on a 12(b)(6) motion may rely on the complaint, its proper attachments, documents incorporated into the complaint by reference, and matters of which a court may take judicial notice.” *Innova Hosp. San Antonio, Ltd. P’ship v. Blue Cross & Blue Shield of Georgia, Inc.*, 892 F.3d 719, 726 (5th Cir. 2018) (citation omitted). The Court takes judicial notice of the Congressional Record in support of the No Surprises Act. *See Territory of Alaska v. Am. Can Co.*, 358 U.S. 224, 226–27 (1959).

NSA protects patients from the severe financial liabilities that could result from surprise medical bills and balance billing. *Id.* at 51. As relevant here, the NSA establishes a dispute resolution system for when healthcare providers and insurers dispute surprise medical bills. 42 U.S.C. § 300gg-111(c)(1)–(5). This system is known as the Independent Dispute Resolution (“IDR”) process, and it works as follows: First, the provider and the insurer negotiate the price for the service. *Id.* § 300gg-111(c)(1)(A). Second, if these negotiations fail, the provider and insurer have four days to begin the IDR process. *Id.* § 300gg-111(c)(1)(B). Third, a certified IDR entity is selected by either the parties or the Department of Health and Human Services (“HHS”). *Id.* § 300gg-111(c)(4). Fourth, the certified IDR entity determines whether the parties’ dispute is eligible for IDR and then decides the amount owed to the provider by the insurer. *Id.* § 300gg-111(c)(5).

Plaintiffs are two air ambulance providers that underwent the IDR process with HCSC. Doc. 1, Compl., ¶¶ 11–12. Plaintiffs bring three claims against HCSC. Their first cause of action is brought under the NSA—they allege that HCSC failed to timely pay the awards determined by a certified IDR entity. *Id.* ¶¶ 15–17. Plaintiffs’ second cause of action is brought under ERISA, claiming that HCSC improperly denied benefits to its beneficiaries by failing to pay Plaintiffs the IDR awards. *Id.* ¶¶ 18–23. Plaintiffs’ third claim is for unjust enrichment, arguing that Plaintiffs conferred a benefit on HCSC’s beneficiaries, yet HCSC never paid for this benefit. *Id.* ¶¶ 24–29. HCSC moves to dismiss all of Plaintiffs’ claims. Doc. 11, Mot., 1. The Court considers the Motion below.

II.

LEGAL STANDARDS

A. *Motion to Dismiss for Lack of Subject-Matter Jurisdiction*

“Federal courts are courts of limited jurisdiction.” *Settlement Funding, L.L.C. v. Rapid Settlements, Ltd.*, 851 F.3d 530, 537 (5th Cir. 2017) (citations omitted). Thus, courts “must presume that a suit lies outside this limited jurisdiction, and the burden of establishing federal jurisdiction rests on the party seeking the federal forum.” *Id.* (citations omitted). “If the record does not contain sufficient evidence to show that subject matter jurisdiction exists, a federal court does not have jurisdiction over the case.” *Id.* (citation omitted). “Congress has plenary authority to regulate federal court jurisdiction and can withhold such jurisdiction at its discretion.” *In re B-727 Aircraft Serial No. 21010*, 272 F.3d 264, 269 (5th Cir. 2001).

B. *Motion to Dismiss for Failure to State a Claim*

Under Federal Rule of Civil Procedure 8(a)(2), a complaint must contain “a short and plain statement of the claim showing that the pleader is entitled to relief.” Rule 12(b)(6) authorizes a court to dismiss a plaintiff’s complaint for “failure to state a claim upon which relief can be granted.” FED. R. CIV. P. 12(b)(6). In considering a Rule 12(b)(6) motion to dismiss, “the Court must accept all well-pleaded facts as true, and view them in the light most favorable to the plaintiff.” *Walker v. Beaumont Indep. Sch. Dist.*, 938 F.3d 724, 735 (5th Cir. 2019) (alteration in original) (citation omitted). But the Court will “not look beyond the face of the pleadings to determine whether relief should be

granted based on the alleged facts.” *Spivey v. Robertson*, 197 F.3d 772, 774 (5th Cir. 1999).

To survive a motion to dismiss, plaintiffs must plead “enough facts to state a claim to relief that is plausible on its face.” *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007). “Threadbare recitals of the elements of a cause of action, supported by mere conclusory statements, do not suffice.” *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). “A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged.” *Id.* “The plausibility standard is not akin to a ‘probability requirement,’ but it asks for more than a sheer possibility that a defendant has acted unlawfully.” *Id.* (quoting *Twombly*, 550 U.S. at 556). When well-pleaded facts fail to meet this standard, “the complaint has alleged—but it has not shown—that the pleader is entitled to relief.” *Id.* at 679 (alteration in original) (citation omitted).

III.

ANALYSIS

First, the Court concludes that Plaintiffs have failed to state a claim because the NSA does not confer a private cause of action to enforce an IDR award and convert that award to a final judgment. Second, the Court lacks subject-matter jurisdiction over Plaintiffs’ ERISA claim because Plaintiffs do not have standing to bring that claim. Third, Plaintiffs did not state a claim for unjust enrichment, or quantum meruit, because they did not provide HCSC with any direct benefit.

A. The NSA Does Not Provide an Express or Implied Cause of Action.

Plaintiffs' first claim is brought pursuant to the NSA, seeking to enforce their IDR awards. However, the Court concludes that the NSA does not provide Plaintiffs with an express or implied cause of action to enforce IDR awards. Therefore, the Court dismisses Plaintiffs' first claim.

The Court first notes that the NSA does not contain any provisions expressly allowing Plaintiffs to file a lawsuit in federal court seeking to enforce an IDR award—thus, the NSA does not contain an express cause of action. In another statutory context, the Federal Arbitration Act (“FAA”), Congress expressly included a provision which enables a court to confirm, or enforce, arbitration awards. 9 U.S.C. § 9. The NSA does not contain any similar provision. Thus, the Court must determine whether the NSA contains an implied cause of action. While Plaintiffs argue that the language in the NSA gives the Court authority to enforce IDR awards without having to imply a cause of action, Doc. 12, Resp., 4–5, this assertion is simply incorrect.

To establish that the NSA contains an implied cause of action, Plaintiffs “must overcome the presumption that Congress did not intend to create a private cause of action.” *Acara v. Banks*, 470 F.3d 569, 571 (5th Cir. 2006). Here, the presumption against a statute containing a cause of action applies because the NSA does not contain an express cause of action. *See id.* A cause of action requires two things—a right and a remedy. *See Alexander v. Sandoval*, 532 U.S. 275, 286 (2001) (“The judicial task is to interpret the statute

Congress has passed to determine whether it displays an intent to create not just a private right but also a private remedy.”). “Statutory intent on this latter point is *determinative*.” *Id.* (emphasis added). So, the Court must look to the text of the NSA to determine whether Congress intended to create a private right and a private remedy. *See id.* While Plaintiffs present compelling arguments that the NSA created a right, they fail to identify any “statutory intent” to create a remedy to enforce that right.

There is no language in the NSA establishing that Congress intended to create a remedy for out-of-network providers. At the outset, the Court will clarify the meaning of the term “remedy” as used in this context. While remedy often refers to the precise relief that a plaintiff is seeking, *see* REMEDY, Black’s Law Dictionary (11th ed. 2019), the Supreme Court used the term differently in the context of determining whether Congress created an implied cause of action. “Remedy,” as used in *Sandoval*, refers to a procedural mechanism which enables a party to enforce its rights. *See Sandoval*, 532 U.S. at 289–90; *see also Diagnostic Affiliates of Ne. Hou, LLC v. Aetna, Inc.*, 654 F. Supp. 3d 595, 610 (S.D. Tex. 2023) (“And while *Sandoval* speaks in terms of legislative language establishing a remedy, it is actually singularly focused on the procedural cause of action, *not* the substantive remedy.” (emphasis added)). With this distinction in mind, the Court concludes that the NSA does not create a procedural mechanism for Plaintiffs to enforce their IDR awards in federal court.

Perhaps the paradigm example of a statute containing an implied cause of action came in *Cannon v. Univ. of Chicago*, 441 U.S. 677 (1979). There, the

Supreme Court determined that Title IX of the Civil Rights Act contained an implied cause of action in large part because Title IX included a fee-shifting provision that awarded attorneys' fees to prevailing parties. *Id.* at 699–700. Therefore, the Supreme Court held, the text of the statute indicated that Congress intended to create a private cause of action. *Id.* at 709.

Unlike Title IX, the NSA does not contain any fee-shifting provisions or any other language suggesting that Congress intended to confer a private cause of action to healthcare providers. In fact, the NSA includes language that almost entirely prohibits judicial review of IDR decisions. The NSA states that IDR decisions “shall not be subject to judicial review” other than permitting courts to vacate IDR decisions under the same four grounds a court can vacate an arbitration award under the FAA. 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II); *see also* 9 U.S.C. § 10(a). Including language almost entirely forbidding judicial review of IDR decisions strongly suggests that Congress did not intend to confer Plaintiffs a cause of action to enforce IDR awards.

Additionally, although Congress borrowed from § 10 of the FAA, it notably did not incorporate the FAA provision that enables parties to confirm arbitration awards, which further indicates that Congress did not intend to create a private cause of action under the NSA. The FAA expressly provides parties with a procedural mechanism to vacate, modify, and confirm arbitration awards in a federal court. 9 U.S.C. §§ 9–11. If Congress intended to create such a procedural mechanism under the NSA, it simply could have incorporated one more section from the FAA, yet Congress did not do so. The Court interprets this

omission in the NSA to mean that Congress did not intend to create a remedy under the NSA. *Cf. Guardian Flight, LLC v. Aetna Health Inc.*, No. 4:22-CV-03805, 2024 WL 484561, at *4 (S.D. Tex. Jan. 5, 2024) (holding that only the vacatur section of the FAA applied to the NSA because Congress would have incorporated other FAA sections if it had intended to) (citation omitted). Therefore, not only is there no “statutory intent” to create a private remedy, *see Sandoval*, 532 U.S. at 286, but the NSA also includes language strongly suggesting that Congress did not intend to create a private remedy.

To the extent Plaintiffs are arguing that the NSA creates a right and thereby a remedy, this proposition is incorrect. Plaintiffs identify two textual provisions within the NSA to support the existence of a cause of action. First, the NSA states that any decision by a certified IDR entity “shall be binding.” Doc. 12, Resp., 3; 42 U.S.C. § 300gg-111(c)(5)(E)(i)(I). Second, the NSA includes a “Timing of Payment” provision which requires healthcare insurers to pay the IDR awards within thirty days. Doc. 12, Resp., 3; 42 U.S.C. § 300gg-112(b)(6). Plaintiffs argue that the “shall be binding” language and the “Timing of Payment” provision establish that Congress “clearly intended to create a private right of action to enforce the timely payment of IDR awards.” Doc. 12, Resp., 7. The Court disagrees. While the NSA appears to create a right that out-of-network providers are entitled to recover their IDR awards within thirty days, these provisions, when read together, do not suggest that Congress intended to create a procedural mechanism for providers to convert IDR awards to final judgments. Further, there is no other language in the statute

suggesting that Congress contemplated providers would be able to file a lawsuit to enforce IDR awards. In other words, these provisions only suggest that Congress created a right, but there is nothing to suggest that Congress also intended to confer a corresponding remedy.

Plaintiffs make several arguments for why Congress *should* have provided a private cause of action to enforce an IDR award. Doc. 12, Resp., 5. However, even if the Court found these policy arguments compelling, “courts may not create [a cause of action], no matter how desirable that might be as a policy matter.” *Cantu v. Moody*, 933 F.3d 414, 424 (5th Cir. 2019) (alteration in original) (quoting *Sandoval*, 532 U.S. at 286–87).

In sum, the NSA does not contain an implied cause of action for out-of-network healthcare providers to enforce IDR awards. Because the NSA does not provide a private cause of action, Plaintiffs cannot state a claim under the NSA. Therefore, the Court grants HCSC’s Motion to Dismiss with respect to Plaintiffs’ NSA claim.

B. Plaintiffs Lack Standing to Bring Their ERISA Cause of Action.

Plaintiffs’ second cause of action is brought under ERISA, claiming that “HCSC improperly denied plan benefits by failing to pay [Plaintiffs] the IDR awards.” Doc. 1, Compl., ¶ 21. Article III of the United States Constitution limits the subject-matter jurisdiction of the federal courts to certain “Cases” and “Controversies.” U.S. CONST. art. III, § 2. “In an attempt to give meaning to Article III’s ‘case or controversy requirement,’ the courts have developed a

series of principles termed ‘justiciability doctrines.’” *United Transp. Union v. Foster*, 205 F.3d 851, 857 (5th Cir. 2000). One such justiciability doctrine is standing. *See Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560 (1992).

“The essence of standing is whether the litigant is entitled to have the court decide the merits of the dispute or of particular issues.” *Mississippi State Democratic Party v. Barbour*, 529 F.3d 538, 544 (5th Cir. 2008) (citations omitted). There are three elements to constitutional standing: (1) “the plaintiff must have suffered an ‘injury in fact’—an invasion of a legally protected interest that is (a) concrete and particularized, and (b) actual or imminent, not conjectural or hypothetical,” (2) “there must be a causal connection between the injury and the conduct complained of,” and (3) “it must be likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision.” *United States v. Hays*, 515 U.S. 737, 742–43 (1995) (citations omitted). “The party invoking federal jurisdiction bears the burden of establishing these elements.” *Lujan*, 504 U.S. at 561. “If the plaintiff does not claim to have suffered an injury that the defendant caused and the court can remedy, there is no case or controversy for the federal court to resolve.” *TransUnion LLC v. Ramirez*, 594 U.S. 413, 423 (2021) (citation omitted).

Here, Plaintiffs’ ERISA claim asserts the rights of some of HCSC’s beneficiaries. Several of HCSC’s beneficiaries assigned some of their rights under their HCSC healthcare plans to Plaintiffs. Doc. 1, Compl., ¶ 12. Because Plaintiffs received valid assignments from the beneficiaries, Plaintiffs “stand[] in the same position as [HCSC’s beneficiaries] stood” with regards to standing. *See Quality Infusion Care, Inc. v. Health*

Care Serv. Corp., 628 F.3d 725, 729 (5th Cir. 2010) (citation omitted). Thus, for Plaintiffs to have standing, they must show that the beneficiaries would have had standing to bring an ERISA claim to require HCSC to pay Plaintiffs the IDR awards. *See id.* The Court concludes that HCSC's beneficiaries would not have had standing to bring such a claim—therefore, Plaintiffs likewise lack standing.

The HCSC beneficiaries suffered no concrete injury from HCSC allegedly failing to pay IDR awards to Plaintiffs. As the Court discussed above, the passage of the NSA means that patients, like the HCSC beneficiaries, are no longer financially responsible for balance billing—i.e., the difference between the out-of-network provider's price and what the insurer agrees to cover. *See* 42 U.S.C. § 300gg-135. The HCSC beneficiaries would incur no financial injury from a dispute between HCSC and Plaintiffs because the beneficiaries do not have to pay the IDR awards. Plaintiffs likewise fail to assert any other non-financial injury that the HCSC beneficiaries would have suffered, thus the Court concludes the HCSC beneficiaries did not suffer any concrete injury. *See Lujan*, 504 U.S. at 561.

Plaintiffs argue that the HCSC beneficiaries suffered three separate concrete injuries. All three arguments lack merit. First, Plaintiffs argue that the HCSC beneficiaries' protections from balance billing, which are codified by statute in the NSA, are endangered “under numerous legal theories” if HCSC fails to pay the IDR awards. Doc. 12, Resp., 10. The Court rejects this argument as it is unaware of these “numerous legal theories” and Plaintiffs fail to elucidate which theories they are referring to. Second,

Plaintiffs argue that the beneficiaries “risk higher premiums if their health plans do not pay IDR awards.” *Id.* In essence, Plaintiffs are arguing that, if HCSC does not pay the IDR awards, it will get sued by out-of-network healthcare providers, which will result in HCSC incurring litigation costs, and subsequently lead to HCSC increasing its beneficiaries’ premiums. *See id.* This claimed injury is merely “conjectural or hypothetical” and falls far short of what is required for standing—a concrete injury. *See Hays*, 515 U.S. at 742–43. Third, Plaintiffs argue that the beneficiaries have an interest in their health plans paying Plaintiffs “so that air ambulance transports remain accessible and providers do not go bankrupt.” Doc. 12, Resp., 10. Plaintiffs speculate that health insurance companies failing to pay IDR awards could force out-of-network air ambulance providers into bankruptcy, which could then injure the HCSC beneficiaries because they would not have access to air ambulance services if they later needed them. This argument fails because this injury is purely conjectural and thus fails to establish standing. *See Hays*, 515 U.S. at 742–43.

