THE BEACON
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NEW GUIDANCE ISSUED ON SURPRISE BILLING, OUT-OF-POCKET LIMITS, AND FACILITY FEES

Late last week, the Departments of Health and Human Services, Labor, and Treasury (the Departments) published a set of FAQs that clarify how certain surprise billing protections interact with the Affordable Care Act's (ACA) maximum out-of-pocket limit (OOP) requirements. The FAQs also clarify whether facility fees are subject to specific transparency in coverage requirements.

Surprise Billing Protections and the ACA's OOP Limits

The No Surprises Act within the Consolidated Appropriations Act 2021 (CAA 2021) and the Affordable Care Act include provisions that seek to regulate participant cost-sharing. Under the ACA, non-grandfathered health plans must impose annual maximum limits on participant OOP costs for in-network essential health benefits. The No Surprises Act addresses out-of-network costs by providing that if a participant receives emergency care or air ambulance services from an out-of-network (OON) provider and/or care from an OON provider at an in-network facility, the participant can only be billed the in-network amount for that service.

The FAQs establish that much of the care a participant receives will fall under one of these protections—plans cannot contractually evade both protections at the participant's expense. If a service or provider is considered OON under the surprise billing protections, the amount the participant pays for their care will not contribute to the participant's OOP limit under the ACA. But, that care will be subject to the surprise billing protections, and therefore the participant can only be billed the in-network cost for that service. Of course, if a participant receives in-network care, that care will not be subject to the surprise billing protections, but the amount the participant pays will count towards the individual's OOP limit.

Importantly, the FAQs emphasize that whether a service or provider is OON according to the surprise billing laws depends on if the plan or issuer has a contractual relationship with the provider, facility, or air ambulance service provider. If a contractual relationship exists (regardless of whether the plan classifies the entity as in-network), then (1) the entity must be considered in-network for purposes of the No Surprises Act's surprise billing protections and (2) the cost of the care the participant receives from that provider or facility must be considered in-network for the plan's maximum out-of-pocket limits.

Facility Fees

The federal Transparency in Coverage (TiC) rules, another component of the CAA 2021, require plans and issuers to make an online, self-service price comparison tool available for enrollees so that they can estimate

their cost-sharing for services covered under the plan. For plan years beginning on or after January 1, 2023, the price comparison information must be available for a list of 500 items and services; for plan years beginning on or after January 1, 2024, the tool must be available for all covered items and services.

In the last section of the FAQs, the Departments acknowledge that participants are frequently charged facility fees when they receive care through a hospital-owned facility outside of the hospital setting (e.g., treatment at an urgent care center owned by a hospital system). The FAQs clarify that these fees qualify as medical care costs under the federal TiC rules; therefore, facility fee information must be available to enrollees in the online price comparison tool.

Finally, the No Surprises Act includes requirements that (1) providers and facilities generate good faith estimates for scheduled items and services and (2) that plans and issuers provide an advanced explanation of benefits to participants for their scheduled items and services. These requirements are currently on hold pending implementation guidance from the Departments. However, the Departments note that they will address facility fees when they release such guidance.