

Report: Federal Qualifying Payment Amount Audit of
School Employees Retirement System
State of Ohio as of April 9, 2026

Audit Report: 2023 – QPA – 11

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I. Scope of Audit

The Center for Consumer Information and Insurance Oversight (CCIIO) conducted a Qualifying Payment Amount (QPA) Audit (Audit) of School Employees Retirement System of Ohio's group health plan (Plan) pursuant to sections 2723(b) and 2799A-1(a)(2)(A) of the Public Health Service Act (PHS Act) and implementing regulations at 45 CFR §§ 150.313 and 149.140(f).

The Audit Period was for items and services furnished between January 1, 2022, through May 31, 2023. The purpose of the Audit was to assess the Plan's compliance with certain Federal requirements under sections 2799A-1(a) and 2799A-2(a) of the PHS Act and the following implementing regulations:

- 45 CFR § 149.130 – Preventing Surprise Medical Bills for Air Ambulance Services; and
- 45 CFR § 149.140 – Methodology for Calculating Qualifying Payment Amount.¹

During this Audit, CCIIO requested claim records, data and documents pertaining to the calculation of QPAs for air ambulance services subject to the surprise billing provisions of the No Surprises Act (referred to in this report as “No Surprises Act-eligible claims”). CCIIO also requested Plan-generated documents, including:

- a comprehensive list of all insurance markets in which the Plan offers coverage;
- a narrative describing the Plan's QPA calculation methodology;
- all claims handling manuals, internal bulletins and guidelines issued by the Plan with respect to the processing and payment of claims;
- claims data relating to air ambulance services for which there was a requirement to apply a QPA;
- QPA calculation data;
- claim samples and related claim processing documents.

¹ The School Employees Retirement System group health plans are self-funded non-federal governmental plans governed by Ohio Admin. Code § 3901-8-17; Ohio Rev. Code §§ 3902.50-3902.53. Ohio state law, ORC 3902.50 – 3902.54 are specified state laws that will apply for purposes of determining the out-of-network rate with respect to emergency services and non-emergency services by nonparticipating providers at in-network facilities. Due to this, the scope of the Audit was specific to air ambulance services, as this is the only claim type to which the federal No Surprises Act regulations (and QPA) would apply.

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This report is by exception. Therefore, the only areas indicated in the report are areas where findings were noted. Any additional practices, procedures, and files subject to review during the Audit are omitted from this report if no findings are indicated. Some non-compliant practices may not have been discovered or noted in this report. Failure to identify or address business practices that do not comply with Federal statutes and regulations or those of other applicable jurisdictions does not constitute acceptance of such practices.

The audit and testing methodologies followed standards established by the National Association of Insurance Commissioners (NAIC)² and procedures developed by CCIIO.

The Audit's scope was limited to (i) QPA calculations for No Surprises Act-eligible claims and (ii) required QPA disclosures for No Surprises Act-eligible claims and was conducted pursuant to CMS's authority under sections 2723(b) and 2799A-1(a)(2)(A) of the PHS Act. Accordingly, CCIIO requested and received from the Plan, QPA calculation data and claims which are summarized in the tables below:

QPA calculation data:

Total Number of QPAs	Contracted Rates
8	36

All No Surprises Act-eligible claims:

Claim Type	Population	Sample Size	QPAs
Air Ambulance	6	6	8

Since the commencement of this Audit, the United States District Court for the Eastern District of Texas (district court) issued an opinion and order in *Texas Medical Association et al. v. United States Department of Health and Human Services et al.*, Case No. 6:22-cv-450-JDK (E.D. Tex) (TMA III) vacating certain provisions of the regulations and guidance regarding calculation of the QPA. On October 30, 2024, the United States Court of Appeals for the Fifth Circuit (Fifth Circuit) issued an opinion and order in TMA III. The Fifth Circuit reversed the district court's holding that vacated challenged provisions related to the

² Market Regulation Handbook Examination Standards Summary 2022.

<https://content.naic.org/sites/default/files/publication-mes-hb-market-handbook-examination.pdf>

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methodology for calculating the QPA; affirmed the district court's vacatur of certain deadline provisions; and affirmed the district court's holding as to the requirements regarding disclosure of information about the QPA. After the Fifth Circuit opinion and order, TMA requested rehearing en banc. On May 30, 2025, the Fifth Circuit vacated the entire panel opinion and granted TMA's request for rehearing en banc.³ TMA III remains under litigation, and as such, this report describes the Plan's compliance with applicable regulations and guidance as modified by the District Court in TMA III.⁴

³ Tex. Med. Ass'n, et al. v. U.S. Dep't of Health & Human Servs., et al., Case No. 23-40605 (5th Cir. May 30, 2025)

⁴ FAQs about Consolidated Appropriations Act, 2021 Implementation Part 71 (July 30, 2025), available at <https://www.cms.gov/files/document/faqs-part-71.pdf>.

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II. Plan Profile

School Employees Retirement System of Ohio (Plan) group health plan is a self-funded non-federal governmental plan that uses Aetna Health Inc. as its third-party administrator (TPA) to administer its members' benefits. Aetna Health Inc. is a licensed TPA in the State of Ohio. TPA services are offered under the brand name Aetna Signature Administrators. Aetna's TPA services, including Aetna Signature Administrators, are available to self-funded health benefit plans, helping them with claims processing, and other administrative tasks.