Plaintiffs lack standing to assert their ERISA claim because the HCSC beneficiaries did not suffer any concrete injury. Accordingly, the Court grants HCSC’s Motion to Dismiss as to Plaintiffs’ ERISA claim.

C. Plaintiffs Failed to State a Claim for Unjust Enrichment.

Plaintiffs’ third cause of action against HCSC is for unjust enrichment. Plaintiffs appear to advance two theories of unjust enrichment. First, Plaintiffs provided their air ambulance services to HCSC’s beneficiaries, and HCSC never paid Plaintiffs, despite

their beneficiaries receiving these benefits. Doc. 1, Compl., ¶ 25. Second, Plaintiffs argue that HCSC was “further unjustly enriched by receiving interest and/or investment income as a result of the unlawful retention of the [IDR awards].” *Id.* ¶ 28.

Most Texas courts have held that unjust enrichment is not an independent cause of action under Texas law. *Richardson Hosp. Auth. v Duru*, 387 S.W.3d 109, 114 (Tex. App.—Dallas 2012, no pet.); *Watson v. City of San Marcos*, No. 03-22-00307-CV, 2023 WL 3010938, at *3 (Tex. App.—Austin Apr. 20, 2023, pet. denied) (mem. op.); *Davis v. OneWest Bank, N.A.*, No. 02-14-00264-CV, 2015 WL 1623541, at *1 (Tex. App.—Fort Worth, Apr. 9, 2015, pet. denied). However, the allegations in support of Plaintiffs’ “unjust enrichment” claim roughly track the elements of a quantum meruit claim, which the Supreme Court of Texas has described as “an equitable theory founded in the principle of unjust enrichment.” *Texas Med. Res., LLP v. Molina Healthcare of Texas, Inc.*, 659 S.W.3d 424, 436 (Tex. 2023) (citations omitted); see Doc. 1, Compl., ¶¶ 25–29. To draw all reasonable inferences in favor of Plaintiffs, the Court construes Plaintiffs’ unjust enrichment claim as a cause of action for quantum meruit. But even construed as such, Plaintiffs have not stated a claim for quantum meruit under either of their proposed theories.

1. Plaintiffs Failed to State a Claim for Quantum Meruit Because They Did Not Provide a Direct Benefit to HCSC.

Under Texas law, quantum meruit claims have four elements: “(1) valuable services were rendered or materials furnished; (2) for the defendant; (3) the

services or materials were accepted by the defendant; and (4) the defendant was reasonably notified that the plaintiff performing the services or providing the materials was expecting to be paid.” *Texas Med. Res.*, 659 S.W.3d at 436 (internal alterations omitted). To establish the second element, it is insufficient that HCSC merely benefitted from Plaintiffs’ services. *Id.* Instead, Plaintiffs’ “efforts must have been undertaken *for* the person sought to be charged.” *Id.* (citations omitted) (emphasis in original).

Plaintiffs fail to state a claim for quantum meruit under their first theory because they did not provide their air ambulance services for HCSC’s benefit. Healthcare providers generally cannot maintain a quantum meruit claim against health insurance companies based on allegations that the providers performed services solely for the health insurance companies’ insureds. *See Encompass Off. Sols., Inc. v. Ingenix, Inc.*, 775 F. Supp. 2d 938, 966 (E.D. Tex. 2011) (“Even if [the health insurance company] received some benefit as a result of [the healthcare provider] providing medical services to its insureds . . . [the healthcare provider’s] services were rendered to and for its patients, not [the health insurance company].”); *see Angelina Emergency Med. Assocs. PA v. Health Care Serv. Corp.*, 506 F. Supp. 3d 425, 432 (N.D. Tex. 2020) (Starr, J.) (“Serving a defendant’s customers is hardly the same as serving the defendant itself.” (emphasis omitted)). The parties do not dispute that it was HCSC’s beneficiaries who received Plaintiffs’ air ambulance services—HCSC never directly received these services. *Compare* Doc. 11, Mot., 19–20, *with* Doc. 12, Resp., 13–14. Therefore, Plaintiffs failed to plead that they rendered a valuable service to HCSC.

Plaintiffs do not argue that they provided a benefit directly to HCSC. Instead, Plaintiffs argue that “the NSA changed the provider-insurer landscape.” Doc. 12, Resp., 13. They argue that because the NSA placed the payment obligation solely on health insurers, Plaintiffs should be able to maintain their quantum meruit claim against HCSC. *Id.* at 13–14. While they are correct that the NSA changed a beneficiary’s obligations to out-of-network healthcare providers, *see* 42 U.S.C. § 300gg-135, the NSA is a federal statute, and it did not change the elements of a Texas tort. Just because Plaintiffs now must resolve payment disputes with health insurance companies instead of directly with the beneficiaries does not mean that healthcare providers now confer a benefit directly to a health insurance company by providing services to its insureds. Therefore, Plaintiffs failed to adequately plead an element of their quantum meruit claim. The Court grants HCSC’s motion to dismiss with regards to the construed quantum meruit claim.

2. Plaintiffs Failed to State a Claim for Quantum Meruit Under Their Second Theory Because They Did Not Perform Any Services for HCSC.

Plaintiffs also allege that HCSC has been further unjustly enriched by receiving interest or investment income because it refused to timely pay the IDR awards. Doc. 1, Compl., ¶ 28. It is not entirely clear whether the interest on the allegedly withheld payments constitutes an entirely separate theory of unjust enrichment or whether this forms part of Plaintiffs’ first theory of unjust enrichment—HCSC not paying for the benefits its beneficiaries received. *See* Doc. 12, Resp., 14. If the latter, Plaintiffs fail to state a claim because HCSC did not directly benefit

from its insureds receiving the air ambulance services, as discussed above. If the former, Plaintiffs fail to adequately plead the first element of a quantum meruit claim because Plaintiffs did not perform any services for HCSC when HCSC allegedly withheld the IDR awards. *See Texas Med. Res.*, 659 S.W.3d at 436.

Accordingly, the Court grants HCSC's motion to dismiss the unjust enrichment claim to the extent Plaintiffs bring an additional unjust enrichment claim against HCSC for receiving interest or investment income from not timely paying the IDR awards.

D. The Court Denies Plaintiffs Leave to Amend Their Complaint.

"[D]istrict courts often afford plaintiffs at least one opportunity to cure pleading deficiencies before dismissing a case, unless it is clear that the defects are incurable or the plaintiffs advise the court that they are unwilling or unable to amend in a manner that will avoid dismissal." *Great Plains Tr. Co. v. Morgan Stanley Dean Witter & Co.*, 313 F.3d 305, 329 (5th Cir. 2002). District courts give plaintiffs leave to amend their complaints "when justice so requires." FED. R. CIV. P. 15(a)(2). This liberal standard, however, is "tempered by the necessary power of a district court to manage a case." *Schiller v. Physicians Res. Grp. Inc.*, 342 F.3d 563, 566 (5th Cir. 2003).

When deciding whether to grant leave to amend, district courts consider the following factors: "undue delay, bad faith or dilatory motive on the part of the movant, repeated failure to cure deficiencies by amendments previously allowed, undue prejudice to the opposing party, and futility of amendment." *Jacobsen v. Osborne*, 133 F.3d 315, 318 (5th Cir. 1998)

(citations and emphasis omitted). Granting leave to amend a complaint is futile if “the amended complaint would fail to state a claim upon which relief could be granted.” *Stripling v. Jordan Prod. Co., LLC*, 234 F.3d 863, 873 (5th Cir. 2000).

While Plaintiffs did not request leave to amend, the Court will nevertheless consider whether to grant them leave to do so. With regards to Plaintiffs’ claim under the NSA, the Court finds leave to amend would be futile because the NSA does not contain a private cause of action for out-of-network healthcare providers to enforce IDR awards. *See Stripling*, 234 F.3d at 873. Thus, the Court denies Plaintiffs leave to amend their NSA claim. The Court also finds it would be futile to give Plaintiffs leave to amend their ERISA claim. Given the highly speculative injuries alleged, the Court is convinced that any amended complaint would also fail to allege facts establishing that HCSC’s beneficiaries suffered a concrete injury from HCSC allegedly not paying Plaintiffs. *See id.* Accordingly, the Court dismisses Plaintiffs’ ERISA claim without prejudice for lack of subject-matter jurisdiction and denies Plaintiffs leave to amend their ERISA claim. *See Mitchell v. Bailey*, 982 F.3d 937, 944 (5th Cir. 2020) (holding that a district court should dismiss a case without prejudice when it lacks subject-matter jurisdiction over the dispute).

Lastly, the Court concludes that it would be futile to allow Plaintiffs to amend their unjust enrichment claim, which the Court construed as a quantum meruit claim. The Court finds that Plaintiffs would not be able to allege any facts to establish they provided any benefits directly to HCSC, as necessary to maintain a quantum meruit claim. *See Stripling*, 234 F.3d at 873;

see *Texas Med. Res.*, 659 S.W.3d at 436. Thus, this defect in the Plaintiffs' Complaint is incurable. See *Great Plains Tr. Co.*, 313 F.3d at 329. Accordingly, the Court denies Plaintiffs leave to amend their Complaint.

IV.

CONCLUSION

For the reasons discussed above, the Court **GRANTS** HCSC's Motion to Dismiss (Doc. 11). Specifically, the Court **DISMISSES WITH PREJUDICE** Plaintiffs' claim under the NSA for failure to state a claim and **DENIES** Plaintiffs leave to replead their NSA claim. The Court **DISMISSES WITHOUT PREJUDICE** Plaintiffs' ERISA claim for lack of subject-matter jurisdiction and **DENIES** Plaintiffs leave to replead their ERISA claim. Lastly, the Court **DISMISSES WITH PREJUDICE** Plaintiffs' claim for unjust enrichment and **DENIES** Plaintiffs leave to replead their unjust enrichment claim. A final judgment will follow.

SO ORDERED.

SIGNED: May 30, 2024.

A handwritten signature in black ink, appearing to read "Jane J. Boyle", written over a horizontal line.

JANE J. BOYLE
UNITED STATES DISTRICT JUDGE

APPENDIX C

United States Court of Appeals
for the Fifth Circuit

No. 24-10561

Guardian Flight, L.L.C.; Med-Trans Corporation,
Plaintiffs — Appellants,
VERSUS

Health Care Service Corporation,
Defendant — Appellee.

United States Court of Appeals
Fifth Circuit
FILED
July 10, 2025
Lyle W. Cayce
Clerk

Case: 24-10561 Document: 107-1 Page: 1 Date Filed:
07/10/2025

Appeal from the United States District Court
for the Northern District of Texas
USDC No. 3:23-CV-1861

ON PETITION FOR REHEARING EN BANC

Before SMITH, CLEMENT, and DUNCAN, *Circuit Judges*.

PER CURIAM:

Treating the petition for rehearing en banc as a petition for panel rehearing (5th Cir. R.40 I.O.P.), the petition for panel rehearing is DENIED. Because no member of the panel or judge in regular active service requested that the court be polled on rehearing en banc (FED. R. APP. P.40 and 5TH CIR. R.40), the petition for rehearing en banc is DENIED.

* Judge Carolyn Dineen King, and Judge Irma Carrillo Ramirez, did not participate in the consideration of the rehearing en banc

APPENDIX D

42 U.S.C. § 300gg-111: Preventing surprise medical bills

§300gg–111. Preventing surprise medical bills**(a) Coverage of emergency services****(1) In general**

If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department (as defined in paragraph (3)(D)), the plan or issuer shall cover emergency services (as defined in paragraph (3)(C))-

(A) without the need for any prior authorization determination;

(B) whether the health care provider furnishing such services is a participating provider or a participating emergency facility, as applicable, with respect to such services;

(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee by a nonparticipating provider or a nonparticipating emergency facility-

(i) such services will be provided without imposing any requirement under the plan or coverage for prior authorization

of services or any limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities with respect to such plan or coverage, respectively;

(ii) the cost-sharing requirement is not greater than the requirement that would apply if such services were provided by a participating provider or a participating emergency facility;

(iii) such cost-sharing requirement is calculated as if the total amount that would have been charged for such services by such participating provider or participating emergency facility were equal to the recognized amount (as defined in paragraph (3)(H)) for such services, plan or coverage, and year;

(iv) the group health plan or health insurance issuer, respectively-

(I) not later than 30 calendar days after the bill for such services is transmitted by such provider or facility, sends to the provider or facility, as applicable, an initial payment or notice of denial of payment; and

(II) pays a total plan or coverage payment directly to such provider or facility, respectively (in accordance, if applicable, with the timing requirement described in subsection

(c)(6)) that is, with application of any initial payment under subclause (I), equal to the amount by which the out-of-network rate (as defined in paragraph (3)(K)) for such services exceeds the cost-sharing amount for such services (as determined in accordance with clauses (ii) and (iii)) and year; and

(v) any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to such emergency services so furnished shall be counted toward any in-network deductible or out-of-pocket maximums applied under the plan or coverage, respectively (and such in-network deductible and out-of-pocket maximums shall be applied) in the same manner as if such cost-sharing payments were made with respect to emergency services furnished by a participating provider or a participating emergency facility; and

(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 300gg–3 of this title, including as incorporated pursuant to section 1185d of title 29 and section 9815 of title 26, and other than applicable cost-sharing).

(2) Audit process and regulations for qualifying payment amounts

(A) Audit process

(i) In general

Not later than October 1, 2021, the Secretary, in consultation with the Secretary of Labor and the Secretary of the Treasury, shall establish through rulemaking a process, in accordance with clause (ii), under which group health plans and health insurance issuers offering group or individual health insurance coverage are audited by the Secretary or applicable State authority to ensure that-

(I) such plans and coverage are in compliance with the requirement of applying a qualifying payment amount under this section; and

(II) such qualifying payment amount so applied satisfies the definition under paragraph (3)(E) with respect to the year involved, including with respect to a group health plan or health insurance issuer described in clause (ii) of such paragraph (3)(E).

(ii) Audit samples

Under the process established pursuant to clause (i), the Secretary-

(I) shall conduct audits described in such clause, with respect to a year (beginning with 2022), of a sample with respect to such year of claims data from not more than 25 group health plans and health insurance issuers offering group or individual health insurance coverage; and

(II) may audit any group health plan or health insurance issuer offering group or individual health insurance coverage if the Secretary has received any complaint or other information about such plan or coverage, respectively, that involves the compliance of the plan or coverage,

respectively, with either of the requirements described in subclauses (I) and (II) of such clause.

(iii) Reports

Beginning for 2022, the Secretary shall annually submit to Congress a report on the number of plans and issuers with respect to which audits were conducted during such year pursuant to this subparagraph.

(B) Rulemaking

Not later than July 1, 2021, the Secretary, in consultation with the Secretary of Labor and the Secretary of the Treasury, shall establish through rulemaking-

(i) the methodology the group health plan or health insurance issuer offering group or individual health insurance coverage shall use to determine the qualifying payment amount, differentiating by individual market, large group market, and small group market;

(ii) the information such plan or issuer, respectively, shall share with the nonparticipating provider or nonparticipating facility, as applicable, when making such a determination;

(iii) the geographic regions applied for purposes of this subparagraph, taking into account access to items and services in rural and underserved areas, including health professional shortage areas, as defined in section 254e of this title; and

(iv) a process to receive complaints of violations of the requirements described in subclauses (I) and (II) of subparagraph (A)(i) by

group health plans and health insurance issuers offering group or individual health insurance coverage.

Such rulemaking shall take into account payments that are made by such plan or issuer, respectively, that are not on a fee-for-service basis. Such methodology may account for relevant payment adjustments that take into account quality or facility type (including higher acuity settings and the case-mix of various facility types) that are otherwise taken into account for purposes of determining payment amounts with respect to participating facilities. In carrying out clause (iii), the Secretary shall consult with the National Association of Insurance Commissioners to establish the geographic regions under such clause and shall periodically update such regions, as appropriate, taking into account the findings of the report submitted under section 109(a) of the No Surprises Act.

(3) Definitions

In this part and part E:

(A) Emergency department of a hospital

The term “emergency department of a hospital” includes a hospital outpatient department that provides emergency services (as defined in subparagraph (C)(i)).

(B) Emergency medical condition

The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an

average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act [42 U.S.C. 1395dd(e)(1)(A)].

(C) Emergency services

(i) In general

The term “emergency services”, with respect to an emergency medical condition, means-

(I) a medical screening examination (as required under section 1867 of the Social Security Act [42 U.S.C. 1395dd], or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

(II) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required under section 1395dd of this title, or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

(ii) Inclusion of additional services

(I) In general

For purposes of this subsection and section 300gg-131 of this title, in the case of a participant, beneficiary, or enrollee who is enrolled in a group health plan or group or individual health insurance coverage offered by a health insurance issuer and who is furnished services described in clause (i) with respect to an emergency medical condition, the term “emergency services” shall include, unless each of the conditions described in subclause (II) are met, in addition to the items and services described in clause (i), items and services-

(aa) for which benefits are provided or covered under the plan or coverage, respectively; and

(bb) that are furnished by a nonparticipating provider or nonparticipating emergency facility (regardless of the department of the hospital in which such items or services are furnished) after the participant, beneficiary, or enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in clause (i) are furnished.

