FAQs (Part 60) Address Interaction of Surprise Billing Rules With ACA Cost-Sharing and Transparency Requirements

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FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 60 (July 7, 2023)

Available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-60.pdf

The DOL, HHS, and IRS have jointly issued FAQs (Part 60) addressing interactions between the No Surprises Act (enacted as part of the Consolidated Appropriations Act, 2021), which provides protections against surprise medical bills, and certain requirements under the Affordable Care Act (ACA). Two FAQs address the interaction of surprise billing cost-sharing requirements and the ACA annual out-of-pocket maximum limitation. A third addresses transparency disclosures. Here are highlights:

Participating/Nonparticipating Status and Network Status. Cost-sharing requirements under the surprise billing rules hinge on whether services are furnished by a "participating" provider or facility (i.e., an entity that has a contractual relationship directly or indirectly with the group health plan or insurer) or a "nonparticipating" provider or facility (i.e., one that does not have a contractual relationship with the plan or insurer) (see our article). The application of ACA cost-sharing limitations, including the out-of-pocket maximum, depends on whether services are received from an "in-network" or "out-of-network" provider or facility.

- Q/A-1 states that cost-sharing for services furnished by a provider or facility that is considered nonparticipating under the surprise billing rules is considered cost-sharing for out-of-network services for purposes of the out-of-pocket maximum. Likewise, cost-sharing for services furnished by a participating provider or facility (for surprise billing purposes) is considered in-network cost-sharing (for purposes of the out-of-pocket maximum).

- Q/A-2 specifies that a plan or insurer that has a contractual relationship with a provider or facility that it does not consider part of its network may not treat that provider or facility as "participating" for purposes of the surprise billing rules while also treating it as "out-of-network" for purposes of the out-of-pocket maximum. Thus, for services covered by the surprise billing rules, either the cost-sharing protections of the surprise billing rules apply (because the services are furnished by a nonparticipating provider), or the ACA out-of-pocket maximum applies (because the services are furnished by an in-network provider).

Disclosure of Facility Fees. The final FAQ addresses disclosure requirements under the ACA transparency in coverage (TiC) rules and the surprise billing rules with respect to facility fees (often charged for services

provided outside of hospital settings). The TiC rules require plans and insurers to make price comparison information available through an internet-based self-service tool and in paper form upon request (see our article). The surprise billing rules require a health care provider or facility to provide a group health plan with a good faith estimate of the expected charges for furnishing a scheduled item or service to an individual who is enrolled in the plan and is seeking to have a claim for the item or service submitted to the plan. The plan must provide the individual with an "advanced explanation of benefits" describing the plan's coverage of the scheduled item or service. Q/A-3 explains that plans and insurers must make price comparison information available for covered facility fees because the TiC rules explicitly include facility fees in the definition of "items and services." In addition, the agencies anticipate that future proposed regulations on the advanced explanation of benefits would address facility fees.

EBIA Comment: While these FAQs provide a few clarifications, many open questions remain about the surprise billing rules and their overlap with preexisting ACA requirements. In particular, the requirement to provide an advanced explanation of benefits bears many similarities to the individual cost-sharing disclosure requirements in the existing TiC regulations. Future guidance is expected to address how these two requirements relate to each other and whether (and in what cases) compliance with one requirement will be deemed to be compliance with both requirements. For more information, see EBIA's Health Care Reform manual at Sections IX.B ("Cost-Sharing Limits"), XII.B.3 ("Surprise Medical Billing: Emergency and Non-Emergency Services"), XII.B.4 ("Surprise Air Ambulance Billing"), XXXVII.D ("Transparency in Coverage Cost-Sharing Disclosures"), and XXXVII.E ("Surprise Medical Billing Transparency Disclosures"). See also EBIA's Group Health Plan Mandates manual at Section XIII.B ("Patient Protections") and EBIA's Self-Insured Health Plans manual at Sections XIII.C ("Federally Mandated Benefits") and XXVIII ("Participant Disclosure Requirements for Self-Insured Health Plans").

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