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III. Executive Summary

CCIIO conducted an Audit to assess the Plan's compliance with select provisions of the following under Title XXVII of the PHS Act and their implementing regulations:

- Section 2799A-1(a) – Qualifying Payment Amount;
- Section 2799A-2(a) – Ending Surprise Air Ambulance Bills;
- 45 CFR § 149.130 – Preventing Surprise Medical Bills for Air Ambulance Services; and
- 45 CFR § 149.140 – Methodology for Calculating Qualifying Payment Amount.

The Audit, for items or services furnished during the period from January 1, 2022, through May 31, 2023, included the review and analysis of claim records, data, and documents pertaining to the calculation of QPAs for No Surprises Act-eligible claims. CCIIO also requested Plan-generated documents, including: a comprehensive list of all insurance markets in which the Plan offers coverage; a narrative describing the Plan's QPA calculation methodology; all claims handling manuals, internal bulletins and guidelines issued by the Plan with respect to the processing and payment of claims; claims data relating to air ambulance services for which there was a requirement to apply a QPA; QPA calculation data; and claim samples and related claim processing documents.

This report is by exception. Therefore, the only areas indicated in the report are areas where findings were noted. Any additional practices, procedures, and files subject to review during the Audit are omitted from this report if no findings are indicated. Please note: TMA III remains under litigation, and as such, this report describes the Plan's compliance with applicable regulations and guidance as modified by the District Court in TMA III.

In summary, findings, along with completed and/or additionally required corrective actions, were identified regarding the following Federal requirements:

Finding 1	
Summary	Failing to prevent surprise medical bills for air ambulance services due to the improper identification of No Surprises Act-eligible claims.
Citation	45 CFR § 149.130

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Finding 1	
Completed Corrective Action	The Plan's TPA implemented a system update to remove the retiree-only plan designation that incorrectly excluded two air ambulance claims from No Surprises Act processing. The Plan provided its rationale for not reprocessing the impacted claims in accordance with the No Surprises Act. No further action is required with respect to the identified claims. The Plan explained that its system update will ensure that all future No Surprises Act-eligible claims will process in accordance with the No Surprises Act regulations and that an additional review of claims will be conducted to identify any necessary remediation.

Finding 1 Additional Required Corrective Action	
Additional Required Corrective Action for Finding 1	Conduct a self-audit of all No Surprises Act-eligible claims from January 1, 2022, through the date of the final report to identify claims that were not processed in accordance with the No Surprises Act. In addition, conduct a thorough review of the claim system requirements to ensure that all No Surprises Act-eligible claims are properly identified and processed in accordance with No Surprises Act requirements. Determine the policy and/or procedural cause for failing to identify and process No Surprises Act-eligible claims according to regulation. Implement changes necessary to ensure that future No Surprises Act-eligible claims are identified and processed as required. For all No Surprises Act-eligible claims that were incorrectly excluded from No Surprises Act processing, recalculate cost-sharing to be based on the lesser of the QPA or billed charges. For claims for which the cost-sharing the consumer paid was higher than the recalculated cost-sharing, refund the consumer any cost-sharing erroneously paid. For claims for which the cost-sharing the consumer paid was lower than the recalculated cost-sharing, no action is required. For guidance on QPA calculations and federal exercises of enforcement discretion in

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Finding 1 Additional Required Corrective Action	
	TMA III, see FAQs about Consolidated Appropriations Act, 2021 Implementation Part 71.⁵ Within 30 calendar days of the date of the final report, provide documentation to CCIIO containing the results from the self-audit, provide the identified policy and/or procedural causes for failing to provide the QPA disclosures, along with the steps taken to remediate the failure, and evidence that any excess cost-sharing amounts have been refunded to consumers. The results must contain the claim numbers, dates of service, calculated QPAs, as well as original and corrected cost-sharing amounts, and dates of refund of cost-sharing differential payments to consumers. The response should include a narrative description of the steps the Plan has taken or intends to take, along with the timeline for completion, to ensure that it is in compliance with the requirements of 45 CFR § 149.130.

Finding 2	
Summary	Failing to provide the required No Surprises Act notices and disclosures (referred to as QPA disclosures) in writing, in paper or electronic form with an initial payment or in a notice of denial of payment for No Surprises Act-eligible claims. Specifically, the Plan failed to: • Provide the QPA for each item or service involved; and • Disclosure that, generally, the provider or facility may initiate the IDR process within four days after the end of the open negotiation period.
Citation	45 CFR § 149.140(d)(1)
Completed Corrective Action	45 CFR § 149.140(d)(1)(i): The Plan's TPA implemented a system upgrade which included adding a QPA field to all disclosures provided with initial payments and notices of denial of payment for all No Surprises Act-eligible claims. This impacted two air ambulance

⁵ *Id.*

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Finding 2	
	claims, one of which was reprocessed with the system update prior to the Audit initiation. No further action is required with respect to the identified claims. 45 CFR § 149.140(d)(1)(iv): The Plan's TPA also updated its standard QPA disclosure language to state "If the 30-day negotiation period does not result in the issue of a determination you have 4 business days beginning on the 31st business day following the conclusion of the Open Negotiation period to initiate the independent dispute resolution process." The revised language is, however, inaccurate and remains noncompliant. This impacted four air ambulance claims. The Plan also acknowledged that it would correct the referenced language. Further action is required with respect to the QPA disclosure language.

