Part III

Administrative, Procedural, and Miscellaneous

26 CFR 54.9816-6T: Calculating the qualifying payment amounts in 2023

Notice 2023-4

SECTION 1. PURPOSE AND SCOPE

Pursuant to Treas. Reg. § 54.9816-6T(c), 29 CFR 2590.716-6(c), and 45 CFR 149.140(c), this notice provides the percentage increase for calculating the qualifying payment amounts for items and services furnished during 2023 for purposes of sections 9816 and 9817 of the Internal Revenue Code (Code), sections 716 and 717 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 2799A-1 and 2799A-2 of the Public Health Service Act (PHS Act). This notice was drafted in consultation with the Departments of Labor and Health and Human Services. Similar guidance for items and services furnished during 2022 was published in Revenue Procedure 2022-11, 2022-3 IRB 449, and Notice 2022-11, 2022-14 IRB 939.[1] Percentage increases for calculating the qualifying payment amounts for items and services furnished in future years may be published in the annual revenue procedure containing inflation-adjusted items for the following tax year.

SECTION 2. BACKGROUND

The No Surprises Act was enacted as Title I of Division BB of the Consolidated Appropriations Act, 2021.[2] The No Surprises Act added sections 9816 and 9817 to the Code, sections 716 and 717 to ERISA, and sections 2799A-1 and 2799A-2 to the PHS

[1] https://www.irs.gov/pub/irs-drop/rp-22-11.pdf and https://www.irs.gov/pub/irs-drop/n-22-11.pdf.
[2] Pub. L. 116-260, 134 Stat. 1182 (2020).

Act. These provisions provide protections against surprise medical bills in certain circumstances. Surprise medical bills can occur when a patient unexpectedly receives health care from a provider, facility, or provider of air ambulance services that does not participate in the network of the individual's group health plan or group or individual health insurance coverage (an out-of-network or nonparticipating provider, facility, or provider of air ambulance services).[3]

Before the enactment of the No Surprises Act, when the terms of a group health plan or group or individual health insurance coverage did not provide for coverage of the entire amount billed by a nonparticipating provider, facility, or provider of air ambulance services, the provider, facility, or provider of air ambulance services could balance bill the patient for the amount in excess of the amount paid by the plan or coverage and any applicable patient cost sharing (unless prohibited under applicable state law). For non-emergency services and air ambulance services, the patient could also have been responsible for out-of-network cost-sharing amounts, which may have been higher than in-network cost-sharing amounts. Under the No Surprises Act, in certain circumstances, the nonparticipating provider, facility, or provider of air ambulance services can no longer balance bill the patient for the excess amount, and patient cost sharing is generally limited to in-network levels. The No Surprises Act and implementing regulations[4] provide that, generally, in the absence of an All-Payer Model Agreement

[3] The protections against surprise billing additionally apply to health benefits plans offered by carriers under the Federal Employees Health Benefits (FEHB) Act pursuant to 5 U.S.C. 8902(p). Accordingly, the guidance provided in this notice applies to FEHB carriers to the extent consistent with their contracts. See also 5 CFR 890.114.
[4] 86 FR 36872 (July 13, 2021).

under section 1115A of the Social Security Act or specified state law,[5] a patient's cost-sharing amount must be calculated based on the lesser of the qualifying payment amount[6] or the amount billed by the provider or facility. In the case of air ambulance services, the patient's cost-sharing amount must be calculated based on the lesser of the qualifying payment amount or the billed amount for the services.

Further, in the absence of an All-Payer Model Agreement or specified state law,[7] the No Surprises Act and its implementing regulations provide for a 30-business-day open negotiation period for group health plans or health insurance issuers offering group or individual health insurance coverage (plans and issuers) and the nonparticipating providers, facilities, or providers of air ambulance services to determine the amount to be paid by the plans or issuers as the out-of-network rate.[8] If the parties are unable to reach an agreement through open negotiation, the No Surprises Act provides for the out-of-network rate to be determined by a certified independent dispute resolution (IDR) entity through a Federal IDR process set forth in sections 9816(c) and 9817(b) of the Code, sections 716(c) and 717(b) of ERISA, and sections 2799A-1(c) and 2799A-2(b) of the PHS Act. The statute and implementing interim final regulations issued in October 2021[9] and the final regulations issued in August 2022[10] provide that, under the Federal IDR process, the certified IDR entity considers the qualifying payment