(II) Conditions

For purposes of subclause (I), the conditions described in this subclause, with respect to a participant, beneficiary, or enrollee who is stabilized and furnished additional items and services described in subclause (I), after such stabilization by a provider or facility described in subclause (I), are the following;

(aa) Such provider or facility determines such individual is able to travel using nonmedical transportation or nonemergency medical transportation.

(bb) Such provider furnishing such additional items and services satisfies the notice and consent criteria of section 300gg–132(d) of this title with respect to such items and services.

(cc) Such individual is in a condition to receive (as determined in accordance with guidelines issued by the Secretary pursuant to rulemaking) the information described in section 300gg–132 of this title and to provide informed consent under such section, in accordance with applicable State law.

(dd) Such other conditions, as specified by the Secretary, such as conditions relating to coordinating care transitions to participating providers and facilities.

(D) Independent freestanding emergency department

The term “independent freestanding emergency department” means a health care facility that-

(i) is geographically separate and distinct and licensed separately from a hospital under applicable State law; and

(ii) provides any of the emergency services (as defined in subparagraph (C)(i)).

(E) Qualifying payment amount

(i) In general

The term “qualifying payment amount” means, subject to clauses (ii) and (iii), with respect to a sponsor of a group health plan and health insurance issuer offering group or individual health insurance coverage-

(I) for an item or service furnished during 2022, the median of the contracted rates recognized by the plan or issuer, respectively (determined with respect to all such plans of such sponsor or all such coverage offered by such issuer that are offered within the same insurance market (specified in subclause (I), (II), (III), or (IV) of clause (iv)) as the plan or coverage) as the total maximum payment (including the cost-sharing amount imposed for such item or service and the amount to be paid by the plan or issuer, respectively) under such plans or coverage, respectively, on January 31, 2019, for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished, consistent with the methodology established by the Secretary under paragraph (2)(B), increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over 2019, such percentage increase over 2020, and such percentage increase over 2021; and

(II) for an item or service furnished during 2023 or a subsequent year, the qualifying payment amount determined under this clause for such an item or service furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

(ii) New plans and coverage

The term “qualifying payment amount” means, with respect to a sponsor of a group health plan or health insurance issuer offering group or individual health insurance coverage in a geographic region in

which such sponsor or issuer, respectively, did not offer any group health plan or health insurance coverage during 2019-

(I) for the first year in which such group health plan, group health insurance coverage, or individual health insurance coverage, respectively, is offered in such region, a rate (determined in accordance with a methodology established by the Secretary) for items and services that are covered by such plan or coverage and furnished during such first year; and

(II) for each subsequent year such group health plan, group health insurance coverage, or individual health insurance coverage, respectively, is offered in such region, the qualifying payment amount determined under this clause for such items and services furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

(iii) Insufficient information; newly covered items and services

In the case of a sponsor of a group health plan or health insurance issuer offering group or individual health insurance coverage that does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019 (or, in the case of a newly covered item or service (as defined in clause (v)(III)), in the first coverage year (as defined in clause (v)(I)) for such item or service with respect to such plan or coverage) for an item or service (including with respect to provider type, or amount, of claims for items or services (as determined

by the Secretary) provided in a particular geographic region (other than in a case with respect to which clause (ii) applies)) the term “qualifying payment amount”-

(I) for an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for such item or service with respect to such plan or coverage), means such rate for such item or service determined by the sponsor or issuer, respectively, through use of any database that is determined, in accordance with rulemaking described in paragraph (2)(B), to not have any conflicts of interest and to have sufficient information reflecting allowed amounts paid to a health care provider or facility for relevant services furnished in the applicable geographic region (such as a State all-payer claims database);

(II) for an item or service furnished in a subsequent year (before the first sufficient information year (as defined in clause (v)(II)) for such item or service with respect to such plan or coverage), means the rate determined under subclause (I) or this subclause, as applicable, for such item or service for the year previous to such subsequent year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year;

(III) for an item or service furnished in the first sufficient information year for such item or service with respect to such plan or coverage, has the meaning given the term qualifying payment amount in clause (i)(I), except that in applying such clause to such item or service, the reference to “furnished

during 2022” shall be treated as a reference to furnished during such first sufficient information year, the reference to “in 2019” shall be treated as a reference to such sufficient information year, and the increase described in such clause shall not be applied; and

(IV) for an item or service furnished in any year subsequent to the first sufficient information year for such item or service with respect to such plan or coverage, has the meaning given such term in clause (i)(II), except that in applying such clause to such item or service, the reference to “furnished during 2023 or a subsequent year” shall be treated as a reference to furnished during the year after such first sufficient information year or a subsequent year.

(iv) Insurance market

For purposes of clause (i)(I), a health insurance market specified in this clause is one of the following:

(I) The individual market.

(II) The large group market (other than plans described in subclause (IV)).

(III) The small group market (other than plans described in subclause (IV)).

(IV) In the case of a self-insured group health plan, other self-insured group health plans.

(v) Definitions

For purposes of this subparagraph:

(I) First coverage year

The term “first coverage year” means, with respect to a group health plan or group or individual health insurance coverage offered by a health insurance

issuer and an item or service for which coverage is not offered in 2019 under such plan or coverage, the first year after 2019 for which coverage for such item or service is offered under such plan or health insurance coverage.

(II) First sufficient information year

The term “first sufficient information year” means, with respect to a group health plan or group or individual health insurance coverage offered by a health insurance issuer-

(aa) in the case of an item or service for which the plan or coverage does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019, the first year subsequent to 2022 for which the sponsor or issuer has such sufficient information to calculate the median of such contracted rates in the year previous to such first subsequent year; and

(bb) in the case of a newly covered item or service, the first year subsequent to the first coverage year for such item or service with respect to such plan or coverage for which the sponsor or issuer has sufficient information to calculate the median of the contracted rates described in clause (i)(I) in the year previous to such first subsequent year.

(III) Newly covered item or service

The term “newly covered item or service” means, with respect to a group health plan or group or individual health insurance issuer offering health insurance coverage, an item or service for which coverage was not offered in 2019 under such plan or coverage, but is offered under such plan or coverage in a year after 2019.

**(F) Nonparticipating emergency facility;
participating emergency facility**

**(i) Nonparticipating emergency
facility**

The term “nonparticipating emergency facility” means, with respect to an item or service and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship directly or indirectly with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

(ii) Participating emergency facility

The term “participating emergency facility” means, with respect to an item or service and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, an emergency department of a hospital, or an independent freestanding emergency department, that has a contractual relationship directly or indirectly with the plan or issuer, respectively, with respect to the furnishing of such an item or service at such facility.

**(G) Nonparticipating providers;
participating providers**

(i) Nonparticipating provider

The term “nonparticipating provider” means, with respect to an item or service and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a physician or other health care provider who is acting within the

scope of practice of that provider's license or certification under applicable State law and who does not have a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

(ii) Participating provider

The term "participating provider" means, with respect to an item or service and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law and who has a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

(H) Recognized amount

The term "recognized amount" means, with respect to an item or service furnished by a nonparticipating provider or nonparticipating emergency facility during a year and a group health plan or group or individual health insurance coverage offered by a health insurance issuer-

(i) subject to clause (iii), in the case of such item or service furnished in a State that has in effect a specified State law with respect to such plan, coverage, or issuer, respectively; such a nonparticipating provider or nonparticipating emergency facility; and such an item or service, the amount determined in accordance with such law;

(ii) subject to clause (iii), in the case of such item or service furnished in a State that does not have in effect a specified State law, with respect to such plan,

coverage, or issuer, respectively; such a nonparticipating provider or nonparticipating emergency facility; and such an item or service, the amount that is the qualifying payment amount (as defined in subparagraph (E)) for such year and determined in accordance with rulemaking described in paragraph (2)(B)) for such item or service; or

(iii) in the case of such item or service furnished in a State with an All-Payer Model Agreement under section 1115A of the Social Security Act [42 U.S.C. 1315a], the amount that the State approves under such system for such item or service so furnished.

(I) Specified State law

The term “specified State law” means, with respect to a State, an item or service furnished by a nonparticipating provider or nonparticipating emergency facility during a year and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a State law that provides for a method for determining the total amount payable under such a plan, coverage, or issuer, respectively (to the extent such State law applies to such plan, coverage, or issuer, subject to section 1144 of title 29) in the case of a participant, beneficiary, or enrollee covered under such plan or coverage and receiving such item or service from such a nonparticipating provider or nonparticipating emergency facility.

(J) Stabilize

The term “to stabilize”, with respect to an emergency medical condition (as defined in subparagraph (B)), has the meaning give in section

1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(K) Out-of-network rate

The term “out-of-network rate” means, with respect to an item or service furnished in a State during a year to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer receiving such item or service from a nonparticipating provider or nonparticipating emergency facility-

(i) subject to clause (iii), in the case of such item or service furnished in a State that has in effect a specified State law with respect to such plan, coverage, or issuer, respectively; such a nonparticipating provider or nonparticipating emergency facility; and such an item or service, the amount determined in accordance with such law;

(ii) subject to clause (iii), in the case such State does not have in effect such a law with respect to such item or service, plan, and provider or facility-

(I) subject to subclause (II), if the provider or facility (as applicable) and such plan or coverage agree on an amount of payment (including if such agreed on amount is the initial payment sent by the plan under subsection (a)(1)(C)(iv)(I), subsection (b)(1)(C), or section 300gg–112(a)(3)(A) of this title, as applicable, or is agreed on through open negotiations under subsection (c)(1)) with respect to such item or service, such agreed on amount; or

(II) if such provider or facility (as applicable) and such plan or coverage enter the independent dispute resolution process under subsection (c) and do not so agree before the date on

which a certified IDR entity (as defined in paragraph (4) of such subsection) makes a determination with respect to such item or service under such subsection, the amount of such determination; or

(iii) in the case such State has an All-Payer Model Agreement under section 1115A of the Social Security Act [42 U.S.C. 1315a], the amount that the State approves under such system for such item or service so furnished.

(L) Cost-sharing

The term “cost-sharing” includes copayments, coinsurance, and deductibles.

(b) Coverage of non-emergency services performed by nonparticipating providers at certain participating facilities

(1) In general

In the case of items or services (other than emergency services to which subsection (a) applies) for which any benefits are provided or covered by a group health plan or health insurance issuer offering group or individual health insurance coverage furnished to a participant, beneficiary, or enrollee of such plan or coverage by a nonparticipating provider (as defined in subsection (a)(3)(G)(i)) (and who, with respect to such items and services, has not satisfied the notice and consent criteria of section 300gg–132(d) of this title) with respect to a visit (as defined by the Secretary in accordance with paragraph (2)(B)) at a participating health care facility (as defined in paragraph (2)(A)), with respect to such plan or coverage, respectively, the plan or coverage, respectively-

(A) shall not impose on such participant, beneficiary, or enrollee a cost-sharing requirement for such items and services so furnished that is greater than the cost-sharing requirement that would apply under such plan or coverage, respectively, had such items or services been furnished by a participating provider (as defined in subsection (a)(3)(G)(ii));

(B) shall calculate such cost-sharing requirement as if the total amount that would have been charged for such items and services by such participating provider were equal to the recognized amount (as defined in subsection (a)(3)(H)) for such items and services, plan or coverage, and year;

(C) not later than 30 calendar days after the bill for such services is transmitted by such provider, shall send to the provider an initial payment or notice of denial of payment;

(D) shall pay a total plan or coverage payment directly, in accordance, if applicable, with the timing requirement described in subsection (c)(6), to such provider furnishing such items and services to such participant, beneficiary, or enrollee that is, with application of any initial payment under subparagraph (C), equal to the amount by which the out-of-network rate (as defined in subsection (a)(3)(K)) for such items and services involved exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such items and services (as determined in accordance with subparagraphs (A) and (B)) and year; and

(E) shall count toward any in-network deductible and in-network out-of-pocket maximums (as applicable) applied under the plan or coverage,

respectively, any cost-sharing payments made by the participant, beneficiary, or enrollee (and such in-network deductible and out-of-pocket maximums shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider.

(2) Definitions

In this section:

(A) Participating health care facility

(i) In general

The term “participating health care facility” means, with respect to an item or service and a group health plan or health insurance issuer offering group or individual health insurance coverage, a health care facility described in clause (ii) that has a direct or indirect contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such an item or service at the facility.

(ii) Health care facility described

A health care facility described in this clause, with respect to a group health plan or group or individual health insurance coverage, is each of the following:

(I) A hospital (as defined in 1861(e) of the Social Security Act [42 U.S.C. 1395x(e)]).

(II) A hospital outpatient department.

(III) A critical access hospital (as defined in section 1861(mm)(1) of such Act [42 U.S.C. 1395x(mm)(1)]).

(IV) An ambulatory surgical center described in section 1833(i)(1)(A) of such Act [42 U.S.C. 1395l(i)(1)(A)].

(V) Any other facility, specified by the Secretary, that provides items or services for which coverage is provided under the plan or coverage, respectively.

(B) Visit

The term “visit” shall, with respect to items and services furnished to an individual at a health care facility, include equipment and devices, telemedicine services, imaging services, laboratory services, preoperative and postoperative services, and such other items and services as the Secretary may specify, regardless of whether or not the provider furnishing such items or services is at the facility.

(c) Determination of out-of-network rates to be paid by health plans; independent dispute resolution process

(1) Determination through open negotiation

(A) In general

With respect to an item or service furnished in a year by a nonparticipating provider or a nonparticipating facility, with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage, in a State described in subsection (a)(3)(K)(ii) with respect to such plan or coverage and provider or facility, and for which a payment is required to be made by the plan or coverage pursuant to subsection (a)(1) or (b)(1), the provider or facility (as applicable) or plan or coverage

may, during the 30-day period beginning on the day the provider or facility receives an initial payment or a notice of denial of payment from the plan or coverage regarding a claim for payment for such item or service, initiate open negotiations under this paragraph between such provider or facility and plan or coverage for purposes of determining, during the open negotiation period, an amount agreed on by such provider or facility, respectively, and such plan or coverage for payment (including any cost-sharing) for such item or service. For purposes of this subsection, the open negotiation period, with respect to an item or service, is the 30-day period beginning on the date of initiation of the negotiations with respect to such item or service.

(B) Accessing independent dispute resolution process in case of failed negotiations

In the case of open negotiations pursuant to subparagraph (A), with respect to an item or service, that do not result in a determination of an amount of payment for such item or service by the last day of the open negotiation period described in such subparagraph with respect to such item or service, the provider or facility (as applicable) or group health plan or health insurance issuer offering group or individual health insurance coverage that was party to such negotiations may, during the 4-day period beginning on the day after such open negotiation period, initiate the independent dispute resolution process under paragraph (2) with respect to such item or service. The independent dispute resolution process shall be initiated by a party pursuant to the previous sentence by submission to the other party

and to the Secretary of a notification (containing such information as specified by the Secretary) and for purposes of this subsection, the date of initiation of such process shall be the date of such submission or such other date specified by the Secretary pursuant to regulations that is not later than the date of receipt of such notification by both the other party and the Secretary.

(2) Independent dispute resolution process available in case of failed open negotiations

(A) Establishment

Not later than 1 year after December 27, 2020, the Secretary, jointly with the Secretary of Labor and the Secretary of the Treasury, shall establish by regulation one independent dispute resolution process (referred to in this subsection as the “IDR process”) under which, in the case of an item or service with respect to which a provider or facility (as applicable) or group health plan or health insurance issuer offering group or individual health insurance coverage submits a notification under paragraph (1)(B) (in this subsection referred to as a “qualified IDR item or service”), a certified IDR entity under paragraph (4) determines, subject to subparagraph (B) and in accordance with the succeeding provisions of this subsection, the amount of payment under the plan or coverage for such item or service furnished by such provider or facility.

(B) Authority to continue negotiations

Under the independent dispute resolution process, in the case that the parties to a determination for a qualified IDR item or service agree on a payment

amount for such item or service during such process but before the date on which the entity selected with respect to such determination under paragraph (4) makes such determination under paragraph (5), such amount shall be treated for purposes of subsection (a)(3)(K)(ii) as the amount agreed to by such parties for such item or service. In the case of an agreement described in the previous sentence, the independent dispute resolution process shall provide for a method to determine how to allocate between the parties to such determination the payment of the compensation of the entity selected with respect to such determination.

(C) Clarification

A nonparticipating provider may not, with respect to an item or service furnished by such provider, submit a notification under paragraph (1)(B) if such provider is exempt from the requirement under subsection (a) of section 300gg-132 of this title with respect to such item or service pursuant to subsection (b) of such section.