Finding 2 Additional Required Corrective Action	
Additional Required Corrective Action for Finding 2	Conduct a thorough review of the claim system requirements to ensure that all QPA disclosures are provided for No Surprises Act-eligible claims with the initial payment or the notice of denial of payment. Determine the policy and/or procedural cause for failing to provide the required QPA disclosures. Implement changes necessary to ensure that QPA disclosures are provided on future claims. Implement a system upgrade to update the non-compliant disclosure language to meet the requirements. For example, revised language could state: • "... you have 4 business days following the conclusion of the Open Negotiation period to initiate the independent dispute resolution process." • "... you have 4 business days beginning on the 1st business day following the conclusion of the Open Negotiation period to initiate the independent resolution process." • "... you have 4 business days beginning on the 31st business day following the beginning/start of the Open Negotiation period to initiate the independent resolution process."

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Finding 2 Additional Required Corrective Action

	Within 30 calendar days of the date of the final report, provide documentation to CCIO for identified policy and/or procedural causes for failing to provide the QPA disclosures with compliant language, along with the steps taken to remediate the failure. The response should include a narrative description of the steps the Plan has taken or intends to take, along with the timeline for completion, to ensure that it is in compliance with the requirements of 45 CFR § 149.140(d)(1).
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One observation was identified regarding No Surprises Act-eligible claims.

Observation 1

Summary	The Plan did not provide disclosures required under the No Surprises Act for a No Surprises Act-eligible claim for which Plan was the secondary payor.
Citation	45 CFR § 149.110(a), 45 CFR § 149.120(a), 45 CFR § 149.130(a), and 45 CFR § 149.140(d)(1)

One observation was identified regarding the Federal QPA Calculation Methodology Requirements:

Observation 2

Summary	The Plan did not calculate the QPA in accordance with then applicable rules by excluding contracted rates for contracts under which no claims were filed. The preamble discussion regarding the specific requirement to include contracted rates regardless of the number of claims paid at that contracted rate was vacated by the district court decision in TMA III.
Citation	45 CFR §§ 149.140(b)(1) and (c)(1)

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Additional details regarding these findings are in the Audit Results section of this report.

The Audit identified practices that did not comply with Federal requirements applicable at the time subject to the Audit. CCIIO strongly recommends that the Plan apply the corrective actions outlined in this Audit Report to and share the corrective actions with all its affiliates, regardless of situs or regulatory jurisdiction for No Surprises Act-eligible claims. Additionally, the Plan may be subject to future audits.

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IV. Audit Results

A. No Surprises Act Coverage Requirements Finding

Violation of 45 CFR § 149.130.

CCIIO identified one finding of this provision in the following instances:

Finding 1 – Failing to prevent surprise medical bills for air ambulance services due to the improper identification of No Surprises Act-eligible claims.

The Plan and its TPA failed to prevent surprise medical bills for air ambulance services in violation of 45 CFR § 149.130. In general, if a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides or covers any benefits for air ambulance services, the plan or issuer must cover such services from a nonparticipating provider of air ambulance services in accordance with the coverage requirements of 45 CFR § 149.130(b). This violation appeared in two sampled claims.

Upon review, Q6 in the FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 55 (FAQs Part 55)⁶ states the following in reference to group health plan or group or individual health insurance coverage that generally does not provide out-of-network coverage:

Q6. Do the surprise billing provisions of the No Surprises Act apply in the case of a group health plan or group or individual health insurance coverage that generally does not provide out-of-network coverage?

A. Yes....Finally, under section 9817(a) of the Code, section 717(a) of ERISA, and section 2799A-2(a) of the PHS Act, if a plan or issuer provides or covers any benefits for air ambulance services, the plan or issuer must cover such services from a nonparticipating provider of air ambulance services in accordance with requirements set forth in 26 CFR 54.9817-1T(b), 29 CFR 2590.717-1(b), and 45 CFR 149.130(b) related to cost sharing, payment amounts, and procedural requirements related to billing disputes. These requirements may result in a plan or coverage providing benefits for out-of-network items and services subject to the surprise billing provisions, even if the plan or coverage otherwise would not provide coverage for these items or services on an out-of-network basis.

⁶ FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 55 (August 19, 2022), available at <https://www.cms.gov/files/document/faqs-part-55.pdf>.

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In the section above, the FAQs Part 55 highlight the coverage requirements for No Surprises Act-eligible air ambulance services, as stated in 45 CFR § 149.130(b), which includes requirements “related to cost sharing, payment amounts, and procedural requirements related to billing disputes.”

CCIIO requested (RFI #1) all No Surprises Act-eligible claims for the Audit Period which totaled six sampled claims and eight QPAs, all of which were air ambulance service claims. CCIIO requested all documentation demonstrating compliance with the No Surprises Act requirements. During its review, CCIIO identified two sampled claims (#2 and #4) which were not processed in accordance with the No Surprises Act.

