Part III

Administrative, Procedural, and Miscellaneous

26 CFR 54.9816-6T Methodology for calculating qualifying payment amount in 2022

Rev. Proc. 2022-11

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 revenue procedure provides the combined percentage increase for calculating the qualifying payment amount for items and services furnished during 2022 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 revenue procedure was drafted in consultation with the Departments of Labor and Health and Human Services.

SECTION 2. BACKGROUND

The No Surprises Act was enacted as Title I of Division BB of the Consolidated Appropriations Act, 2021.[1] Section 102 of the No Surprises Act added section 9816 to the Code, section 716 to ERISA, and section 2799A-1 to the PHS Act. Section 105 of the No Surprises Act added section 9817 to the Code, section 717 to ERISA, and section 2799A-2 to the PHS Act. These provisions provide protections against surprise

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

medical bills in certain circumstances. Surprise medical bills can occur when a patient unexpectedly receives out-of-network health care, that is, 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).[2]

Before the enactment of the No Surprises Act, when the terms of a group health plan or group or individual insurance coverage did not provide for coverage of the entire amount billed, 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, the patient could be responsible for out-of-network cost-sharing amounts, which may be higher than in-network costs. Under the No Surprises Act, in certain circumstances, the provider, facility, or provider of air ambulance services can no longer balance bill the patient for the excess amount, and patient cost sharing is limited to in-network levels.

In July 2021, interim final regulations were issued to implement sections 9816 and 9817 of the Code, sections 716 and 717 of ERISA, and sections 2799A-1 and 2799A-2 of the PHS Act.[3] The No Surprises Act and those interim final regulations provide that, generally, in the absence of an All-Payer Model Agreement under section

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[2] The protections against surprise billing also apply to health benefits plans offered by carriers under the Federal Employees Health Benefits (FEHB) Act. Accordingly, the guidance provided in this revenue procedure also applies to FEHB carriers. *See* 5 U.S.C. 8901(p).

[3] 86 FR 36872 (7/13/21).

1115A of the Social Security Act or specified state law,[4] a patient's cost-sharing amount is based on the qualifying payment amount.[5]

Furthermore, in the absence of an All-Payer Model Agreement or specified state law,[6] the No Surprises Act provides for negotiation between the group health plan or group or individual health insurance issuer and the provider, facility, or provider of air ambulance services to determine the amount to be paid by the plan or issuer, if any. If the parties are unable to reach an agreement through open negotiation, the No Surprises Act provides for the amount payable 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. To the extent that the amount payable for items and services by a group health plan or group or individual health insurance issuer to an out-of-network provider, facility, or provider of air ambulance services is determined by a certified IDR entity under that federal IDR process, the statute and implementing interim final regulations issued in October 2021 provide that the certified IDR entity takes into account the qualifying payment amount for the item or service, among other additional factors and circumstances as provided for in the statute and implementing regulations.[7]

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[4] 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.

[5] 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).

[6] If an All-Payer Model Agreement or specified state law applies, the applicable Agreement or law determines the out-of-network payment amount.

[7] The applicable regulations are §§ 54.9816-8T, 54.9817-2T, 29 CFR 2590.716-8, 2590.717-2, 45 CFR 149.510, and 149.520. *See* 86 FR 55980 (10/7/21).

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, the group health plan or group or individual health insurance issuer 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))[8] 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.[9] The combined percentage increase is provided in section 3 of this revenue procedure.

For an item or service furnished during 2023 or a subsequent year, a group health plan or group or individual health insurance issuer must calculate the qualifying payment amount by increasing the qualifying payment amount determined for the item or service furnished in the immediately preceding year, by the percentage increase as published by the Treasury Department and the IRS.

[8] If there is insufficient information to determine the median contracted rate, the plan or issuer generally must use data from an eligible database to determine the qualifying payment amount. The same indexing rules apply.

[9] The calculations of the qualifying payment amount for anesthesia services, air ambulance services, and other items or services 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).

The annual percentage increase will be published in guidance by the IRS. The Treasury Department and the IRS must calculate the annual percentage increase using the CPI–U published by the Bureau of Labor Statistics of the Department of Labor.

This revenue procedure reflects the terms of the interim final regulations under the No Surprises Act in effect as of December 28, 2021. The Treasury Department and the IRS anticipate issuing additional guidance regarding the calculation of the qualifying payment amount to the extent that final regulations reflect different terms.

SECTION 3. PROCEDURE

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 is 1.0648523983.[10] Pursuant to this revenue procedure, group health plans and group and individual health insurance issuers may round any resulting qualifying payment amount to the nearest dollar.

Example. A group health plan sponsor calculates a median contracted rate for a service with service code X; the service is not an anesthesia service or air ambulance service. The median contracted rate for service code X is $12,480 as of January 31, 2019. For a service with service code X furnished during 2022, increasing the median contracted rate by the combined percentage increase of 1.0648523983 results in $13,289.36; rounding to the nearest dollar results in a qualifying payment amount of $13,289.

[10] The formula for the combined percentage increase for 2019, 2020, and 2021 is expressed as: (CPI-U 2019/CPI-U 2018) × (CPI-U 2020/CPI-U 2019) × (CPI-U 2021/CPI-U 2020). *See* § 54.9816-6T(c)(1)(i)(C), 29 CFR 2590.716-6(c)(1)(i)(C), and 45 CFR 149.140(c)(1)(i)(C).

SECTION 4. EFFECTIVE DATE

The effective date of this revenue procedure is January 1, 2022.

SECTION 5. DRAFTING INFORMATION

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