[5] If an All-Payer Model Agreement or specified state law applies, the applicable Agreement or law determines the cost-sharing amount. "Specified state law" is defined in § 54.9816-3T, 29 CFR 2590.716-3, and 45 CFR 149.30.
[6] "Qualifying payment amount" is defined in § 54.9816-6T(a)(16), 29 CFR 2590.716-6(a)(16), and 45 CFR 149.140(a)(16).
[7] If an All-Payer Model Agreement or specified state law applies, the applicable Agreement or law determines the out-of-network rate.
[8] "Out-of-network rate" is defined in § 54.9816-3T, 29 CFR 2590.716-3, and 45 CFR 149.30.
[9] 86 FR 55980 (October 7, 2021).
[10] 87 FR 52618 (August 26, 2022).

amount for the item or service, among other additional circumstances and information as provided for in the statute and implementing regulations, in determining which offer to select as the out-of-network rate.

Under § 54.9816-6T(c), 29 CFR 2590.716-6(c), and 45 CFR 149.140(c), for an item or service furnished during 2022, plans and issuers must calculate the qualifying payment amount by increasing the median contracted rate (as determined in accordance with § 54.9816-6T(b), 29 CFR 2590.716-6(b), and 45 CFR 149.140(b)) for the same or similar item or service under such plan or coverage, on January 31, 2019, by the combined percentage increase as published by the Department of the Treasury (Treasury Department) and the Internal Revenue Service (IRS) to reflect the percentage increase in the consumer price index for all urban consumers (U.S. city average) (CPI-U) over 2019, such percentage increase over 2020, and such percentage increase over 2021.[11] Pursuant to Rev. Proc. 2022-11, for items and services provided on or after January 1, 2022, and before January 1, 2023, the combined percentage increase to adjust the median contracted rate for the same or similar item or service under such plan or coverage, on January 31, 2019, is 1.0648523983. The revenue procedure also provides that plans and issuers may round to the nearest dollar any resulting qualifying payment amounts.

Pursuant to § 54.9816-6T(c)(3)(i), 29 CFR 2590.716-6(c)(3)(i), and 45 CFR 149.140(c)(3)(i), for an item or service furnished during 2022, a plan or issuer that does

[11] The calculations of the qualifying payment amounts for anesthesia services, air ambulance services, and certain other items or services furnished during 2022 for which a plan or issuer has sufficient information to calculate the median of the contracted rates in 2019 differ slightly, but all use the same formula for increasing a base rate by the combined percentage increase as published by the Treasury Department and the IRS to reflect the percentage increase in the CPI-U over 2019 and subsequent years. See § 54.9816-6T(c)(1)(iii)-(vii), 29 CFR 2590.716-6(c)(1)(iii)-(vii), and 45 CFR 149.140(c)(1)(iii)-(vii).

not have sufficient information to calculate the median of the contracted rates in 2019 for the same or similar item or service provided in a geographic region must calculate the qualifying payment amount by first identifying the rate that is equal to the median of the in-network allowed amounts for the same or similar item or service provided in the geographic region in 2021, determined by the plan or issuer through use of any eligible database, and then increasing that rate by the percentage increase in the CPI-U over 2021. Similarly, in the case of a newly covered item or service furnished during the first coverage year, when a plan or issuer does not have sufficient information to calculate the median of the contracted rates in the first coverage year for the item or service, the plan or issuer must calculate the qualifying payment amount by using an eligible database to determine the rate that is equal to the median of the in-network allowed amounts for the same or similar item or service provided in the geographic region in the year immediately preceding the first coverage year, and then increasing that rate by the percentage increase in the CPI-U over the preceding year.

Under § 54.9816-6T(c)(3)(ii), 29 CFR 2590.716-6(c)(3)(ii), and 45 CFR 149.140(c)(3)(ii), for an item or service furnished in a subsequent year (before the first sufficient information year for the item or service with respect to the plan or coverage), the plan or issuer must calculate the qualifying payment amount by increasing the qualifying payment amount determined for the item or service for the year immediately preceding the subsequent year, by the percentage increase in the CPI-U over the preceding year.