CCIIO sought clarification (RFI #2) from the Plan as to why these two claims were not reprocessed after it was discovered they had not been processed in accordance with the No Surprises Act. CCIIO also requested a narrative providing the Plan’s current procedures to prevent claims from being incorrectly excluded from No Surprises Act processing.

In response, the Plan produced *RFI-2_Response_08.29.2023* which confirmed that the two sampled claims were incorrectly excluded from the No Surprises Act processing because of an error in the TPA’s administrative system. The Plan explained that:

Claim samples #2 and [#]4 were not processed in accordance with the NSA. An analysis by SERS [Plan] concluded that complex circumstances surrounding the inclusion of some re-employed retirees in the SERS Plan precluded the plan from qualifying as a retiree-only plan under the NSA. However, the SERS plan was inadvertently designated as “retiree only” in Aetna’s system which caused two claims to bypass NSA claims processing logic. The error was discovered in June 2023.

Claim samples #2 and [#]4 have not been processed under NSA requirements. The actual impact to the member and provider is illustrated in the table below. Rationale for Sample #2: After the claim was originally processed, the provider balance billed the member and Aetna reprocessed the claim and paid an additional \$16,296.27, for a total payment to the provider of \$19,426.28. Because the total amount paid to the provider is greater than the payment the provider would have received under the NSA claims logic to pay QPA, the decision was made not to reprocess the claim. Rationale for Sample #4: If the claim was reprocessed in accordance with the NSA requirements, any additional amounts paid to the

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provider would result in an increase of \$247.95 to the member's cost-share. Due to the adverse impact to the member, the decision was made not to reprocess the claim unless the provider attempted to balance bill the member or contacted Aetna to negotiate the amount paid. Our records indicate that the provider has not taken either action which may be an indication that the provider accepted the amount paid.

	Current processing	If processed under NSA
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	Amount allowed	Member cost-share	Total paid to provider	QPA	Member cost-share	Total paid to provider
Sample #2 (initial processing)	\$3,912.51	\$782.50	\$3,130.01	\$19,841.72	\$1,201.32	\$18,640.40
Sample #2 (after reprocessing)	\$20,627.60	\$1201.32	\$19,426.28			
Sample #4	\$4,113.31	\$1183.54	\$2,929.77			
				\$22,553.59	\$1431.49	\$21,122.10

Upon discovery of the SERS plan's incorrect designation as "retiree only", Aetna initiated a system update that will go into effect on or before 9/15/2023 to remove the retiree-only plan designation. This update will ensure that all future NSA-eligible claims will process in accordance with the NSA regulations. All NSA-eligible SERS claims processed for dates of services between 1/1/2022 and 5/31/2023 were reviewed and claim samples #2 and 4 were the only NSA-eligible claims that were not processed under the NSA. When the system update is complete, an additional review of claims processed between 6/1/2023 and 9/15/2023 will be conducted to identify any NSA-eligible claims that require remediation.

The Plan's production referenced above confirmed that these claims were not reprocessed under the No Surprises Act due to the potential adverse impact on the member's cost-share amount. Pursuant to 45 CFR § 149.130(b)(1), plans and issuers must provide coverage for air ambulance services such that the cost-sharing requirements with respect to the services must be the same requirements that would apply if the services were provided by a participating provider of air ambulance services. This includes applying the in-network cost-sharing to the lesser of billed charges or the calculated QPA, since the QPA is calculated using the median of contracted rates for the same or similar service.

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The FAQs about Consolidated Appropriations Act, 2021 Implementation Part 69⁷ reiterate this as follows:

Additionally, under the No Surprises Act, nonparticipating providers, facilities, and providers of air ambulance services are prohibited from billing or holding liable such individual for a payment amount that is more than the cost-sharing amount allowed to be charged under the No Surprises Act (calculated using the recognized amount, or in the case of air ambulance services, the lesser of the billed charge or the QPA).

Since these claims were not processed as No Surprises Act claims, the required disclosures were also not provided.

Additionally, pursuant to 45 CFR § 149.130(b)(4)(i), plans and issuers are required to send an initial payment or notice of denial of payment to the provider or facility not later than 30 calendar days after the bill for such services was transmitted. Plan failed to do this in one sampled claim referenced above (sampled claim #4).

CCIIO requested (RFI #1) that the Plan produce all documentation demonstrating compliance with disclosure requirements, which includes information regarding when the bill was transmitted/received and when the Plan processed the claim. CCIIO identified one occurrence for which the initial payment was sent to the provider later than 30 calendar days after the bill was transmitted by the provider.

CCIIO sought clarification (RFI #4) regarding the apparent noncompliance. CCIIO requested confirmation that the Plan failed to issue a payment or notice of denial of payment within 30 calendar days after the bill was transmitted and a narrative describing the Plan's reason for the delay. In response, the Plan produced *RFI-4_Response_09.25.2023* which confirmed one violation:

The Plan confirms that the initial payment or notice of denial was later than 30 calendar days after transmission/receipt of the bill by the provider or facility.

Below is a processing timeline for claim sample #4 (claim ID EVTXW1DVJ00), explaining the handling steps that resulted in a processing delay:

⁷ FAQs about Consolidated Appropriations Act, 2021 Implementation Part 69 (January 14, 2025), available at <https://www.cms.gov/files/document/faqs-part-69.pdf>.

