

§ 149.110

Model Agreement for the item or service.

Specified State law means a State law that provides for a method for determining the total amount payable under a group health plan or group or individual health insurance coverage offered by a health insurance issuer to the extent such State law applies for an item or service furnished by a nonparticipating provider or nonparticipating emergency facility (including where it applies because the State has allowed a plan that is not otherwise subject to applicable State law an opportunity to opt in, subject to section 514 of the Employee Retirement Income Security Act of 1974). A group health plan that opts in to such a specified State law must do so for all items and services to which the specified State law applies and in a manner determined by the applicable State authority, and must prominently display in its plan materials describing the coverage of out-of-network services a statement that the plan has opted into the specified State law, identify the relevant State (or States), and include a general description of the items and services provided by nonparticipating facilities and providers that are covered by the specified State law.

State means each of the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Treating provider is a physician or health care provider who has evaluated the individual.

Visit, with respect to items and services furnished to an individual at a health care facility, includes, in addition to items and services furnished by a provider at the facility, equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services, regardless of whether the provider furnishing such items or services is at the facility.

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Subpart B—Protections Against Balance Billing for the Group and Individual Health Insurance Markets

§ 149.110 Preventing surprise medical bills for emergency services.

(a) *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, the plan or issuer must cover emergency services, as defined in paragraph (c)(2) of this section, and this coverage must be provided in accordance with paragraph (b) of this section.

(b) *Coverage requirements.* A plan or issuer described in paragraph (a) of this section must provide coverage for emergency services in the following manner—

(1) Without the need for any prior authorization determination, even if the services are provided on an out-of-network basis.

(2) Without regard to whether the health care provider furnishing the emergency services is a participating provider or a participating emergency facility, as applicable, with respect to the services.

(3) If the emergency services are provided by a nonparticipating provider or a nonparticipating emergency facility—

(i) Without imposing any administrative requirement or 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.

(ii) Without imposing cost-sharing requirements that are greater than the requirements that would apply if the services were provided by a participating provider or a participating emergency facility.

(iii) By calculating the cost-sharing requirement as if the total amount that would have been charged for the services by such participating provider or participating emergency facility

were equal to the recognized amount for such services.

(iv) The plan or issuer—

(A) Not later than 30 calendar days after the bill for the services is transmitted by the provider or facility (or, in cases where the recognized amount is determined by a specified State law or All-Payer Model Agreement, such other timeframe as specified by the State law or All-Payer Model Agreement), determines whether the services are covered under the plan or coverage and, if the services are covered, sends to the provider or facility, as applicable, an initial payment or a notice of denial of payment. For purposes of this paragraph (b)(3)(iv)(A), the 30-calendar-day period begins on the date the plan or issuer receives the information necessary to decide a claim for payment for the services.

(B) Pays a total plan or coverage payment directly to the nonparticipating provider or nonparticipating facility that is equal to the amount by which the out-of-network rate for the services exceeds the cost-sharing amount for the services (as determined in accordance with paragraphs (b)(3)(ii) and (iii) of this section), less any initial payment amount made under paragraph (b)(3)(iv)(A) of this section. The total plan or coverage payment must be made in accordance with the timing requirement described in section 2799A-1(c)(6) of the PHS Act, or in cases where the out-of-network rate is determined under a specified State law or All-Payer Model Agreement, such other timeframe as specified by the State law or All-Payer Model Agreement.

(v) By counting any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to the emergency services toward any in-network deductible or in-network out-of-pocket maximums (including the annual limitation on cost sharing under section 2707(b) of the PHS Act) (as applicable) applied under the plan or coverage (and the in-network deductible and in-network out-of-pocket maximums must be applied) in the same manner as if the cost-sharing payments were made with respect to emergency services furnished by a participating

provider or a participating emergency facility.

(4) Without limiting what constitutes an emergency medical condition (as defined in paragraph (c)(1) of this section) solely on the basis of diagnosis codes.

(5) Without regard to any other term or condition of the coverage, other than—

(i) The exclusion or coordination of benefits (to the extent not inconsistent with benefits for an emergency medical condition, as defined in paragraph (c)(1) of this section).

(ii) An affiliation or waiting period (each as defined in §144.103 of this subchapter).

(iii) Applicable cost sharing.

(c) *Definitions.* In this section—

(1) *Emergency medical condition* means a medical condition, including a mental health condition or substance use disorder, 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)). (In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.)

(2) *Emergency services* means, with respect to an emergency medical condition—

(i) *In general.* (A) An appropriate 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

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to evaluate such emergency medical condition; and

(B) 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 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, 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.* (A) Subject to paragraph (c)(2)(ii)(B) of this section, items and services—

(1) For which benefits are provided or covered under the plan or coverage; and

(2) 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 paragraph (c)(2)(i) of this section are furnished.

(B) Items and services described in paragraph (c)(2)(ii)(A) of this section are not included as emergency services if all of the conditions in §149.410(b) are met.

(3) *To stabilize*, with respect to an emergency medical condition, has the meaning given such term in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(d) *Applicability date.* The provisions of this section are applicable with respect to plan years (in the individual market, policy years) beginning on or after January 1, 2022.

§ 149.120 Preventing surprise medical bills for non-emergency services performed by nonparticipating providers at certain participating facilities.

(a) *In general.* If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides or covers any bene-

fits with respect to items and services described in paragraph (b) of this section, the plan or issuer must cover the items and services when furnished by a nonparticipating provider in accordance with paragraph (c) of this section.

(b) *Items and services described.* The items and services described in this paragraph (b) are items and services (other than emergency services) furnished to a participant, beneficiary, or enrollee by a nonparticipating provider with respect to a visit at a participating health care facility, unless the provider has satisfied the notice and consent criteria of §149.420(c) through (i) with respect to such items and services.

(c) *Coverage requirements.* In the case of items and services described in paragraph (b) of this section, the plan or issuer—

(1) Must not impose a cost-sharing requirement for the items and services that is greater than the cost-sharing requirement that would apply if the items or services had been furnished by a participating provider.

(2) Must calculate the cost-sharing requirements as if the total amount that would have been charged for the items and services by such participating provider were equal to the recognized amount for the items and services.

(3) Not later than 30 calendar days after the bill for the items or services is transmitted by the provider (or in cases where the recognized amount is determined by a specified State law or All-Payer Model Agreement, such other timeframe as specified under the State law or All-Payer Model Agreement), must determine whether the items and services are covered under the plan or coverage and, if the items and services are covered, send to the provider an initial payment or a notice of denial of payment. For purposes of this paragraph (c)(3), the 30-calendar-day period begins on the date the plan or issuer receives the information necessary to decide a claim for payment for the items or services.

(4) Must pay a total plan or coverage payment directly to the nonparticipating provider that is equal to the amount by which the out-of-network rate for the items and services involved