The percentage increase in the CPI-U for items and services provided in 2022 over the preceding year is the average CPI-U for 2021 over the average CPI-U for

2020. Pursuant to Notice 2022-11, the percentage increase from 2021 to 2022 is 1.0299772040. The notice also provides that plans and issuers may round any resulting qualifying payment amounts to the nearest dollar.

Under § 54.9816-6T(c)(2)(i), 29 CFR 2590.716-6(c)(2)(i), and 45 CFR 149.140(c)(2)(i), with respect to a sponsor of a plan or issuer offering group or individual health insurance coverage in a geographic region in which the sponsor or issuer did not offer any group health plan or health insurance coverage in 2019, for the first year in which the group health plan or group or individual health insurance coverage is offered in the region, if the plan or issuer does not have sufficient information to calculate the median of the contracted rates for an item or service provided in the geographic region, the plan or issuer must determine the qualifying payment amount pursuant to § 54.9816-6T(c)(3)(i), 29 CFR 2590.716-6(c)(3)(i), and 45 CFR 149.140(c)(3)(i) for an item or service furnished in 2022, as previously discussed. For each subsequent year the group health plan or group or individual health insurance coverage is offered in the region, the plan or issuer must calculate the qualifying payment amounts by increasing the qualifying payment amounts so determined for items or services provided in the immediately preceding year, by the percentage increase in the CPI-U over the preceding year.[12]

Under § 54.9816-6T(c)(4)(i), 29 CFR 2590.716-6(c)(4)(i), and 45 CFR 149.140(c)(4)(i), in the case of a plan or issuer that does not have sufficient information

[12] The calculations of the qualifying payment amounts for anesthesia services, air ambulance services, and certain other items or services furnished in a subsequent year differ slightly, but all use the same formula for increasing the indexed median contracted rate determined for the item or service in the immediately preceding year by the percentage increase. See § 54.9816-6T(c)(2)(ii), 29 CFR 2590.716-6(c)(2)(ii), and 45 CFR 149.140(c)(2)(ii).

to calculate the median of the contracted rates for the same or similar item or service provided in a geographic region and determine the qualifying payment amount in accordance with the previously described methodology because the item or service is billed under a new service code, for items or services furnished in 2022 (or for newly covered items and services, during the first coverage year for the item or service), the plan or issuer must calculate the qualifying payment amounts pursuant to § 54.9816-6T(c)(4)(i), 29 CFR 2590.716-6(c)(4)(i), and 45 CFR 149.140(c)(4)(i).

Under § 54.9816-6T(c)(4)(ii), 29 CFR 2590.716-6(c)(4)(ii), and 45 CFR 149.140(c)(4)(ii), for such an item or service furnished in a subsequent year (before the first sufficient information year for the item or service with respect to such plan or coverage or before the first year for which an eligible database has sufficient information to calculate a rate under § 54.9816-6T(c)(3)(i), 29 CFR 2590.716-6(c)(3)(i), and 45 CFR 149.140(c)(3)(i) in the immediately preceding year), the plan or issuer must calculate the qualifying payment amount by increasing the qualifying payment amount determined for the item or service for the year immediately preceding the subsequent year, by the percentage increase in the CPI-U over the preceding year.

SECTION 3. GUIDANCE

The percentage increase in the CPI-U over a preceding year is calculated by dividing the average CPI-U for the preceding year by the average CPI-U for the year immediately prior to the preceding year. For this purpose, the average CPI-U for a year is the average of the monthly CPI-Us published by the Bureau of Labor Statistics of the Department of Labor for the 12-month period ending on August 31 of each year, rounded to 10 decimal places. The percentage increase in the CPI-U for items and

services provided in 2023 over the preceding year is the average CPI-U for 2022 over the average CPI-U for 2021. Pursuant to this calculation, the percentage increase from 2022 to 2023 is 1.0768582128. Further, pursuant to this notice, plans and issuers may round any resulting qualifying payment amounts to the nearest dollar.

.01 Adjusting qualifying payment amounts based on January 31, 2019 rates.

For qualifying payment amounts calculated by increasing the median contracted rate for 2019[13], the qualifying payment amounts for items and services furnished in 2023 are determined by taking the qualifying payment amounts calculated for items and services furnished in 2022 and multiplying the 2022 adjusted qualifying payment amounts by the percentage increase from 2022 to 2023, that is, 1.0768582128.