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- Claim was received on 3/28/2022
- Routed for external pricing attempt on 3/29/2022
- Pended for air ambulance review/pricing on 4/1/2022
- Pended for internal review on 4/6/2022 due to member's retiree status in Aetna's system (prior to Aetna determining that the member's retiree status should be removed)
- Claim remained in pended status awaiting internal review until 5/5/2022, when the claim payment was released, with interest, due to the delay in processing.

The delayed payment processing timeline for sampled claim #4 totaled eight calendar days out of compliance.

Since the commencement of this Audit, the United States District Court for the Eastern District of Texas (district court) issued an opinion and order in *Texas Medical Association et al. v. United States Department of Health and Human Services et al.*, Case No. 6:22-cv-450-JDK (E.D. Tex) (TMA III) vacating certain provisions of the regulations and guidance regarding the air ambulance requirement of starting the 30-day deadline for notice or denial of payment when the insurer receives the information "necessary to decide a claim". On October 30, 2024, the United States Court of Appeals for the Fifth Circuit (Fifth Circuit) issued an opinion and order in TMA III.⁸ The Fifth Circuit affirmed the district court's vacatur of certain deadline provisions related to 45 CFR § 149.130(b)(4)(i). TMA III remains under litigation, and as such, this report describes the Plan's compliance with applicable regulations and guidance as modified by the District Court in TMA III. The air ambulance services provided for the one sampled claim occurred prior to TMA III and the Plan had all necessary information to decide the claim.

The Plan agreed with this finding in Criticism⁹ #4 and provided the following response:

The plan designation matter that impacted the two referenced claims was corrected in June 2023. No other claims were affected.

Completed Corrective Action for Finding 1:

⁸ *Tex. Med. Ass'n, et al. v. U.S. Dep't of Health & Human Servs., et al.*, Case No. 23-40605 (5th Cir. Oct. 30, 2024).

⁹ Criticisms are used during the audit to communicate potential findings of violation of federal requirements. Issuers have the ability to provide additional information to demonstrate compliance with the federal requirements or agree with the violation finding.

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The Plan's TPA implemented a system update to remove the retiree-only plan designation that incorrectly excluded two air ambulance claims from No Surprises Act processing. The Plan provided its rationale for not reprocessing these claims in accordance with the No Surprises Act. Further action is required with respect to the identified claims. The Plan stated that:

This update will ensure that all future NSA-eligible claims will process in accordance with the NSA regulations. All NSA-eligible SERS claims processed for dates of services between 1/1/2022 and 5/31/2023 were reviewed and claim samples #2 and 4 were the only NSA-eligible claims that were not processed under the NSA. When the system update is complete, an additional review of claims processed between 6/1/2023 and 9/15/2023 will be conducted to identify any NSA-eligible claims that require remediation.

Additional Required Corrective Action for Finding 1:

Conduct a self-audit of all No Surprises Act-eligible claims from January 1, 2022, through the date of the final report, to identify claims that were not processed in accordance with the No Surprises Act. In addition, conduct a thorough review of the claim system requirements to ensure that all No Surprises Act-eligible claims are properly identified and processed in accordance with No Surprises Act requirements. Determine the policy and/or procedural cause for failing to identify and process No Surprises Act-eligible claims according to regulation. Implement changes necessary to ensure that future No Surprises Act-eligible claims are identified and processed as required.

For all No Surprises Act-eligible claims that were incorrectly excluded from No Surprises Act processing, recalculate cost-sharing to be based on the lesser of the QPA or billed charges. For claims for which the cost-sharing the consumer paid was higher than the recalculated cost-sharing, refund the consumer the any cost-sharing erroneously paid. For claims for which the initial cost-sharing was lower than the recalculated cost-sharing, no action is required. For guidance on QPA calculations and federal exercises of enforcement discretion in TMA III, see FAQs about Consolidated Appropriations Act, 2021 Implementation Part 71.¹⁰

¹⁰ FAQs about Consolidated Appropriations Act, 2021 Implementation Part 71 (July 30, 2025), available at <https://www.cms.gov/files/document/faqs-part-71.pdf>.

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Within 30 calendar days of the date of this final report, provide documentation to CCIIO containing the results from the self-audit, provide the identified policy and/or procedural causes for failing to provide the QPA disclosures, along with the steps taken to remediate the failure, and evidence that any excess cost-sharing amounts have been refunded to consumers. The results must contain the claim numbers, dates of service, calculated QPAs, as well as original and corrected cost-sharing amounts, and dates of refund of cost-sharing differential payments to consumers. The response must include a narrative description of the steps the Plan has taken or intends to take, along with the timeline for completion, to ensure that it is in compliance with the requirements of 45 CFR § 149.130.

Plan Response: The Plan concurs with CCIIO's findings in the draft final report ("Report") dated February 12, 2026. The Plan's corrective actions will be implemented as follows:

- Finding 1: As noted in the report, the Plan's TPA implemented a system update to correct the retiree-only designation that resulted in two NSA-eligible claims being excluded from NSA processing. The Plan's TPA will conduct a self-audit as described in the Report to ensure that the system update was effective in preventing NSA-eligible claims from being processed in accordance with NSA regulations.

CCIIO concurs with the Plan's position.

B. QPA Disclosure Requirements Findings

Violation of 45 CFR § 149.140(d)(1).