(3) Treatment of batching of items and services

(A) In general

Under the IDR process, the Secretary shall specify criteria under which multiple qualified IDR dispute items and services are permitted to be considered jointly as part of a single determination by an entity for purposes of encouraging the efficiency (including minimizing costs) of the IDR process. Such items and services may be so considered only if-

(i) such items and services to be included in such determination are furnished by the same provider or facility;

(ii) payment for such items and services is required to be made by the same group health plan or health insurance issuer;

(iii) such items and services are related to the treatment of a similar condition; and

(iv) such items and services were furnished during the 30 day period following the date on which the first item or service included with respect to such determination was furnished or an alternative period as determined by the Secretary, for use in limited situations, such as by the consent of the parties or in the case of low-volume items and services, to encourage procedural efficiency and minimize health plan and provider administrative costs.

(B) Treatment of bundled payments

In carrying out subparagraph (A), the Secretary shall provide that, in the case of items and services which are included by a provider or facility as part of a bundled payment, such items and services included in such bundled payment may be part of a single determination under this subsection.

(4) Certification and selection of IDR entities

(A) In general

The Secretary, in consultation with the Secretary of Labor and Secretary of the Treasury, shall establish a process to certify (including to recertify) entities under this paragraph. Such process shall ensure that an entity so certified-

(i) has (directly or through contracts or other arrangements) sufficient medical, legal, and other expertise and sufficient staffing to make determinations described in paragraph (5) on a timely basis;

(ii) is not-

(I) a group health plan or health insurance issuer offering group or individual health insurance coverage, provider, or facility;

(II) an affiliate or a subsidiary of such a group health plan or health insurance issuer, provider, or facility; or

(III) an affiliate or subsidiary of a professional or trade association of such group health plans or health insurance issuers or of providers or facilities;

(iii) carries out the responsibilities of such an entity in accordance with this subsection;

(iv) meets appropriate indicators of fiscal integrity;

(v) maintains the confidentiality (in accordance with regulations promulgated by the Secretary) of individually identifiable health information obtained in the course of conducting such determinations;

(vi) does not under the IDR process carry out any determination with respect to which the entity would not pursuant to subclause (I), (II), or (III) of subparagraph (F)(i) be eligible for selection; and

(vii) meets such other requirements as determined appropriate by the Secretary.

(B) Period of certification

Subject to subparagraph (C), each certification (including a recertification) of an entity under the process described in subparagraph (A) shall be for a 5-year period.

(C) Revocation

A certification of an entity under this paragraph may be revoked under the process described in subparagraph (A) if the entity has a pattern or practice of noncompliance with any of the requirements described in such subparagraph.

(D) Petition for denial or withdrawal

The process described in subparagraph (A) shall ensure that an individual, provider, facility, or group health plan or health insurance issuer offering group or individual health insurance coverage may petition for a denial of a certification or a revocation of a certification with respect to an entity under this paragraph for failure of meeting a requirement of this subsection.

(E) Sufficient number of entities

The process described in subparagraph (A) shall ensure that a sufficient number of entities are certified under this paragraph to ensure the timely and efficient provision of determinations described in paragraph (5).

(F) Selection of certified IDR entity

The Secretary shall, with respect to the determination of the amount of payment under this subsection of an item or service, provide for a method-

(i) that allows for the group health plan or health insurance issuer offering group or individual health insurance coverage and the nonparticipating

provider or the nonparticipating emergency facility (as applicable) involved in a notification under paragraph (1)(B) to jointly select, not later than the last day of the 3-business day period following the date of the initiation of the process with respect to such item or service, for purposes of making such determination, an entity certified under this paragraph that-

(I) is not a party to such determination or an employee or agent of such a party;

(II) does not have a material familial, financial, or professional relationship with such a party; and

(III) does not otherwise have a conflict of interest with such a party (as determined by the Secretary); and

(ii) that requires, in the case such parties do not make such selection by such last day, the Secretary to, not later than 6 business days after such date of initiation-

(I) select such an entity that satisfies subclauses (I) through (III) of clause (i)); and

(II) provide notification of such selection to the provider or facility (as applicable) and the plan or issuer (as applicable) party to such determination.

An entity selected pursuant to the previous sentence to make a determination described in such sentence shall be referred to in this subsection as the “certified IDR entity” with respect to such determination.

(5) Payment determination

(A) In general

Not later than 30 days after the date of selection of the certified IDR entity with respect to a determination for a qualified IDR item or service, the certified IDR entity shall-

(i) taking into account the considerations specified in subparagraph (C), select one of the offers submitted under subparagraph (B) to be the amount of payment for such item or service determined under this subsection for purposes of subsection (a)(1) or (b)(1), as applicable; and

(ii) notify the provider or facility and the group health plan or health insurance issuer offering group or individual health insurance coverage party to such determination of the offer selected under clause (i).

(B) Submission of offers

Not later than 10 days after the date of selection of the certified IDR entity with respect to a determination for a qualified IDR item or service, the provider or facility and the group health plan or health insurance issuer offering group or individual health insurance coverage party to such determination-

(i) shall each submit to the certified IDR entity with respect to such determination-

(I) an offer for a payment amount for such item or service furnished by such provider or facility; and

(II) such information as requested by the certified IDR entity relating to such offer; and

(ii) may each submit to the certified IDR entity with respect to such determination any information relating to such offer submitted by either

party, including information relating to any circumstance described in subparagraph (C)(ii).

(C) Considerations in determination

(i) In general

In determining which offer is the payment to be applied pursuant to this paragraph, the certified IDR entity, with respect to the determination for a qualified IDR item or service shall consider-

(I) the qualifying payment amounts (as defined in subsection (a)(3)(E)) for the applicable year for items or services that are comparable to the qualified IDR item or service and that are furnished in the same geographic region (as defined by the Secretary for purposes of such subsection) as such qualified IDR item or service; and

(II) subject to subparagraph (D), information on any circumstance described in clause (ii), such information as requested in subparagraph (B)(i)(II), and any additional information provided in subparagraph (B)(ii).

(ii) Additional circumstances

For purposes of clause (i)(II), the circumstances described in this clause are, with respect to a qualified IDR item or service of a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer of group or individual health insurance coverage the following:

(I) The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished such item or service (such as those endorsed by the consensus-based entity

authorized in section 1890 of the Social Security Act [42 U.S.C. 1395aaa]).

(II) The market share held by the nonparticipating provider or facility or that of the plan or issuer in the geographic region in which the item or service was provided.

(III) The acuity of the individual receiving such item or service or the complexity of furnishing such item or service to such individual.

(IV) The teaching status, case mix, and scope of services of the nonparticipating facility that furnished such item or service.

(V) Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network agreements and, if applicable, contracted rates between the provider or facility, as applicable, and the plan or issuer, as applicable, during the previous 4 plan years.

(D) Prohibition on consideration of certain factors

In determining which offer is the payment to be applied with respect to qualified IDR items and services furnished by a provider or facility, the certified IDR entity with respect to a determination shall not consider usual and customary charges, the amount that would have been billed by such provider or facility with respect to such items and services had the provisions of section 300gg–131 or 300gg–132 of this title (as applicable) not applied, or the payment or reimbursement rate for such items and services furnished by such provider or facility payable by a public payor, including under the Medicare program

under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], under the Medicaid program under title XIX of such Act [42 U.S.C. 1396 et seq.], under the Children's Health Insurance Program under title XXI of such Act [42 U.S.C. 1397aa et seq.], under the TRICARE program under chapter 55 of title 10, or under chapter 17 of title 38.

(E) Effects of determination

(i) In general

A determination of a certified IDR entity under subparagraph (A)-

(I) shall be binding upon the parties involved, in the absence of a fraudulent claim or evidence of misrepresentation of facts presented to the IDR entity involved regarding such claim; and

(II) shall not be subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a) of title 9.

(ii) Suspension of certain subsequent IDR requests

In the case of a determination of a certified IDR entity under subparagraph (A), with respect to an initial notification submitted under paragraph (1)(B) with respect to qualified IDR items and services and the two parties involved with such notification, the party that submitted such notification may not submit during the 90-day period following such determination a subsequent notification under such paragraph involving the same other party to such notification with respect to such an item or service that was the subject of such initial notification.

(iii) Subsequent submission of requests permitted

In the case of a notification that pursuant to clause (ii) is not permitted to be submitted under paragraph (1)(B) during a 90-day period specified in such clause, if the end of the open negotiation period specified in paragraph (1)(A), that but for this clause would otherwise apply with respect to such notification, occurs during such 90-day period, such paragraph (1)(B) shall be applied as if the reference in such paragraph to the 4-day period beginning on the day after such open negotiation period were instead a reference to the 30-day period beginning on the day after the last day of such 90-day period.

(iv) Reports

The Secretary, jointly with the Secretary of Labor and the Secretary of the Treasury, shall examine the impact of the application of clause (ii) and whether the application of such clause delays payment determinations or impacts early, alternative resolution of claims (such as through open negotiations), and shall submit to Congress, not later than 2 years after the date of implementation of such clause an interim report (and not later than 4 years after such date of implementation, a final report) on whether any group health plans or health insurance issuers offering group or individual health insurance coverage or types of such plans or coverage have a pattern or practice of routine denial, low payment, or down-coding of claims, or otherwise abuse the 90-day period described in such clause, including recommendations on ways to discourage such a pattern or practice.

(F) Costs of independent dispute resolution process

In the case of a notification under paragraph (1)(B) submitted by a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer offering group or individual health insurance coverage and submitted to a certified IDR entity-

(i) if such entity makes a determination with respect to such notification under subparagraph (A), the party whose offer is not chosen under such subparagraph shall be responsible for paying all fees charged by such entity; and

(ii) if the parties reach a settlement with respect to such notification prior to such a determination, each party shall pay half of all fees charged by such entity, unless the parties otherwise agree.

(6) Timing of payment

The total plan or coverage payment required pursuant to subsection (a)(1) or (b)(1), with respect to a qualified IDR item or service for which a determination is made under paragraph (5)(A) or with respect to an item or service for which a payment amount is determined under open negotiations under paragraph (1), shall be made directly to the nonparticipating provider or facility not later than 30 days after the date on which such determination is made.

(7) Publication of information relating to the IDR process

(A) Publication of information

For each calendar quarter in 2022 and each calendar quarter in a subsequent year, the Secretary shall make available on the public website of the Department of Health and Human Services-

(i) the number of notifications submitted under paragraph (1)(B) during such calendar quarter;

(ii) the size of the provider practices and the size of the facilities submitting notifications under paragraph (1)(B) during such calendar quarter;

(iii) the number of such notifications with respect to which a determination was made under paragraph (5)(A);

(iv) the information described in subparagraph (B) with respect to each notification with respect to which such a determination was so made;

(v) the number of times the payment amount determined (or agreed to) under this subsection exceeds the qualifying payment amount, specified by items and services;

(vi) the amount of expenditures made by the Secretary during such calendar quarter to carry out the IDR process;

(vii) the total amount of fees paid under paragraph (8) during such calendar quarter; and

(viii) the total amount of compensation paid to certified IDR entities under paragraph (5)(F) during such calendar quarter.

(B) Information

For purposes of subparagraph (A), the information described in this subparagraph is, with respect to a notification under paragraph (1)(B) by a

nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer offering group or individual health insurance coverage-

(i) a description of each item and service included with respect to such notification;

(ii) the geography in which the items and services with respect to such notification were provided;

(iii) the amount of the offer submitted under paragraph (5)(B) by the group health plan or health insurance issuer (as applicable) and by the nonparticipating provider or nonparticipating emergency facility (as applicable) expressed as a percentage of the qualifying payment amount;

(iv) whether the offer selected by the certified IDR entity under paragraph (5) to be the payment applied was the offer submitted by such plan or issuer (as applicable) or by such provider or facility (as applicable) and the amount of such offer so selected expressed as a percentage of the qualifying payment amount;

(v) the category and practice specialty of each such provider or facility involved in furnishing such items and services;

(vi) the identity of the health plan or health insurance issuer, provider, or facility, with respect to the notification;

(vii) the length of time in making each determination;

(viii) the compensation paid to the certified IDR entity with respect to the settlement or determination; and

(ix) any other information specified by the Secretary.

(C) IDR entity requirements

For 2022 and each subsequent year, an IDR entity, as a condition of certification as an IDR entity, shall submit to the Secretary such information as the Secretary determines necessary to carry out the provisions of this subsection.

(D) Clarification

The Secretary shall ensure the public reporting under this paragraph does not contain information that would disclose privileged or confidential information of a group health plan or health insurance issuer offering group or individual health insurance coverage or of a provider or facility.

(8) Administrative fee

(A) In general

Each party to a determination under paragraph (5) to which an entity is selected under paragraph (3) in a year shall pay to the Secretary, at such time and in such manner as specified by the Secretary, a fee for participating in the IDR process with respect to such determination in an amount described in subparagraph (B) for such year.

(B) Amount of fee

The amount described in this subparagraph for a year is an amount established by the Secretary in a manner such that the total amount of fees paid under this paragraph for such year is estimated to be equal

to the amount of expenditures estimated to be made by the Secretary for such year in carrying out the IDR process.

(9) Waiver authority

The Secretary may modify any deadline or other timing requirement specified under this subsection (other than the establishment date for the IDR process under paragraph (2)(A) and other than under paragraph (6)) in cases of extenuating circumstances, as specified by the Secretary, or to ensure that all claims that occur during a 90-day period described in paragraph (5)(E)(ii), but with respect to which a notification is not permitted by reason of such paragraph to be submitted under paragraph (1)(B) during such period, are eligible for the IDR process.

(d) Certain access fees to certain databases

In the case of a sponsor of a group health plan or health insurance issuer offering group or individual health insurance coverage that, pursuant to subsection (a)(3)(E)(iii), uses a database described in such subsection to determine a rate to apply under such subsection for an item or service by reason of having insufficient information described in such subsection with respect to such item or service, such sponsor or issuer shall cover the cost for access to such database.

(e) Transparency regarding in-network and out-of-network deductibles and out-of-pocket limitations

A group health plan or a health insurance issuer offering group or individual health insurance coverage and providing or covering any benefit with respect to items or services shall include, in clear

writing, on any physical or electronic plan or insurance identification card issued to the participants, beneficiaries, or enrollees in the plan or coverage the following:

(1) Any deductible applicable to such plan or coverage.

(2) Any out-of-pocket maximum limitation applicable to such plan or coverage.

(3) A telephone number and Internet website address through which such individual may seek consumer assistance information, such as information related to hospitals and urgent care facilities that have in effect a contractual relationship with such plan or coverage for furnishing items and services under such plan or coverage 6

(f) Advanced explanation of benefits

(1) In general

For plan years beginning on or after January 1, 2022, each group health plan, or a health insurance issuer offering group or individual health insurance coverage shall, with respect to a notification submitted under section 300gg-136 of this title by a health care provider or health care facility to the plan or issuer for a participant, beneficiary, or enrollee under plan or coverage scheduled to receive an item or service from the provider or facility (or authorized representative of such participant, beneficiary, or enrollee), not later than 1 business day (or, in the case such item or service was so scheduled at least 10 business days before such item or service is to be furnished (or in the case of a request made to such plan or coverage by such participant, beneficiary, or

enrollee), 3 business days) after the date on which the plan or coverage receives such notification (or such request), provide to the participant, beneficiary, or enrollee (through mail or electronic means, as requested by the participant, beneficiary, or enrollee) a notification (in clear and understandable language) including the following:

(A) Whether or not the provider or facility is a participating provider or a participating facility with respect to the plan or coverage with respect to the furnishing of such item or service and-

(i) in the case the provider or facility is a participating provider or facility with respect to the plan or coverage with respect to the furnishing of such item or service, the contracted rate under such plan or coverage for such item or service (based on the billing and diagnostic codes provided by such provider or facility); and

(ii) in the case the provider or facility is a nonparticipating provider or facility with respect to such plan or coverage, a description of how such individual may obtain information on providers and facilities that, with respect to such plan or coverage, are participating providers and facilities, if any.

(B) The good faith estimate included in the notification received from the provider or facility (if applicable) based on such codes.

(C) A good faith estimate of the amount the plan or coverage is responsible for paying for items and services included in the estimate described in subparagraph (B).

(D) A good faith estimate of the amount of any cost-sharing for which the participant,

beneficiary, or enrollee would be responsible for such item or service (as of the date of such notification).

(E) A good faith estimate of the amount that the participant, beneficiary, or enrollee has incurred toward meeting the limit of the financial responsibility (including with respect to deductibles and out-of-pocket maximums) under the plan or coverage (as of the date of such notification).

(F) In the case such item or service is subject to a medical management technique (including concurrent review, prior authorization, and step-therapy or fail-first protocols) for coverage under the plan or coverage, a disclaimer that coverage for such item or service is subject to such medical management technique.

(G) A disclaimer that the information provided in the notification is only an estimate based on the items and services reasonably expected, at the time of scheduling (or requesting) the item or service, to be furnished and is subject to change.