For example: An item is furnished in 2023. The median contracted rate for the item on January 31, 2019 was $1,500. The 2022 adjusted qualifying payment amount for the item was $1,597 ($1,500 x 1.0648523983). The 2023 adjusted qualifying payment amount for the item is $1,720 ($1,597 x 1.0768582128).

.02 Adjusting qualifying payment amounts based on 2021 rates.

For items and services furnished in 2022, for which the qualifying payment amounts were calculated by increasing the median of the in-network allowed amounts for the same or similar item or service provided in the geographic region in 2021, drawn from any eligible database, by the percentage increase from 2021 to 2022[14], the qualifying payment amounts for items and services furnished in 2023 are determined by

[13] These qualifying payment amounts are calculated by increasing the median contracted rate for the same or similar item or service under the plan or coverage, on January 31, 2019, by the combined percentage increase (2019, 2020, and 2021) published in Rev. Proc. 2022-11 (that is, 1.0648523983).
[14] These qualifying payment amounts are calculated by multiplying the median of the in-network allowed amounts for the same or similar item or service provided in the geographic region in 2021, drawn from any eligible database, by the percentage increase from 2021 to 2022 (that is, 1.0299772040).

taking the qualifying payment amounts calculated for the items and services furnished in 2022 and multiplying the 2022 adjusted qualifying payment amounts by the percentage increase from 2022 to 2023 (that is, 1.0768582128).

For example: A newly covered service for which the plan or issuer does not have sufficient information to calculate the median of the contracted rates is furnished in 2022. The median of the in-network allowed amounts for the same or similar service provided in the geographic region in 2021, drawn from an eligible database, was $2,100. The 2022 adjusted qualifying payment amount for the service was $2,163 ($2,100 x 1.0299772040). The 2023 adjusted qualifying payment amount for the service is $2,329 ($2,163 x 1.0768582128).

The adjustment to the qualifying payment amounts will be applied similarly for items and services covered by a new plan or new group or individual health insurance coverage that was not offered in a geographic region in a prior year. For items and services first offered by a new plan or new group or individual health insurance coverage in a geographic region in 2022 for which the plan or issuer does not have sufficient information to calculate the median of the contracted rates for the items or services provided in the geographic region[15], the qualifying payment amounts would be calculated by increasing the median of the in-network allowed amounts for the same or similar item or service provided in the geographic region in 2021, drawn from any eligible database, by the percentage increase from 2021 to 2022 (1.0299772040). For that plan or coverage, the qualifying payment amounts for items and services furnished

[15] These qualifying payment amounts are calculated by multiplying the median of the in-network allowed amounts for the same or similar item or service provided in the geographic region in 2021, drawn from any eligible database, by the percentage increase from 2021 to 2022 (that is, 1.0299772040).

in 2023 is determined by taking the qualifying payment amounts calculated for items and services furnished in 2022 and multiplying the 2022 adjusted qualifying payment amounts by the percentage increase from 2022 to 2023, that is, 1.0768582128.

.03 Calculating qualifying payment amounts when 2023 is the first coverage year.

For newly covered items and services furnished in 2023 for which the plan or issuer does not have sufficient information, when 2023 is the first coverage year for the item or service with respect to the plan or coverage, the qualifying payment amounts for the items and services first furnished in 2023 are determined by multiplying the median of the in-network allowed amounts for the same or similar item or service provided in the geographic region in 2022, drawn from any eligible database, by the percentage increase from 2022 to 2023, that is, 1.0768582128.

For example: A newly covered service is furnished in 2023. The median of the in-network allowed amounts for the service provided in the geographic region in 2022, drawn from an eligible database, was $3,000. The 2023 adjusted qualifying payment amount for the service is $3,231 ($3,000 x 1.0768582128).

SECTION 4. EFFECTIVE DATE

The effective date of this notice is January 1, 2023.

SECTION 5. DRAFTING INFORMATION

The principal author of this notice is Jason Sandoval of the Office of Associate Chief Counsel (Employee Benefits, Exempt Organizations, and Employment Taxes). For further information regarding this notice, contact Jason Sandoval at 202-317-5500 (not a toll-free call).