CCIIO identified one finding related to these provisions in the following instances:

Finding 2 – Failing to provide the required No Surprises Act notices and disclosures (referred to as QPA disclosures) in writing, in paper or electronic form with an initial payment or in a notice of denial of payment for No Surprises Act-eligible claims.

The Plan failed to provide QPA disclosures in violation of 45 CFR § 149.140(d)(1). Plans and issuers are required to provide, in writing, in paper or electronic form, the QPA for each item or service, certain certification statements, and contact information to the provider or facility with each initial payment or notice of denial of payment. This violation appeared in four claims totaling four QPAs on which the Plan failed to disclose that the provider has the option to initiate the independent dispute resolution (IDR)

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process within 4 days after the end of the open negotiation period and, on some of the same claims failed to disclose the QPA for each item or service.

Incomplete QPA Disclosures 45 CFR § 149.140(d)(1)(i)

In cases in which the recognized amount with respect to an item or service is the QPA, plans and issuers must provide, in writing, in paper or electronic form, the QPA for each item or service, to the nonparticipating provider of air ambulance services. CCIIO noted that for two of the six sampled claims, the Plan failed to share four QPAs in violation of 45 CFR § 149.140(d)(1)(i).

CCIIO requested (RFI #1) that the Plan produce all documentation demonstrating compliance with disclosure requirements, which includes sharing the QPA with each item or service. During its review, CCIIO identified two sampled claims (#1 and #5), totaling four QPAs, for which the Plan sent QPA disclosures but failed to share the QPA in compliance with the No Surprises Act.

During the Audit, the Plan disclosed that its TPA implemented a system change which updated the provider explanation of benefit (EOB) to include “QPA” in its “ALLOWABLE AMOUNT” field. CCIIO sought clarification (RFI #3) regarding the reason for the referenced system update. In response, the Plan produced *RFI-3_Response_09.25.2023* which explained the following:

Although Aetna’s EOB did not contain a stand-alone field explicitly displaying the QPA prior to 11/03/2022, the information needed to determine the QPA paid on the claim had been present on the EOB since 1/1/2022. However, an opportunity was identified as part of Aetna’s Continuous Quality Improvement processes, to eliminate confusion by updating the EOB to align more clearly to the QPA disclosure requirements pursuant to 45 CFR § 149.140(d).

On 5/26/2022, Aetna implemented an interim enhancement while the more complex QPA field enhancement was under development. This update modified the remarks language on the EOB to better explain how the QPA was derived. A sentence was added which stated: The QPA is the difference between the "submitted charges" and "not payable" amount shown on each covered service line.

On 11/3/2022, the permanent enhancement adding “QPA” to the “allowable amount” field was implemented to more clearly identify the QPA for NSA-eligible claims.

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The Plan's TPA initially processed sampled claim #1 on 07/08/2022 and did not share the QPA with the initial payment. Following an IDR decision, on 01/03/2023, however, the TPA reprocessed this claim to include "QPA" in its EOB "ALLOWABLE AMOUNT" field, subsequently complying with the requirement to share the QPA.

Conversely, the Plan's TPA processed sampled claim #5 on 03/01/2022 and the TPA did not reprocess this claim after the TPA implemented the corrective actions noted above. As a result, the TPA did not share the QPAs for each item or service and did not comply with the requirement to share the QPA.

Incomplete IDR Statement 45 CFR § 149.140(d)(1)(iv)

Plans and issuers are required to provide certain notices and disclosures with the initial payment or in a notice of denial of payment when the cost-sharing amount with respect to an item or service furnished by a nonparticipating provider of air ambulance services is calculated based on the QPA. These disclosures include a statement that if the provider or facility, as applicable, wishes to initiate a 30-day open negotiation period for purposes of determining the amount of total payment, the provider or facility may contact the appropriate person or office to initiate open negotiation, and that if the 30-day open negotiation period does not result in a determination, generally, the provider may initiate the IDR process within four days after the end of the open negotiation period. The Plan failed to provide a statement containing the required disclosure with the initial payment or notice of denial of payment in violation of 45 CFR § 149.140(d)(1)(iv). This appeared in four of the six sampled claims.

CCIIO requested (RFI #1) that the Plan produce all documentation demonstrating compliance with disclosure requirements, which includes a statement about the option to initiate the IDR process within 4 days after the end of the open negotiation period. During its review, CCIIO identified four claims for which the Plan failed to provide the required disclosure.

In response to RFI #1, CCIIO observed that sampled claim #1 was initially processed with QPA disclosure language that was not compliant and was missing the required four-day IDR process statement. The Plan produced *Sample 1c_prov EOB* which stated the following:

If no agreement is reached during the Open Negotiation, you may initiate the Federal Independent Dispute Resolution (IDR) process for eligible claims on business day 31.

In response to RFI #1, the Plan also produced reprocessed *Sample 1b_prov EOB*, that contained the following updated language:

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If the 30-day negotiation period does not result in the issue of a determination you have 4 business days beginning on the 31st business day following the conclusion of the Open Negotiation period to initiate the independent dispute resolution process.