(H) Any other information or disclaimer the plan or coverage determines appropriate that is consistent with information and disclaimers required under this section.

(2) Authority to modify timing requirements in the case of specified items and services

(A) In general

In the case of a participant, beneficiary, or enrollee scheduled to receive an item or service that is a specified item or service (as defined in subparagraph (B)), the Secretary may modify any timing

requirements relating to the provision of the notification described in paragraph (1) to such participant, beneficiary, or enrollee with respect to such item or service. Any modification made by the Secretary pursuant to the previous sentence may not result in the provision of such notification after such participant, beneficiary, or enrollee has been furnished such item or service.

**(B) Specified item or service
defined**

For purposes of subparagraph (A), the term “specified item or service” means an item or service that has low utilization or significant variation in costs (such as when furnished as part of a complex treatment), as specified by the Secretary.

(July 1, 1944, ch. 373, title XXVII, §2799A–1, as added and amended Pub. L. 116–260, div. BB, title I, §§102(a)(1), 103(a), 107(a), 111(a), Dec. 27, 2020, 134 Stat. 2759 , 2797, 2858, 2861.)

42 U.S.C. § 300gg-112: Ending surprise air ambulance bills

§300gg–112. Ending surprise air ambulance bills**(a) In general**

In the case of a participant, beneficiary, or enrollee who is in a group health plan or group or individual health insurance coverage offered by a health insurance issuer and who receives air ambulance services from a nonparticipating provider (as defined in section 300gg–111(a)(3)(G) of this title) with respect to such plan or coverage, if such services would be covered if provided by a participating provider (as defined in such section) with respect to such plan or coverage-

(1) the cost-sharing requirement with respect to such services shall be the same requirement that would apply if such services were provided by such a participating provider, and any coinsurance or deductible shall be based on rates that would apply for such services if they were furnished by such a participating provider;

(2) such cost-sharing amounts shall be counted towards the in-network deductible and in-network out-of-pocket maximum amount under the plan or coverage for the plan year (and such in-network deductible shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider; and

(3) the group health plan or health insurance issuer, respectively, shall-

(A) not later than 30 calendar days after the bill for such services is transmitted by such provider, send to the provider, an initial payment or notice of denial of payment; and

(B) pay a total plan or coverage payment, in accordance with, if applicable, subsection (b)(6), directly to such provider furnishing such services to such participant, beneficiary, or enrollee that is, with application of any initial payment under subparagraph (A), equal to the amount by which the out-of-network rate (as defined in section 300gg-111(a)(3)(K) of this title) for such services and year involved exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such services (as determined in accordance with paragraphs (1) and (2)).

(b) Determination of out-of-network rates to be paid by health plans; independent dispute resolution process

(1) Determination through open negotiation

(A) In general

With respect to air ambulance services furnished in a year by a nonparticipating provider, with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage, and for which a payment is required to be made by the plan or coverage pursuant to subsection (a)(3), the provider or plan or coverage may, during the 30-day period beginning on the day the provider receives an initial payment or a notice of denial of

payment from the plan or coverage regarding a claim for payment for such service, initiate open negotiations under this paragraph between such provider and plan or coverage for purposes of determining, during the open negotiation period, an amount agreed on by such provider, and such plan or coverage for payment (including any cost-sharing) for such service. For purposes of this subsection, the open negotiation period, with respect to air ambulance services, is the 30-day period beginning on the date of initiation of the negotiations with respect to such services.

(B) Accessing independent dispute resolution process in case of failed negotiations

In the case of open negotiations pursuant to subparagraph (A), with respect to air ambulance services, that do not result in a determination of an amount of payment for such services by the last day of the open negotiation period described in such subparagraph with respect to such services, the provider or group health plan or health insurance issuer offering group or individual health insurance coverage that was party to such negotiations may, during the 4-day period beginning on the day after such open negotiation period, initiate the independent dispute resolution process under paragraph (2) with respect to such item or service. The independent dispute resolution process shall be initiated by a party pursuant to the previous sentence by submission to the other party and to the Secretary of a notification (containing such information as specified by the Secretary) and for

purposes of this subsection, the date of initiation of such process shall be the date of such submission or such other date specified by the Secretary pursuant to regulations that is not later than the date of receipt of such notification by both the other party and the Secretary.

(2) Independent dispute resolution process available in case of failed open negotiations

(A) Establishment

Not later than 1 year after December 27, 2020, the Secretary, jointly with the Secretary of Labor and the Secretary of the Treasury, shall establish by regulation one independent dispute resolution process (referred to in this subsection as the “IDR process”) under which, in the case of air ambulance services with respect to which a provider or group health plan or health insurance issuer offering group or individual health insurance coverage submits a notification under paragraph (1)(B) (in this subsection referred to as a “qualified IDR air ambulance services”), a certified IDR entity under paragraph (4) determines, subject to subparagraph (B) and in accordance with the succeeding provisions of this subsection, the amount of payment under the plan or coverage for such services furnished by such provider.

(B) Authority to continue negotiations

Under the independent dispute resolution process, in the case that the parties to a determination for qualified IDR air ambulance services agree on a payment amount for such services during such process but before the date

on which the entity selected with respect to such determination under paragraph (4) makes such determination under paragraph (5), such amount shall be treated for purposes of section 300gg–111(a)(3)(K)(ii) of this title as the amount agreed to by such parties for such services. In the case of an agreement described in the previous sentence, the independent dispute resolution process shall provide for a method to determine how to allocate between the parties to such determination the payment of the compensation of the entity selected with respect to such determination.

(C) Clarification

A nonparticipating provider may not, with respect to an item or service furnished by such provider, submit a notification under paragraph (1)(B) if such provider is exempt from the requirement under subsection (a) of section 300gg–132 of this title with respect to such item or service pursuant to subsection (b) of such section.

(3) Treatment of batching of services

The provisions of section 300gg–111(c)(3) of this title shall apply with respect to a notification submitted under this subsection with respect to air ambulance services in the same manner and to the same extent such provisions apply with respect to a notification submitted under section 300gg–111(c) of this title with respect to items and services described in such section.

(4) IDR entities**(A) Eligibility**

An IDR entity certified under this subsection is an IDR entity certified under section 300gg–111(c)(4) of this title.

(B) Selection of certified IDR entity

The provisions of subparagraph (F) of section 300gg–111(c)(4) of this title shall apply with respect to selecting an IDR entity certified pursuant to subparagraph (A) with respect to the determination of the amount of payment under this subsection of air ambulance services in the same manner as such provisions apply with respect to selecting an IDR entity certified under such section with respect to the determination of the amount of payment under section 300gg–111(c) of this title of an item or service. An entity selected pursuant to the previous sentence to make a determination described in such sentence shall be referred to in this subsection as the “certified IDR entity” with respect to such determination.

(5) Payment determination**(A) In general**

Not later than 30 days after the date of selection of the certified IDR entity with respect to a determination for qualified IDR ambulance services, the certified IDR entity shall-

(i) taking into account the considerations specified in subparagraph (C), select one of the offers submitted under subparagraph (B) to be the amount of payment for such services

determined under this subsection for purposes of subsection (a)(3); and

(ii) notify the provider or facility and the group health plan or health insurance issuer offering group or individual health insurance coverage party to such determination of the offer selected under clause (i).

(B) Submission of offers

Not later than 10 days after the date of selection of the certified IDR entity with respect to a determination for qualified IDR air ambulance services, the provider and the group health plan or health insurance issuer offering group or individual health insurance coverage party to such determination-

(i) shall each submit to the certified IDR entity with respect to such determination-

(I) an offer for a payment amount for such services furnished by such provider; and

(II) such information as requested by the certified IDR entity relating to such offer; and

(ii) may each submit to the certified IDR entity with respect to such determination any information relating to such offer submitted by either party, including information relating to any circumstance described in subparagraph (C)(ii).

(C) Considerations in determination

(i) In general

In determining which offer is the payment to be applied pursuant to this paragraph, the

certified IDR entity, with respect to the determination for a qualified IDR air ambulance service shall consider-

(I) the qualifying payment amounts (as defined in section 300gg-111(a)(3)(E) of this title) for the applicable year for items or services that are comparable to the qualified IDR air ambulance service and that are furnished in the same geographic region (as defined by the Secretary for purposes of such subsection) as such qualified IDR air ambulance service; and

(II) subject to clause (iii), information on any circumstance described in clause (ii), such information as requested in subparagraph (B)(i)(II), and any additional information provided in subparagraph (B)(ii).

(ii) Additional circumstances

For purposes of clause (i)(II), the circumstances described in this clause are, with respect to air ambulance services included in the notification submitted under paragraph (1)(B) of a nonparticipating provider, group health plan, or health insurance issuer the following:

(I) The quality and outcomes measurements of the provider that furnished such services.

(II) The acuity of the individual receiving such services or the complexity of furnishing such services to such individual.

(III) The training, experience, and quality of the medical personnel that furnished such services.

(IV) Ambulance vehicle type, including the clinical capability level of such vehicle.

(V) Population density of the pick up location (such as urban, suburban, rural, or frontier).

(VI) Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network agreements and, if applicable, contracted rates between the provider and the plan or issuer, as applicable, during the previous 4 plan years.

(iii) Prohibition on consideration of certain factors

In determining which offer is the payment amount to be applied with respect to qualified IDR air ambulance services furnished by a provider, the certified IDR entity with respect to such determination shall not consider usual and customary charges, the amount that would have been billed by such provider with respect to such services had the provisions of section 300gg–135 of this title not applied, or the payment or reimbursement rate for such services furnished by such provider payable by a public payor, including under the Medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], under the Medicaid program under title XIX of such Act

[42 U.S.C. 1396 et seq.], under the Children's Health Insurance Program under title XXI of such Act [42 U.S.C. 1397aa et seq.], under the TRICARE program under chapter 55 of title 10, or under chapter 17 of title 38.

(D) Effects of determination

The provisions of section 300gg–111(c)(5)(E) of this title shall apply with respect to a determination of a certified IDR entity under subparagraph (A), the notification submitted with respect to such determination, the services with respect to such notification, and the parties to such notification in the same manner as such provisions apply with respect to a determination of a certified IDR entity under section 300gg–111(c)(5)(E) of this title, the notification submitted with respect to such determination, the items and services with respect to such notification, and the parties to such notification.

(E) Costs of independent dispute resolution process

The provisions of section 300gg–111(c)(5)(F) of this title shall apply to a notification made under this subsection, the parties to such notification, and a determination under subparagraph (A) in the same manner and to the same extent such provisions apply to a notification under section 300gg–111(c) of this title, the parties to such notification and a determination made under section 300gg–111(c)(5)(A) of this title.

(6) Timing of payment

The total plan or coverage payment required pursuant to subsection (a)(3), with respect to

qualified IDR air ambulance services for which a determination is made under paragraph (5)(A) or with respect to an air ambulance service for which a payment amount is determined under open negotiations under paragraph (1), shall be made directly to the nonparticipating provider not later than 30 days after the date on which such determination is made.

(7) Publication of information relating to the IDR process

(A) In general

For each calendar quarter in 2022 and each calendar quarter in a subsequent year, the Secretary shall publish on the public website of the Department of Health and Human Services-

(i) the number of notifications submitted under the IDR process during such calendar quarter;

(ii) the number of such notifications with respect to which a final determination was made under paragraph (5)(A);

(iii) the information described in subparagraph (B) with respect to each notification with respect to which such a determination was so made.

(iv) the number of times the payment amount determined (or agreed to) under this subsection exceeds the qualifying payment amount;

(v) the amount of expenditures made by the Secretary during such calendar quarter to carry out the IDR process;

(vi) the total amount of fees paid under paragraph (8) during such calendar quarter; and

(vii) the total amount of compensation paid to certified IDR entities under paragraph (5)(E) during such calendar quarter.

(B) Information with respect to requests

For purposes of subparagraph (A), the information described in this subparagraph is, with respect to a notification under the IDR process of a nonparticipating provider, group health plan, or health insurance issuer offering group or individual health insurance coverage-

(i) a description of each air ambulance service included in such notification;

(ii) the geography in which the services included in such notification were provided;

(iii) the amount of the offer submitted under paragraph (2) by the group health plan or health insurance issuer (as applicable) and by the nonparticipating provider expressed as a percentage of the qualifying payment amount;

(iv) whether the offer selected by the certified IDR entity under paragraph (5) to be the payment applied was the offer submitted by such plan or issuer (as applicable) or by such provider and the amount of such offer so selected expressed as a percentage of the qualifying payment amount;

(v) ambulance vehicle type, including the clinical capability level of such vehicle;

(vi) the identity of the group health plan or health insurance issuer or air ambulance provider with respect to such notification;

(vii) the length of time in making each determination;

(viii) the compensation paid to the certified IDR entity with respect to the settlement or determination; and

(ix) any other information specified by the Secretary.

(C) IDR entity requirements

For 2022 and each subsequent year, an IDR entity, as a condition of certification as an IDR entity, shall submit to the Secretary such information as the Secretary determines necessary for the Secretary to carry out the provisions of this paragraph.

(D) Clarification

The Secretary shall ensure the public reporting under this paragraph does not contain information that would disclose privileged or confidential information of a group health plan or health insurance issuer offering group or individual health insurance coverage or of a provider or facility.

(8) Administrative fee

(A) In general

Each party to a determination under paragraph (5) to which an entity is selected under paragraph (4) in a year shall pay to the Secretary, at such time and in such manner as specified by the Secretary, a fee for participating in the IDR

process with respect to such determination in an amount described in subparagraph (B) for such year.

(B) Amount of fee

The amount described in this subparagraph for a year is an amount established by the Secretary in a manner such that the total amount of fees paid under this paragraph for such year is estimated to be equal to the amount of expenditures estimated to be made by the Secretary for such year in carrying out the IDR process.

(9) Waiver authority

The Secretary may modify any deadline or other timing requirement specified under this subsection (other than the establishment date for the IDR process under paragraph (2)(A) and other than under paragraph (6)) in cases of extenuating circumstances, as specified by the Secretary, or to ensure that all claims that occur during a 90-day period applied through paragraph (5)(D), but with respect to which a notification is not permitted by reason of such paragraph to be submitted under paragraph (1)(B) during such period, are eligible for the IDR process.

(c) Definitions

For purposes of this section:

(1) Air ambulance service

The term “air ambulance service” means medical transport by helicopter or airplane for patients.

(2) Qualifying payment amount

The term “qualifying payment amount” has the meaning given such term in section 300gg–111(a)(3) of this title.

(3) Nonparticipating provider

The term “nonparticipating provider” has the meaning given such term in section 300gg–111(a)(3) of this title. (July 1, 1944, ch. 373, title XXVII, §2799A–2, as added Pub. L. 116–260, div. BB, title I, §105(a)(1), Dec. 27, 2020, 134 Stat. 2831 .)

29 U.S.C. § 1185e: Preventing surprise medical bills**§1185e. Preventing surprise medical bills****(a) Coverage of emergency services****(1) In general**

If a group health plan, or a health insurance issuer offering group health insurance coverage, provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department (as defined in paragraph (3)(D)), the plan or issuer shall cover emergency services (as defined in paragraph (3)(C))-

(A) without the need for any prior authorization determination;

(B) whether the health care provider furnishing such services is a participating provider or a participating emergency facility, as applicable, with respect to such services;

(C) in a manner so that, if such services are provided to a participant or beneficiary by a nonparticipating provider or a nonparticipating emergency facility-

(i) such services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency

facilities with respect to such plan or coverage, respectively;

(ii) the cost-sharing requirement is not greater than the requirement that would apply if such services were provided by a participating provider or a participating emergency facility;

(iii) such cost-sharing requirement is calculated as if the total amount that would have been charged for such services by such participating provider or participating emergency facility were equal to the recognized amount (as defined in paragraph (3)(H)) for such services, plan or coverage, and year;

(iv) the group health plan or health insurance issuer, respectively-

(I) not later than 30 calendar days after the bill for such services is transmitted by such provider or facility, sends to the provider or facility, as applicable, an initial payment or notice of denial of payment; and

(II) pays a total plan or coverage payment directly to such provider or facility, respectively (in accordance, if applicable, with the timing requirement described in subsection (c)(6)) that is, with application of any initial payment under subclause (I), equal to the amount by which the out-of-network rate (as defined in paragraph (3)(K)) for such services exceeds the cost-sharing amount for such services (as determined in accordance with clauses (ii) and (iii)) and year; and

(v) any cost-sharing payments made by the participant or beneficiary with respect to such emergency services so furnished shall be counted toward any in-network deductible or out-of-pocket maximums applied under the plan or coverage, respectively (and such in-network deductible and out-of-pocket maximums shall be applied) in the same manner as if such cost-sharing payments were made with respect to emergency services furnished by a participating provider or a participating emergency facility; and

(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 300gg-3 of title 42, including as incorporated pursuant to section 1185d of this title and section 9815 of title 26, and other than applicable cost-sharing).