CCIIO noted that three sampled claims (#3, #5, and #6) contain the same non-compliant language on provider EOBs. For claim sample #5, the Plan produced *Sample 5b&c_prov EOB* that stated:

If no agreement is reached during the Open Negotiation, you may initiate the Federal Independent Dispute Resolution (IDR) process for eligible claims on business day 31.

For sampled claims #3 and #6, the Plan produced *Sample 3b&c_prov EOB* & *Sample 6b&c_prov EOB* that both stated:

If the 30-day negotiation period does not result in the issue of a determination you have 4 business days beginning on the 31st business day following the conclusion of the Open Negotiation period to initiate the independent dispute resolution process.

CCIIO observed that for all of the referenced sampled claims above, the language is inaccurate and inconsistent with the requirements of 45 CFR § 149.140(d)(1)(iv).

The Plan partially agreed with this finding in Criticism #1, however the Plan disagreed with the findings with respect to noncompliance with 45 CFR § 149.140(d)(1)(iv), and provided the following response:

Plan's Comments: We agree that the initial provider EOB for claims sample 1, Sample 1c_prov EOB, and the sole provider EOB for claims sample 5, Sample 5b&c_prov EOB, do not include the required 4-day IDR process statement and are therefore in violation of 45 C.F.R. § 149.140(d)(1)(iv). Sample 1 was corrected upon reprocessing prior to the initiation of the audit and therefore should be considered compliant. We respectfully disagree that the language found in Sample 1b_prov EOB, Sample 3b&c_prov EOB, and Sample 6b&c_prov EOB are in violation of 45 C.F.R. § 149.140(d)(1)(iv). The TPA recognizes CCIIO's interpretation that the language "may" or "could" cause confusion and appreciates their recommendations for revised language to improve clarity. To that end, the TPA will update the referenced language in an effort to eliminate any confusion.

CCIIO observed that the revised language referenced above is inaccurate and noncompliant because it states that the 4-business day period to initiate IDR begins on the 31st business day following the *conclusion* of the Open Negotiation period, when the 4-

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business day period begins on the 31st business day following the *beginning* of the Open Negotiation period. The recommended revised language is located below under the Additional Required Corrective Action for Finding 3 section.

Completed Corrective Action for Finding 2:

45 CFR § 149.140(d)(1)(i): The Plan's TPA implemented a system upgrade which included adding a QPA field to all disclosures provided with initial payments and notices of denial of payment for items and services for which the QPA applies. This impacted two No Surprises Act-eligible claims, one of which was reprocessed with the system update prior to the Audit initiation. The Plan explained that:

On 11/3/2022, the permanent enhancement adding "QPA" to the "allowable amount" field was implemented to more clearly identify the QPA for NSA-eligible claims.

45 CFR § 149.140(d)(1)(iv): In response to Criticism #1, the Plan disagreed with the finding specific to this regulation, however the Plan also provided the following acknowledgement:

The TPA recognizes CCIIO's interpretation that the language "may" or "could" cause confusion and appreciates their recommendations for revised language to improve clarity. To that end, the TPA will update the referenced language in an effort to eliminate any confusion.

Additional Required Corrective Action for Finding 2:

Conduct a thorough review of the claim system requirements to ensure that all QPA disclosures are provided for No Surprises Act-eligible claims with the initial payment or the notice of denial of payment. Determine the policy and/or procedural cause for failing to provide the required QPA disclosures. Implement changes necessary to ensure that QPA disclosures are provided on future claims.

Implement a system upgrade to update the non-compliant disclosure language to meet the requirements. For example, revised language could state,

- "... you have 4 business days following the conclusion of the Open Negotiation period to initiate the independent dispute resolution process."

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- “... you have 4 business days beginning on the 1st business day following the conclusion of the Open Negotiation period to initiate the independent resolution process.”
- “... you have 4 business days beginning on the 31st business day following the beginning/start of the Open Negotiation period to initiate the independent resolution process.”

Within 30 calendar days of the date of the final report, provide documentation to CCIIO for identified policy and/or procedural causes for failing to provide the QPA disclosures with compliant language, along with the steps taken to remediate the failure. The response should include a narrative description of the steps the Plan has taken or intends to take, along with the timeline for completion, to ensure that it is in compliance with the requirements of 45 CFR § 149.140(d)(1).

Plan Response: The Plan concurs with CCIIO’s findings in the draft final report (“Report”) dated February 12, 2026. The Plan’s corrective actions will be implemented as follows:

- Finding 2: As noted in the Report, a field displaying the QPA was added to the Plan’s EOB. The NSA disclosures that appear on the Plan’s Explanation of Benefits (EOB) for NSA-eligible claims were updated on 12/8/2023 to include the following statement: “You have 4 business days following the conclusion of the Open Negotiation period to initiate the independent resolution process.”

The Plan will complete the required self-audit for Finding 1 and provide the requested results, along with evidence of remediation for Finding 2, within 30 days of receipt of the final report.

CCIIO concurs with the Plan’s position.

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C. No Surprises Act Coverage Requirements Observation

Observation related to 45 CFR § 149.110(a), 45 CFR § 149.120(a), 45 CFR § 149.130(a), and 45 CFR § 149.140(d)(1).

CCIIO identified one observation of these provisions in the following instance:

Observation 1 – The Plan did not provide disclosures under the No Surprises Act for a No Surprises Act-eligible claim for which Plan was the secondary payor.

CCIIO reviewed the Plan's policies and procedures for applying the No Surprises Act to and providing appropriate disclosures for No Surprises Act-eligible claims as well as a narrative describing the claims handling process for No Surprises Act-eligible claims for which the Plan was the secondary payor during the Audit Period. CCIIO determined that the Plan did not apply the No Surprises Act to, nor did it provide disclosures for, No Surprises Act-eligible claims where the Plan was the secondary payor under applicable coordination of benefits rules.

45 CFR § 149.110(b)(5)(i) generally requires plans and issuers to cover emergency services consistent with the No Surprises Act, without regard to any other term or condition of the coverage, other than the exclusion or coordination of benefits¹¹. We interpret this to mean that, in determining whether to cover an emergency item or service, a plan or issuer may consider whether another plan is obligated to cover it pursuant to the plan or issuer's coordination of benefit rules. However, when a plan or issuer is obligated to provide coverage for an emergency item or service, nothing in the No Surprises Act or its implementing regulations appears to exempt the plan or the issuer from disclosing the QPA or other applicable requirements based on the presence of other coverage. As specified in 45 CFR § 149.20, the requirements of 45 CFR part 149, subpart B, D and H apply to group health plans and health insurance issuers offering group or individual health insurance coverage (including grandfathered health plans as defined in §147.10 of this subchapter), except as specified in 45 CFR § 149.20(b). This is true regardless of whether the plan or issuer pays primary or secondary to another payer.

¹¹ There are certain other exceptions not relevant here.

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D. QPA Calculation Methodology Requirements Observation

Observation related to compliance with the rule¹² preamble specifying which contracts must be included in the calculation of the median contract rate under 45 CFR §§ 149.140(b)(1) and (c)(1).

CCIIO identified an observation of this requirement in the following instances:

Observation 2 – The plan did not calculate the QPA in accordance with rules by excluding contracted rates for contracts under which no claims were filed.

CCIIO reviewed the Plan’s policies and procedures for calculating QPAs as well as the Plan’s complete list of QPAs for air ambulance service calculations made, and claims for air ambulance services furnished, by a nonparticipating provider during the Audit Period. CCIIO determined that the Plan did not calculate QPAs as described in the preamble discussion in the Requirements Related to Surprise Billing; Part I (86 FR 36872) that was subsequently vacated by the court decision in TMA III.¹³ The Plan excluded contracted rates for air ambulance services recognized by the Plan on January 31, 2019 that were not billed during the Audit Period.

Preamble discussion outlined in Requirements Related to Surprise Billing; Part I (86 FR 36872) defines contracted rate. In particular, the preamble notes, “The No Surprises Act envisions that each contracted rate for a given item or service be treated as a single data point when calculating a median contracted rate. Therefore, if a plan or issuer has a contract with a provider group or facility, the rate negotiated with that provider group or facility under the contract is treated as a single contracted rate, if the same rate applies to all providers of such provider group or facility under the single contract. *Likewise, the rate negotiated under a contract constitutes a single contracted rate regardless of the number of claims paid at that contracted rate. ...*” (Emphasis added).

¹² 86 Fed. Reg. 36,872, at 36,889

¹³ Tex. Med. Ass’n, et al. v. U.S. Dep’t of Health & Human Servs., et al., Case No. 23-40605 (5th Cir. May 30, 2025)

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V. Closing

Violations

No Surprises Act Coverage Requirements: CCIIO reviewed all air ambulance claims' methodologies as part of this Audit. Of this review, there was one finding with two occurrences.

- Failing to prevent surprise medical bills for air ambulance services due to the improper identification of No Surprises Act-eligible claims. There were two occurrences.

QPA Disclosure Requirements Findings: CCIIO reviewed all air ambulance claims, totaling six claims, as part of this Audit. From these claims, there was one finding and four occurrences.

- Failing to provide the required No Surprises Act notices and disclosures in writing, in paper or electronic form with an initial payment or in a notice of denial of payment for No Surprises Act-eligible claims.
 - Failing to provide either a statement itself or compliant statement that, generally, the provider or facility may initiate the IDR process within four days after the end of open negotiation period. On some of the same claims, the Plan also failed to disclose the QPA for each item or service. There were four occurrences.

Observations

No Surprises Act Coverage Requirements Observation: CCIIO reviewed the Plan's policies and procedures for preventing medical bills for coordination of benefits claims (COB) claims as part of this Audit. Of this review, there was one observation with one occurrence.

- The Plan did not apply the No Surprises Act to No Surprises Act-eligible claims for which the Plan was the secondary payor, resulting in a failure to provide disclosures under the No Surprises Act.

QPA Calculation Methodology Requirements Observations: CCIIO reviewed all air ambulance QPAs as part of this Audit. Of this review, there was one observation with one occurrence.

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- The Plan did not calculate the QPA in accordance with the rules by excluding contracted rates for contracts under which no claims were filed.

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VI. Audit Report Submission

The courtesy and cooperation extended by the officers and employees of the Plan during the course of the Audit are hereby acknowledged.

JEFFREY C. WU -S

Digitally signed by JEFFREY C. WU

Date: 2026.04.05 23:00:33 -0400

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In addition, the following individuals participated in this Audit and in the preparation of this report:

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