(2) Regulations for qualifying payment amounts

Not later than July 1, 2021, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Health and Human Services, shall establish through rulemaking-

(A) the methodology the group health plan or health insurance issuer offering health insurance coverage in the group market shall use to determine the qualifying payment amount, differentiating by large group market, and small group market;

(B) the information such plan or issuer, respectively, shall share with the

nonparticipating provider or nonparticipating facility, as applicable, when making such a determination;

(C) the geographic regions applied for purposes of this subparagraph, taking into account access to items and services in rural and underserved areas, including health professional shortage areas, as defined in section 254e of title 42; and

(D) a process to receive complaints of violations of the requirements described in subclauses (I) and (II) of subparagraph (A)(i) by group health plans and health insurance issuers offering health insurance coverage in the group market.

Such rulemaking shall take into account payments that are made by such plan or issuer, respectively, that are not on a fee-for-service basis. Such methodology may account for relevant payment adjustments that take into account quality or facility type (including higher acuity settings and the case-mix of various facility types) that are otherwise taken into account for purposes of determining payment amounts with respect to participating facilities. In carrying out clause (iii), the Secretary shall consult with the National Association of Insurance Commissioners to establish the geographic regions under such clause and shall periodically update such regions, as appropriate, taking into account the findings of the report submitted under section 109(a) of the No Surprises Act.

(3) Definitions

In this subpart:

(A) Emergency department of a hospital

The term “emergency department of a hospital” includes a hospital outpatient department that provides emergency services (as defined in subparagraph (C)(i)).

(B) Emergency medical condition

The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act [42 U.S.C. 1395dd(e)(1)(A)].

(C) Emergency services**(i) In general**

The term “emergency services”, with respect to an emergency medical condition, means

(I) a medical screening examination (as required under section 1867 of the Social Security Act [42 U.S.C. 1395dd], or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to

evaluate such emergency medical condition;
and

(II) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required under section 1867 of such Act [42 U.S.C. 1395dd], or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

(ii) Inclusion of additional services

(I) In general

For purposes of this subsection and section 300gg–131 of title 42, in the case of a participant or beneficiary who is enrolled in a group health plan or group health insurance coverage offered by a health insurance issuer and who is furnished services described in clause (i) with respect to an emergency medical condition, the term “emergency services” shall include, unless each of the conditions described in subclause (II) are met, in addition to the items and services described in clause (i), items and services-

(aa) for which benefits are provided or covered under the plan or coverage, respectively; and

(bb) that are furnished by a nonparticipating provider or nonparticipating emergency facility (regardless of the department of the hospital in which such items or services are furnished) after the participant or beneficiary is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in clause (i) are furnished.

(II) Conditions

For purposes of subclause (I), the conditions described in this subclause, with respect to a participant or beneficiary who is stabilized and furnished additional items and services described in subclause (I) after such stabilization by a provider or facility described in subclause (I), are the following;

(aa) Such provider or facility determines such individual is able to travel using nonmedical transportation or nonemergency medical transportation.

(bb) Such provider furnishing such additional items and services satisfies the notice and consent criteria of section 300gg–132(d) 1 of title 42 with respect to such items and services.

(cc) Such individual is in a condition to receive (as determined in accordance with guidelines issued by the Secretary pursuant to rulemaking) the information described in section 300gg–132 1 of title 42

and to provide informed consent under such section, in accordance with applicable State law.

(dd) Such other conditions, as specified by the Secretary, such as conditions relating to coordinating care transitions to participating providers and facilities.

(D) Independent freestanding emergency department

The term “independent freestanding emergency department” means a health care facility that-

(i) is geographically separate and distinct and licensed separately from a hospital under applicable State law; and

(ii) provides any of the emergency services (as defined in subparagraph (C)(i)).

(E) Qualifying payment amount

(i) In general

The term “qualifying payment amount” means, subject to clauses (ii) and (iii), with respect to a sponsor of a group health plan and health insurance issuer offering group health insurance coverage-

(I) for an item or service furnished during 2022, the median of the contracted rates recognized by the plan or issuer, respectively (determined with respect to all such plans of such sponsor or all such coverage offered by such issuer that are offered within the same insurance market (specified in subclause (I), (II), or (III) of clause (iv)) as the plan or

coverage) as the total maximum payment (including the cost-sharing amount imposed for such item or service and the amount to be paid by the plan or issuer, respectively) under such plans or coverage, respectively, on January 31, 2019, for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished, consistent with the methodology established by the Secretary under paragraph (2), increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over 2019, such percentage increase over 2020, and such percentage increase over 2021; and

(II) for an item or service furnished during 2023 or a subsequent year, the qualifying payment amount determined under this clause for such an item or service furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

(ii) New plans and coverage

The term “qualifying payment amount” means, with respect to a sponsor of a group health plan or health insurance issuer offering group health insurance coverage in a geographic region in which such sponsor or issuer, respectively, did not offer any group

health plan or health insurance coverage during 2019-

(I) for the first year in which such group health plan or health insurance coverage, respectively, is offered in such region, a rate (determined in accordance with a methodology established by the Secretary) for items and services that are covered by such plan and furnished during such first year; and

(II) for each subsequent year such group health plan or health insurance coverage, respectively, is offered in such region, the qualifying payment amount determined under this clause for such items and services furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

(iii) Insufficient information; newly covered items and services

In the case of a sponsor of a group health plan or health insurance issuer offering group health insurance coverage that does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019 (or, in the case of a newly covered item or service (as defined in clause (v)(III)), in the first coverage year (as defined in clause (v)(I)) for such item or service with respect to such plan or coverage) for an item or service (including with respect to provider type, or amount, of claims for items or services (as

determined by the Secretary) provided in a particular geographic region (other than in a case with respect to which clause (ii) applies)) the term “qualifying payment amount”-

(I) for an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for such item or service with respect to such plan or coverage), means such rate for such item or service determined by the sponsor or issuer, respectively, through use of any database that is determined, in accordance with rulemaking described in paragraph (2), to not have any conflicts of interest and to have sufficient information reflecting allowed amounts paid to a health care provider or facility for relevant services furnished in the applicable geographic region (such as a State all-payer claims database);

(II) for an item or service furnished in a subsequent year (before the first sufficient information year (as defined in clause (v)(II)) for such item or service with respect to such plan or coverage), means the rate determined under subclause (I) or this subclause, as applicable, for such item or service for the year previous to such subsequent year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year;

(III) for an item or service furnished in the first sufficient information year for such item

or service with respect to such plan or coverage, has the meaning given the term qualifying payment amount in clause (i)(I), except that in applying such clause to such item or service, the reference to “furnished during 2022” shall be treated as a reference to furnished during such first sufficient information year, the reference to “in 2019” shall be treated as a reference to such sufficient information year, and the increase described in such clause shall not be applied; and

(IV) for an item or service furnished in any year subsequent to the first sufficient information year for such item or service with respect to such plan or coverage, has the meaning given such term in clause (i)(II), except that in applying such clause to such item or service, the reference to “furnished during 2023 or a subsequent year” shall be treated as a reference to furnished during the year after such first sufficient information year or a subsequent year.

(iv) Insurance market

For purposes of clause (i)(I), a health insurance market specified in this clause is one of the following:

(I) The large group market (other than plans described in subclause (III)).

(II) The small group market (other than plans described in subclause (III)).

(III) In the case of a self-insured group health plan, other self-insured group health plans.

(v) Definitions

For purposes of this subparagraph:

(I) First coverage year

The term “first coverage year” means, with respect to a group health plan or group health insurance coverage offered by a health insurance issuer and an item or service for which coverage is not offered in 2019 under such plan or coverage, the first year after 2019 for which coverage for such item or service is offered under such plan or health insurance coverage.

(II) First sufficient information year

The term “first sufficient information year” means, with respect to a group health plan or group health insurance coverage offered by a health insurance issuer-

(aa) in the case of an item or service for which the plan or coverage does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019, the first year subsequent to 2022 for which such sponsor or issuer has such sufficient information to calculate the median of such contracted rates in the year previous to such first subsequent year; and

(bb) in the case of a newly covered item or service, the first year subsequent to the

first coverage year for such item or service with respect to such plan or coverage for which the sponsor or issuer has sufficient information to calculate the median of the contracted rates described in clause (i)(I) in the year previous to such first subsequent year.

(III) Newly covered item or service

The term “newly covered item or service” means, with respect to a group health plan or health insurance issuer offering group health insurance coverage, an item or service for which coverage was not offered in 2019 under such plan or coverage, but is offered under such plan or coverage in a year after 2019.

**(F) Nonparticipating emergency facility;
participating emergency facility**

(i) Nonparticipating emergency facility

The term “nonparticipating emergency facility” means, with respect to an item or service and a group health plan or group health insurance coverage offered by a health insurance issuer, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship directly or indirectly with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

(ii) Participating emergency facility

The term “participating emergency facility” means, with respect to an item or service and a group health plan or group health insurance coverage offered by a health insurance issuer, an emergency department of a hospital, or an independent freestanding emergency department, that has a contractual relationship directly or indirectly with the plan or issuer, respectively, with respect to the furnishing of such an item or service at such facility.

**(G) Nonparticipating providers;
participating providers****(i) Nonparticipating provider**

The term “nonparticipating provider” means, with respect to an item or service and a group health plan or group health insurance coverage offered by a health insurance issuer, a physician or other health care provider who is acting within the scope of practice of that provider’s license or certification under applicable State law and who does not have a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

(ii) Participating provider

The term “participating provider” means, with respect to an item or service and a group health plan or group health insurance coverage offered by a health insurance issuer, a physician or other health care provider who is acting within the scope of practice of that

provider's license or certification under applicable State law and who has a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

(H) Recognized amount

The term "recognized amount" means, with respect to an item or service furnished by a nonparticipating provider or nonparticipating emergency facility during a year and a group health plan or group health insurance coverage offered by a health insurance issuer-

(i) subject to clause (iii), in the case of such item or service furnished in a State that has in effect a specified State law with respect to such plan, coverage, or issuer, respectively; such a nonparticipating provider or nonparticipating emergency facility; and such an item or service, the amount determined in accordance with such law;

(ii) subject to clause (iii), in the case of such item or service furnished in a State that does not have in effect a specified State law, with respect to such plan, coverage, or issuer, respectively; such a nonparticipating provider or nonparticipating emergency facility; and such an item or service, the amount that is the qualifying payment amount (as defined in subparagraph (E)) for such year and determined in accordance with rulemaking described in paragraph (2))² for such item or service; or

(iii) in the case of such item or service furnished in a State with an All-Payer Model Agreement under section 1115A of the Social Security Act [42 U.S.C. 1315a], the amount that the State approves under such system for such item or service so furnished.

(I) Specified State law

The term “specified State law” means, with respect to a State, an item or service furnished by a nonparticipating provider or nonparticipating emergency facility during a year and a group health plan or group health insurance coverage offered by a health insurance issuer, a State law that provides for a method for determining the total amount payable under such a plan, coverage, or issuer, respectively (to the extent such State law applies to such plan, coverage, or issuer, subject to section 1144 of this title) in the case of a participant or beneficiary covered under such plan or coverage and receiving such item or service from such a nonparticipating provider or nonparticipating emergency facility.

(J) Stabilize

The term “to stabilize”, with respect to an emergency medical condition (as defined in subparagraph (B)), has the meaning give in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(K) Out-of-network rate

The term “out-of-network rate” means, with respect to an item or service furnished in a State during a year to a participant or beneficiary of a group health plan or group health insurance

coverage offered by a health insurance issuer receiving such item or service from a nonparticipating provider or nonparticipating emergency facility-

(i) subject to clause (iii), in the case of such item or service furnished in a State that has in effect a specified State law with respect to such plan, coverage, or issuer, respectively; such a nonparticipating provider or nonparticipating emergency facility; and such an item or service, the amount determined in accordance with such law;

(ii) subject to clause (iii), in the case such State does not have in effect such a law with respect to such item or service, plan, and provider or facility-

(I) subject to subclause (II), if the provider or facility (as applicable) and such plan or coverage agree on an amount of payment (including if such agreed on amount is the initial payment sent by the plan under subsection (a)(1)(C)(iv)(I), subsection (b)(1)(C), or section 1185f(a)(3)(A) of this title, as applicable, or is agreed on through open negotiations under subsection (c)(1)) with respect to such item or service, such agreed on amount; or

(II) if such provider or facility (as applicable) and such plan or coverage enter the independent dispute resolution process under subsection (c) and do not so agree before the date on which a certified IDR entity (as defined in paragraph (4) of such

subsection) makes a determination with respect to such item or service under such subsection, the amount of such determination; or

(iii) in the case such State has an All-Payer Model Agreement under section 1115A of the Social Security Act [42 U.S.C. 1315a], the amount that the State approves under such system for such item or service so furnished.

(L) Cost-sharing

The term “cost-sharing” includes copayments, coinsurance, and deductibles.

(b) Coverage of non-emergency services performed by nonparticipating providers at certain participating facilities

(1) In general

In the case of items or services (other than emergency services to which subsection (a) applies) for which any benefits are provided or covered by a group health plan or health insurance issuer offering group health insurance coverage furnished to a participant or beneficiary of such plan or coverage by a nonparticipating provider (as defined in subsection (a)(3)(G)(i)) (and who, with respect to such items and services, has not satisfied the notice and consent criteria of section 300gg–132(d) of title 42) with respect to a visit (as defined by the Secretary in accordance with paragraph (2)(B)) at a participating health care facility (as defined in paragraph (2)(A)), with respect to such plan or coverage, respectively, the plan or coverage, respectively-

(A) shall not impose on such participant or beneficiary a cost-sharing requirement for such items and services so furnished that is greater than the cost-sharing requirement that would apply under such plan or coverage, respectively, had such items or services been furnished by a participating provider (as defined in subsection (a)(3) (G)(ii));

(B) shall calculate such cost-sharing requirement as if the total amount that would have been charged for such items and services by such participating provider were equal to the recognized amount (as defined in subsection (a)(3)(H)) for such items and services, plan or coverage, and year;

(C) not later than 30 calendar days after the bill for such items or services is transmitted by such provider, shall send to the provider an initial payment or notice of denial of payment;

(D) shall pay a total plan or coverage payment directly, in accordance, if applicable, with the timing requirement described in subsection (c)(6), to such provider furnishing such items and services to such participant or beneficiary that is, with application of any initial payment under subparagraph (C), equal to the amount by which the out-of-network rate (as defined in subsection (a)(3)(K)) for such items and services exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such items and services (as determined in accordance with subparagraphs (A) and (B)) and year; and

(E) shall count toward any in-network deductible and in-network out-of-pocket maximums (as applicable) applied under the plan or coverage, respectively, any cost-sharing payments made by the participant or beneficiary (and such in-network deductible and out-of-pocket maximums shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider.

(2) Definitions

In this section:

(A) Participating health care facility

(i) In general

The term “participating health care facility” means, with respect to an item or service and a group health plan or health insurance issuer offering group health insurance coverage, a health care facility described in clause (ii) that has a direct or indirect contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such an item or service at the facility.

(ii) Health care facility described

A health care facility described in this clause, with respect to a group health plan or group health insurance coverage, is each of the following:

(I) A hospital (as defined in 1861(e) of the Social Security Act [42 U.S.C. 1395x(e)]).

(II) A hospital outpatient department.

(III) A critical access hospital (as defined in section 1861(mm)(1) of such Act [42 U.S.C. 1395x(mm)(1)]).

(IV) An ambulatory surgical center described in section 1833(i)(1)(A) of such Act [42 U.S.C. 1395l(i)(1)(A)].

(V) Any other facility, specified by the Secretary, that provides items or services for which coverage is provided under the plan or coverage, respectively.

(B) Visit

The term “visit” shall, with respect to items and services furnished to an individual at a health care facility, include equipment and devices, telemedicine services, imaging services, laboratory services, preoperative and postoperative services, and such other items and services as the Secretary may specify, regardless of whether or not the provider furnishing such items or services is at the facility.

(c) Determination of out-of-network rates to be paid by health plans; independent dispute resolution process

(1) Determination through open negotiation

(A) In general

With respect to an item or service furnished in a year by a nonparticipating provider or a nonparticipating facility, with respect to a group health plan or health insurance issuer offering group health insurance coverage, in a State described in subsection (a)(3)(K)(ii) with respect to such plan or coverage and provider or facility,

and for which a payment is required to be made by the plan or coverage pursuant to subsection (a)(1) or (b)(1), the provider or facility (as applicable) or plan or coverage may, during the 30-day period beginning on the day the provider or facility receives an initial payment or a notice of denial of payment from the plan or coverage regarding a claim for payment for such item or service, initiate open negotiations under this paragraph between such provider or facility and plan or coverage for purposes of determining, during the open negotiation period, an amount agreed on by such provider or facility, respectively, and such plan or coverage for payment (including any cost-sharing) for such item or service. For purposes of this subsection, the open negotiation period, with respect to an item or service, is the 30-day period beginning on the date of initiation of the negotiations with respect to such item or service.

(B) Accessing independent dispute resolution process in case of failed negotiations

In the case of open negotiations pursuant to subparagraph (A), with respect to an item or service, that do not result in a determination of an amount of payment for such item or service by the last day of the open negotiation period described in such subparagraph with respect to such item or service, the provider or facility (as applicable) or group health plan or health insurance issuer offering group health insurance coverage that was party to such negotiations may, during the 4-day period beginning on the day

after such open negotiation period, initiate the independent dispute resolution process under paragraph (2) with respect to such item or service. The independent dispute resolution process shall be initiated by a party pursuant to the previous sentence by submission to the other party and to the Secretary of a notification (containing such information as specified by the Secretary) and for purposes of this subsection, the date of initiation of such process shall be the date of such submission or such other date specified by the Secretary pursuant to regulations that is not later than the date of receipt of such notification by both the other party and the Secretary.

(2) Independent dispute resolution process available in case of failed open negotiations

(A) Establishment

Not later than 1 year after December 27, 2020, the Secretary, jointly with the Secretary of Health and Human Services and the Secretary of the Treasury, shall establish by regulation one independent dispute resolution process (referred to in this subsection as the “IDR process”) under which, in the case of an item or service with respect to which a provider or facility (as applicable) or group health plan or health insurance issuer offering group health insurance coverage submits a notification under paragraph (1)(B) (in this subsection referred to as a “qualified IDR item or service”), a certified IDR entity under paragraph (4) determines, subject to subparagraph (B) and in accordance with the succeeding provisions of this subsection, the

amount of payment under the plan or coverage for such item or service furnished by such provider or facility.

(B) Authority to continue negotiations

Under the independent dispute resolution process, in the case that the parties to a determination for a qualified IDR item or service agree on a payment amount for such item or service during such process but before the date on which the entity selected with respect to such determination under paragraph (4) makes such determination under paragraph (5), such amount shall be treated for purposes of subsection (a)(3)(K)(ii) as the amount agreed to by such parties for such item or service. In the case of an agreement described in the previous sentence, the independent dispute resolution process shall provide for a method to determine how to allocate between the parties to such determination the payment of the compensation of the entity selected with respect to such determination.

(C) Clarification

A nonparticipating provider may not, with respect to an item or service furnished by such provider, submit a notification under paragraph (1)(B) if such provider is exempt from the requirement under subsection (a) of section 300gg-132 of title 42 with respect to such item or service pursuant to subsection (b) of such section.

(3) Treatment of batching of items and services**(A) In general**

Under the IDR process, the Secretary shall specify criteria under which multiple qualified IDR dispute items and services are permitted to be considered jointly as part of a single determination by an entity for purposes of encouraging the efficiency (including minimizing costs) of the IDR process. Such items and services may be so considered only if-

(i) such items and services to be included in such determination are furnished by the same provider or facility;

(ii) payment for such items and services is required to be made by the same group health plan or health insurance issuer;

(iii) such items and services are related to the treatment of a similar condition; and

(iv) such items and services were furnished during the 30 day period following the date on which the first item or service included with respect to such determination was furnished or an alternative period as determined by the Secretary, for use in limited situations, such as by the consent of the parties or in the case of low-volume items and services, to encourage procedural efficiency and minimize health plan and provider administrative costs.

(B) Treatment of bundled payments

In carrying out subparagraph (A), the Secretary shall provide that, in the case of items

and services which are included by a provider or facility as part of a bundled payment, such items and services included in such bundled payment may be part of a single determination under this subsection.

(4) Certification and selection of IDR entities

(A) In general

The Secretary, jointly with the Secretary of Health and Human Services and Secretary of the Treasury, shall establish a process to certify (including to recertify) entities under this paragraph. Such process shall ensure that an entity so certified-

(i) has (directly or through contracts or other arrangements) sufficient medical, legal, and other expertise and sufficient staffing to make determinations described in paragraph (5) on a timely basis;

(ii) is not-

(I) a group health plan or health insurance issuer offering group health insurance coverage, provider, or facility;

(II) an affiliate or a subsidiary of such a group health plan or health insurance issuer, provider, or facility; or

(III) an affiliate or subsidiary of a professional or trade association of such group health plans or health insurance issuers or of providers or facilities;

(iii) carries out the responsibilities of such an entity in accordance with this subsection;

(iv) meets appropriate indicators of fiscal integrity;

(v) maintains the confidentiality (in accordance with regulations promulgated by the Secretary) of individually identifiable health information obtained in the course of conducting such determinations;

(vi) does not under the IDR process carry out any determination with respect to which the entity would not pursuant to subclause (I), (II), or (III) of subparagraph (F)(i) be eligible for selection; and

(vii) meets such other requirements as determined appropriate by the Secretary.

(B) Period of certification

Subject to subparagraph (C), each certification (including a recertification) of an entity under the process described in subparagraph (A) shall be for a 5-year period.

(C) Revocation

A certification of an entity under this paragraph may be revoked under the process described in subparagraph (A) if the entity has a pattern or practice of noncompliance with any of the requirements described in such subparagraph.

(D) Petition for denial or withdrawal

The process described in subparagraph (A) shall ensure that an individual, provider, facility, or group health plan or health insurance issuer offering group health insurance coverage may petition for a denial of a certification or a revocation of a certification with respect to an

entity under this paragraph for failure of meeting a requirement of this subsection.

(E) Sufficient number of entities

The process described in subparagraph (A) shall ensure that a sufficient number of entities are certified under this paragraph to ensure the timely and efficient provision of determinations described in paragraph (5).

(F) Selection of certified IDR entity

The Secretary shall, with respect to the determination of the amount of payment under this subsection of an item or service, provide for a method-

(i) that allows for the group health plan or health insurance issuer offering group health insurance coverage and the nonparticipating provider or the nonparticipating emergency facility (as applicable) involved in a notification under paragraph (1)(B) to jointly select, not later than the last day of the 3-business day period following the date of the initiation of the process with respect to such item or service, for purposes of making such determination, an entity certified under this paragraph that-

(I) is not a party to such determination or an employee or agent of such a party;

(II) does not have a material familial, financial, or professional relationship with such a party; and

(III) does not otherwise have a conflict of interest with such a party (as determined by the Secretary); and

(ii) that requires, in the case such parties do not make such selection by such last day, the Secretary to, not later than 6 business days after such date of initiation-

(I) select such an entity that satisfies subclauses (I) through (III) of clause (i)); and

(II) provide notification of such selection to the provider or facility (as applicable) and the plan or issuer (as applicable) party to such determination.

An entity selected pursuant to the previous sentence to make a determination described in such sentence shall be referred to in this subsection as the “certified IDR entity” with respect to such determination.

(5) Payment determination

(A) In general

Not later than 30 days after the date of selection of the certified IDR entity with respect to a determination for a qualified IDR item or service, the certified IDR entity shall-

(i) taking into account the considerations specified in subparagraph (C), select one of the offers submitted under subparagraph (B) to be the amount of payment for such item or service determined under this subsection for purposes of subsection (a)(1) or (b)(1), as applicable; and

(ii) notify the provider or facility and the group health plan or health insurance issuer offering group health insurance coverage party to such determination of the offer selected under clause (i).

(B) Submission of offers

Not later than 10 days after the date of selection of the certified IDR entity with respect to a determination for a qualified IDR item or service, the provider or facility and the group health plan or health insurance issuer offering group health insurance coverage party to such determination-

(i) shall each submit to the certified IDR entity with respect to such determination-

(I) an offer for a payment amount for such item or service furnished by such provider or facility; and

(II) such information as requested by the certified IDR entity relating to such offer; and

(ii) may each submit to the certified IDR entity with respect to such determination any information relating to such offer submitted by either party, including information relating to any circumstance described in subparagraph (C)(ii).

(C) Considerations in determination**(i) In general**

In determining which offer is the payment to be applied pursuant to this paragraph, the certified IDR entity, with respect to the determination for a qualified IDR item or service shall consider-

(I) the qualifying payment amounts (as defined in subsection (a)(3)(E)) for the applicable year for items or services that are

comparable to the qualified IDR item or service and that are furnished in the same geographic region (as defined by the Secretary for purposes of such subsection) as such qualified IDR item or service; and

(II) subject to subparagraph (D), information on any circumstance described in clause (ii), such information as requested in subparagraph (B)(i)(II), and any additional information provided in subparagraph (B)(ii).

(ii) Additional circumstances

For purposes of clause (i)(II), the circumstances described in this clause are, with respect to a qualified IDR item or service of a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer of group health insurance coverage the following:

(I) The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished such item or service (such as those endorsed by the consensus-based entity authorized in section 1890 of the Social Security Act [42 U.S.C. 1395aaa]).

(II) The market share held by the nonparticipating provider or facility or that of the plan or issuer in the geographic region in which the item or service was provided.

(III) The acuity of the individual receiving such item or service or the complexity of

furnishing such item or service to such individual.

(IV) The teaching status, case mix, and scope of services of the nonparticipating facility that furnished such item or service.

(V) Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network agreements and, if applicable, contracted rates between the provider or facility, as applicable, and the plan or issuer, as applicable, during the previous 4 plan years.

(D) Prohibition on consideration of certain factors

In determining which offer is the payment to be applied with respect to qualified IDR items and services furnished by a provider or facility, the certified IDR entity with respect to a determination shall not consider usual and customary charges, the amount that would have been billed by such provider or facility with respect to such items and services had the provisions of section 300gg–131 of title 42 or section 300gg–132 of such title (as applicable) not applied, or the payment or reimbursement rate for such items and services furnished by such provider or facility payable by a public payor, including under the Medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], under the Medicaid program under title XIX of such Act [42 U.S.C. 1396 et seq.], under the

Children's Health Insurance Program under title XXI of such Act [42 U.S.C. 1397aa et seq.], under the TRICARE program under chapter 55 of title 10, or under chapter 17 of title 38.

(E) Effects of determination

(i) In general

A determination of a certified IDR entity under subparagraph (A)-

(I) shall be binding upon the parties involved, in the absence of a fraudulent claim or evidence of misrepresentation of facts presented to the IDR entity involved regarding such claim; and

(II) shall not be subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a) of title 9.

(ii) Suspension of certain subsequent IDR requests

In the case of a determination of a certified IDR entity under subparagraph (A), with respect to an initial notification submitted under paragraph (1)(B) with respect to qualified IDR items and services and the two parties involved with such notification, the party that submitted such notification may not submit during the 90-day period following such determination a subsequent notification under such paragraph involving the same other party to such notification with respect to such an item or service that was the subject of such initial notification.

(iii) Subsequent submission of requests permitted

In the case of a notification that pursuant to clause (ii) is not permitted to be submitted under paragraph (1)(B) during a 90-day period specified in such clause, if the end of the open negotiation period specified in paragraph (1)(A), that but for this clause would otherwise apply with respect to such notification, occurs during such 90-day period, such paragraph (1)(B) shall be applied as if the reference in such paragraph to the 4-day period beginning on the day after such open negotiation period were instead a reference to the 30-day period beginning on the day after the last day of such 90-day period.

(iv) Reports

The Secretary, jointly with the Secretary of Health and Human Services and the Secretary of the Treasury, shall examine the impact of the application of clause (ii) and whether the application of such clause delays payment determinations or impacts early, alternative resolution of claims (such as through open negotiations), and shall submit to Congress, not later than 2 years after the date of implementation of such clause an interim report (and not later than 4 years after such date of implementation, a final report) on whether any group health plans or health insurance issuers offering group or individual health insurance coverage or types of such plans or coverage have a pattern or practice of routine denial, low payment, or down-coding of

claims, or otherwise abuse the 90-day period described in such clause, including recommendations on ways to discourage such a pattern or practice.

(F) Costs of independent dispute resolution process

In the case of a notification under paragraph (1)(B) submitted by a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer offering group health insurance coverage and submitted to a certified IDR entity-

(i) if such entity makes a determination with respect to such notification under subparagraph (A), the party whose offer is not chosen under such subparagraph shall be responsible for paying all fees charged by such entity; and

(ii) if the parties reach a settlement with respect to such notification prior to such a determination, each party shall pay half of all fees charged by such entity, unless the parties otherwise agree.

(6) Timing of payment

The total plan or coverage payment required pursuant to subsection (a)(1) or (b)(1), with respect to a qualified IDR item or service for which a determination is made under paragraph (5)(A) or with respect to an item or service for which a payment amount is determined under open negotiations under paragraph (1), shall be made directly to the nonparticipating provider or facility

not later than 30 days after the date on which such determination is made.

(7) Publication of information relating to the IDR process

(A) Publication of information

For each calendar quarter in 2022 and each calendar quarter in a subsequent year, the Secretary shall make available on the public website of the Department of Labor-

(i) the number of notifications submitted under paragraph (1)(B) during such calendar quarter;

(ii) the size of the provider practices and the size of the facilities submitting notifications under paragraph (1)(B) during such calendar quarter;

(iii) the number of such notifications with respect to which a determination was made under paragraph (5)(A);

(iv) the information described in subparagraph (B) with respect to each notification with respect to which such a determination was so made;

(v) the number of times the payment amount determined (or agreed to) under this subsection exceeds the qualifying payment amount, specified by items and services;

(vi) the amount of expenditures made by the Secretary during such calendar quarter to carry out the IDR process;

(vii) the total amount of fees paid under paragraph (8) during such calendar quarter; and

(viii) the total amount of compensation paid to certified IDR entities under paragraph (5)(F) during such calendar quarter.

(B) Information

For purposes of subparagraph (A), the information described in this subparagraph is, with respect to a notification under paragraph (1)(B) by a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer offering group health insurance coverage-

(i) a description of each item and service included with respect to such notification;

(ii) the geography in which the items and services with respect to such notification were provided;

(iii) the amount of the offer submitted under paragraph (5)(B) by the group health plan or health insurance issuer (as applicable) and by the nonparticipating provider or nonparticipating emergency facility (as applicable) expressed as a percentage of the qualifying payment amount;

(iv) whether the offer selected by the certified IDR entity under paragraph (5) to be the payment applied was the offer submitted by such plan or issuer (as applicable) or by such provider or facility (as applicable) and the

amount of such offer so selected expressed as a percentage of the qualifying payment amount;

(v) the category and practice specialty of each such provider or facility involved in furnishing such items and services;

(vi) the identity of the health plan or health insurance issuer, provider, or facility, with respect to the notification;

(vii) the length of time in making each determination;

(viii) the compensation paid to the certified IDR entity with respect to the settlement or determination; and

(ix) any other information specified by the Secretary.

(C) IDR entity requirements

For 2022 and each subsequent year, an IDR entity, as a condition of certification as an IDR entity, shall submit to the Secretary such information as the Secretary determines necessary to carry out the provisions of this subsection.

(D) Clarification

The Secretary shall ensure the public reporting under this paragraph does not contain information that would disclose privileged or confidential information of a group health plan or health insurance issuer offering group or individual health insurance coverage or of a provider or facility.

(8) Administrative fee**(A) In general**

Each party to a determination under paragraph (5) to which an entity is selected under paragraph (3) in a year shall pay to the Secretary, at such time and in such manner as specified by the Secretary, a fee for participating in the IDR process with respect to such determination in an amount described in subparagraph (B) for such year.

(B) Amount of fee

The amount described in this subparagraph for a year is an amount established by the Secretary in a manner such that the total amount of fees paid under this paragraph for such year is estimated to be equal to the amount of expenditures estimated to be made by the Secretary for such year in carrying out the IDR process.

(9) Waiver authority

The Secretary may modify any deadline or other timing requirement specified under this subsection (other than the establishment date for the IDR process under paragraph (2)(A) and other than under paragraph (6)) in cases of extenuating circumstances, as specified by the Secretary, or to ensure that all claims that occur during a 90-day period described in paragraph (5)(E)(ii), but with respect to which a notification is not permitted by reason of such paragraph to be submitted under paragraph (1)(B) during such period, are eligible for the IDR process.

(d) Certain access fees to certain databases

In the case of a sponsor of a group health plan or health insurance issuer offering group health insurance coverage that, pursuant to subsection (a)(3)(E)(iii), uses a database described in such subsection to determine a rate to apply under such subsection for an item or service by reason of having insufficient information described in such subsection with respect to such item or service, such sponsor or issuer shall cover the cost for access to such database.

(e) Transparency regarding in-network and out-of-network deductibles and out-of-pocket limitations

A group health plan or a health insurance issuer offering group health insurance coverage and providing or covering any benefit with respect to items or services shall include, in clear writing, on any physical or electronic plan or insurance identification card issued to the participants or beneficiaries in the plan or coverage the following:

(1) Any deductible applicable to such plan or coverage.

(2) Any out-of-pocket maximum limitation applicable to such plan or coverage.

(3) A telephone number and Internet website address through which such individual may seek consumer assistance information, such as information related to hospitals and urgent care facilities that have in effect a contractual relationship with such plan or coverage for furnishing items and services under such plan or coverage

(f) Advanced explanation of benefits**(1) In general**

For plan years beginning on or after January 1, 2022, each group health plan, or a health insurance issuer offering group health insurance coverage shall, with respect to a notification submitted under section 300gg–136 of title 42 by a health care provider or health care facility to the plan or issuer for a participant or beneficiary under plan or coverage scheduled to receive an item or service from the provider or facility (or authorized representative of such participant or beneficiary), not later than 1 business day (or, in the case such item or service was so scheduled at least 10 business days before such item or service is to be furnished (or in the case of a request made to such plan or coverage by such participant or beneficiary), 3 business days) after the date on which the plan or coverage receives such notification (or such request), provide to the participant or beneficiary (through mail or electronic means, as requested by the participant or beneficiary) a notification (in clear and understandable language) including the following:

(A) Whether or not the provider or facility is a participating provider or a participating facility with respect to the plan or coverage with respect to the furnishing of such item or service and-

(i) in the case the provider or facility is a participating provider or facility with respect to the plan or coverage with respect to the furnishing of such item or service, the contracted rate under such plan for such item

or service (based on the billing and diagnostic codes provided by such provider or facility); and

(ii) in the case the provider or facility is a nonparticipating provider or facility with respect to such plan or coverage, a description of how such individual may obtain information on providers and facilities that, with respect to such plan or coverage, are participating providers and facilities, if any.

(B) The good faith estimate included in the notification received from the provider or facility (if applicable) based on such codes.

(C) A good faith estimate of the amount the health plan is responsible for paying for items and services included in the estimate described in subparagraph (B).

(D) A good faith estimate of the amount of any cost-sharing for which the participant or beneficiary would be responsible for such item or service (as of the date of such notification).

(E) A good faith estimate of the amount that the participant or beneficiary has incurred toward meeting the limit of the financial responsibility (including with respect to deductibles and out-of-pocket maximums) under the plan or coverage (as of the date of such notification).

(F) In the case such item or service is subject to a medical management technique (including concurrent review, prior authorization, and step-therapy or fail-first protocols) for coverage under the plan or coverage, a disclaimer that coverage

for such item or service is subject to such medical management technique.

(G) A disclaimer that the information provided in the notification is only an estimate based on the items and services reasonably expected, at the time of scheduling (or requesting) the item or service, to be furnished and is subject to change.

(H) Any other information or disclaimer the plan or coverage determines appropriate that is consistent with information and disclaimers required under this section.

(2) Authority to modify timing requirements in the case of specified items and services

(A) In general

In the case of a participant or beneficiary scheduled to receive an item or service that is a specified item or service (as defined in subparagraph (B)), the Secretary may modify any timing requirements relating to the provision of the notification described in paragraph (1) to such participant or beneficiary with respect to such item or service. Any modification made by the Secretary pursuant to the previous sentence may not result in the provision of such notification after such participant or beneficiary has been furnished such item or service.

(B) Specified item or service defined

For purposes of subparagraph (A), the term “specified item or service” means an item or service that has low utilization or significant variation in costs (such as when furnished as part

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of a complex treatment), as specified by the Secretary.

29 U.S.C. § 1185f: Ending surprise air ambulance bills

§1185f. Ending surprise air ambulance bills**(a) In general**

In the case of a participant or beneficiary who is in a group health plan or group health insurance coverage offered by a health insurance issuer and who receives air ambulance services from a nonparticipating provider (as defined in section 1185e(a)(3)(G) of this title) with respect to such plan or coverage, if such services would be covered if provided by a participating provider (as defined in such section) with respect to such plan or coverage-

(1) the cost-sharing requirement with respect to such services shall be the same requirement that would apply if such services were provided by such a participating provider, and any coinsurance or deductible shall be based on rates that would apply for such services if they were furnished by such a participating provider;

(2) such cost-sharing amounts shall be counted towards the in-network deductible and in-network out-of-pocket maximum amount under the plan or coverage for the plan year (and such in-network deductible shall be applied)with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider; and

(3) the group health plan or health insurance issuer, respectively, shall-

(A) not later than 30 calendar days after the bill for such services is transmitted by such provider, send to the provider, an initial payment or notice of denial of payment; and

(B) pay a total plan or coverage payment, in accordance with, if applicable, subsection (b)(6), directly to such provider furnishing such services to such participant, beneficiary, or enrollee that is, with application of any initial payment under subparagraph (A), equal to the amount by which the out-of-network rate (as defined in section 1185e(a)(3)(K) of this title) for such services and year involved exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such services (as determined in accordance with paragraphs (1) and (2)).

(b) Determination of out-of-network rates to be paid by health plans; independent dispute resolution process

(1) Determination through open negotiation

(A) In general

With respect to air ambulance services furnished in a year by a nonparticipating provider, with respect to a group health plan or health insurance issuer offering group health insurance coverage, and for which a payment is required to be made by the plan or coverage pursuant to subsection (a)(3), the provider or plan or coverage may, during the 30-day period beginning on the day the provider receives a payment or a statement of denial of payment from the plan or coverage regarding a claim for

payment for such service, initiate open negotiations under this paragraph between such provider and plan or coverage for purposes of determining, during the open negotiation period, an amount agreed on by such provider, and such plan or coverage for payment (including any cost-sharing) for such service. For purposes of this subsection, the open negotiation period, with respect to air ambulance services, is the 30-day period beginning on the date of initiation of the negotiations with respect to such services.

(B) Accessing independent dispute resolution process in case of failed negotiations

In the case of open negotiations pursuant to subparagraph (A), with respect to air ambulance services, that do not result in a determination of an amount of payment for such services by the last day of the open negotiation period described in such subparagraph with respect to such services, the provider or group health plan or health insurance issuer offering group health insurance coverage that was party to such negotiations may, during the 4-day period beginning on the day after such open negotiation period, initiate the independent dispute resolution process under paragraph (2) with respect to such item or service. The independent dispute resolution process shall be initiated by a party pursuant to the previous sentence by submission to the other party and to the Secretary of a notification (containing

such information as specified by the Secretary) and for purposes of this subsection, the date of initiation of such process shall be the date of such submission or such other date specified by the Secretary pursuant to regulations that is not later than the date of receipt of such notification by both the other party and the Secretary.

(2) Independent dispute resolution process available in case of failed open negotiations

(A) Establishment

Not later than 1 year after December 27, 2020, the Secretary, jointly with the Secretary of Health and Human Services and the Secretary of the Treasury, shall establish by regulation one independent dispute resolution process (referred to in this subsection as the “IDR process”) under which, in the case of air ambulance services with respect to which a provider or group health plan or health insurance issuer offering group health insurance coverage submits a notification under paragraph (1)(B) (in this subsection referred to as a “qualified IDR air ambulance services”), a certified IDR entity under paragraph (4) determines, subject to subparagraph (B) and in accordance with the succeeding provisions of this subsection, the amount of payment under the plan or coverage for such services furnished by such provider.

(B) Authority to continue negotiations

Under the independent dispute resolution process, in the case that the parties to a

determination for qualified IDR air ambulance services agree on a payment amount for such services during such process but before the date on which the entity selected with respect to such determination under paragraph (4) makes such determination under paragraph (5), such amount shall be treated for purposes of section 1185e(a)(3)(K)(ii) of this title as the amount agreed to by such parties for such services. In the case of an agreement described in the previous sentence, the independent dispute resolution process shall provide for a method to determine how to allocate between the parties to such determination the payment of the compensation of the entity selected with respect to such determination.

(C) Clarification

A nonparticipating provider may not, with respect to an item or service furnished by such provider, submit a notification under paragraph (1)(B) if such provider is exempt from the requirement under subsection (a) of section 300gg-132 of title 42 with respect to such item or service pursuant to subsection (b) of such section.

(3) Treatment of batching of services

The provisions of section 1185e(c)(3) of this title shall apply with respect to a notification submitted under this subsection with respect to air ambulance services in the same manner and to the same extent such provisions apply with respect to a notification submitted under

section 1185e(c) of this title with respect to items and services described in such section.

(4) IDR entities

(A) Eligibility

An IDR entity certified under this subsection is an IDR entity certified under section 1185e(c)(4) of this title.

(B) Selection of certified IDR entity

The provisions of subparagraph (F) of section 1185e(c)(4) of this title shall apply with respect to selecting an IDR entity certified pursuant to subparagraph (A) with respect to the determination of the amount of payment under this subsection of air ambulance services in the same manner as such provisions apply with respect to selecting an IDR entity certified under such section with respect to the determination of the amount of payment under section 1185e(c) of this title of an item or service. An entity selected pursuant to the previous sentence to make a determination described in such sentence shall be referred to in this subsection as the “certified IDR entity” with respect to such determination.

(5) Payment determination

(A) In general

Not later than 30 days after the date of selection of the certified IDR entity with respect to a determination for qualified IDR ambulance services, the certified IDR entity shall-

(i) taking into account the considerations specified in subparagraph (C), select one of the offers submitted under subparagraph (B) to be the amount of payment for such services determined under this subsection for purposes of subsection (a)(3); and

(ii) notify the provider or facility and the group health plan or health insurance issuer offering group health insurance coverage party to such determination of the offer selected under clause (i).

(B) Submission of offers

Not later than 10 days after the date of selection of the certified IDR entity with respect to a determination for qualified IDR air ambulance services, the provider and the group health plan or health insurance issuer offering group health insurance coverage party to such determination-

(i) shall each submit to the certified IDR entity with respect to such determination-

(I) an offer for a payment amount for such services furnished by such provider; and

(II) such information as requested by the certified IDR entity relating to such offer; and

(ii) may each submit to the certified IDR entity with respect to such determination any information relating to such offer submitted by either party, including information relating to any circumstance described in subparagraph (C)(ii).

(C) Considerations in determination**(i) In general**

In determining which offer is the payment to be applied pursuant to this paragraph, the certified IDR entity, with respect to the determination for a qualified IDR air ambulance service shall consider-

(I) the qualifying payment amounts (as defined in section 1185e(a)(3)(E) of this title) for the applicable year for items and services that are comparable to the qualified IDR air ambulance service and that are furnished in the same geographic region (as defined by the Secretary for purposes of such subsection) as such qualified IDR air ambulance service; and

(II) subject to clause (iii), information on any circumstance described in clause (ii), such information as requested in subparagraph (B)(i)(II), and any additional information provided in subparagraph (B)(ii).

(ii) Additional circumstances

For purposes of clause (i)(II), the circumstances described in this clause are, with respect to air ambulance services included in the notification submitted under paragraph (1)(B) of a nonparticipating provider, group health plan, or health insurance issuer the following:

(I) The quality and outcomes measurements of the provider that furnished such services.

(II) The acuity of the individual receiving such services or the complexity of furnishing such services to such individual.

(III) The training, experience, and quality of the medical personnel that furnished such services.

(IV) Ambulance vehicle type, including the clinical capability level of such vehicle.

(V) Population density of the pick up location (such as urban, suburban, rural, or frontier).

(VI) Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network agreements and, if applicable, contracted rates between the provider and the plan or issuer, as applicable, during the previous 4 plan years.

(iii) Prohibition on consideration of certain factors

In determining which offer is the payment amount to be applied with respect to qualified IDR air ambulance services furnished by a provider, the certified IDR entity with respect to such determination shall not consider usual and customary

charges, the amount that would have been billed by such provider with respect to such services had the provisions of section 300gg–135 of title 42 not applied, or the payment or reimbursement rate for such services furnished by such provider payable by a public payor, including under the Medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], under the Medicaid program under title XIX of such Act [42 U.S.C. 1396 et seq.], under the Children’s Health Insurance Program under title XXI of such Act [42 U.S.C. 1397aa et seq.], under the TRICARE program under chapter 55 of title 10, or under chapter 17 of title 38.

(D) Effects of determination

The provisions of section 1185e(c)(5)(E) of this title shall apply with respect to a determination of a certified IDR entity under subparagraph (A), the notification submitted with respect to such determination, the services with respect to such notification, and the parties to such notification in the same manner as such provisions apply with respect to a determination of a certified IDR entity under section 1185e(c)(5)(E) of this title, the notification submitted with respect to such determination, the items and services with respect to such notification, and the parties to such notification.

(E) Costs of independent dispute resolution process

The provisions of section 1185e(c)(5)(F) of this title shall apply to a notification made under this subsection, the parties to such notification, and a determination under subparagraph (A) in the same manner and to the same extent such provisions apply to a notification under section 1185e(c) of this title, the parties to such notification and a determination made under section 1185e(c)(5)(A) of this title.

(6) Timing of payment

The total plan or coverage payment required pursuant to subsection (a)(3), with respect to qualified IDR air ambulance services for which a determination is made under paragraph (5)(A) or with respect to air ambulance services for which a payment amount is determined under open negotiations under paragraph (1), shall be made directly to the nonparticipating provider not later than 30 days after the date on which such determination is made.

(7) Publication of information relating to the IDR process

(A) In general

For each calendar quarter in 2022 and each calendar quarter in a subsequent year, the Secretary shall publish on the public website of the Department of Labor-

- (i) the number of notifications submitted under the IDR process during such calendar quarter;

(ii) the number of such notifications with respect to which a final determination was made under paragraph (5)(A);

(iii) the information described in subparagraph (B) with respect to each notification with respect to which such determination was so made.

(iv) the number of times the payment amount determined (or agreed to) under this subsection exceeds the qualifying payment amount;

(v) the amount of expenditures made by the Secretary during such calendar quarter to carry out the IDR process;

(vi) the total amount of fees paid under paragraph (8) during such calendar quarter; and

(vii) the total amount of compensation paid to certified IDR entities under paragraph (5)(E) during such calendar quarter.

(B) Information with respect to requests

For purposes of subparagraph (A), the information described in this subparagraph is, with respect to a notification under the IDR process of a nonparticipating provider, group health plan, or health insurance issuer offering group health insurance coverage-

(i) a description of each air ambulance service included in such notification;

(ii) the geography in which the services included in such notification were provided;

(iii) the amount of the offer submitted under paragraph (2) by the group health plan or health insurance issuer(as applicable) and by the nonparticipating provider expressed as a percentage of the qualifying payment amount;

(iv) whether the offer selected by the certified IDR entity under paragraph (5) to be the payment applied was the offer submitted by such plan or issuer (as applicable) or by such provider and the amount of such offer so selected expressed as a percentage of the qualifying payment amount;

(v) ambulance vehicle type, including the clinical capability level of such vehicle;

(vi) the identity of the group health plan or health insurance issuer or air ambulance provider with respect to such notification;

(vii) the length of time in making each determination;

(viii) the compensation paid to the certified IDR entity with respect to the settlement or determination; and

(ix) any other information specified by the Secretary.

(C) IDR entity requirements

For 2022 and each subsequent year, an IDR entity, as a condition of certification as an IDR entity, shall submit to the Secretary such information as the Secretary determines

necessary for the Secretary to carry out the provisions of this paragraph.

(D) Clarification

The Secretary shall ensure the public reporting under this paragraph does not contain information that would disclose privileged or confidential information of a group health plan or health insurance issuer offering group or individual health insurance coverage or of a provider or facility.

(8) Administrative fee

(A) In general

Each party to a determination under paragraph (5) to which an entity is selected under paragraph (4) in a year shall pay to the Secretary, at such time and in such manner as specified by the Secretary, a fee for participating in the IDR process with respect to such determination in an amount described in subparagraph (B) for such year.

(B) Amount of fee

The amount described in this subparagraph for a year is an amount established by the Secretary in a manner such that the total amount of fees paid under this paragraph for such year is estimated to be equal to the amount of expenditures estimated to be made by the Secretary for such year in carrying out the IDR process.

(9) Waiver authority

The Secretary may modify any deadline or other timing requirement specified under this

subsection (other than the establishment date for the IDR process under paragraph (2)(A) and other than under paragraph (6)) in cases of extenuating circumstances, as specified by the Secretary, or to ensure that all claims that occur during a 90-day period applied through paragraph (5)(D), but with respect to which a notification is not permitted by reason of such paragraph to be submitted under paragraph (1)(B) during such period, are eligible for the IDR process.

(c) Definition

For purposes of this section:

(1) Air ambulance services

The term “air ambulance service” means medical transport by helicopter or airplane for patients.

(2) Qualifying payment amount

The term “qualifying payment amount” has the meaning given such term in section 1185e(a)(3) of this title.

(3) Nonparticipating provider

The term “nonparticipating provider” has the meaning given such term in section 1185e(a)(3) of this title. (Pub. L. 93–406, title I, §717, as added Pub. L. 116–260, div. BB, title I, §105(a)(2)(A), Dec. 27, 2020, 134 Stat. 2838.)