

FAQS ABOUT AFFORDABLE CARE ACT AND CONSOLIDATED APPROPRIATIONS ACT, 2021 IMPLEMENTATION PART 60

July 7, 2023

Set out below are Frequently Asked Questions (FAQs) regarding implementation of certain provisions of the Affordable Care Act (ACA) and Title I (the No Surprises Act)¹ of Division BB of the Consolidated Appropriations Act, 2021. These FAQs have been prepared jointly by the Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the Departments). Like previously issued FAQs (available at <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs> and <http://www.cms.gov/ccii/resources/fact-sheets-and-faqs/index.html>), these FAQs answer questions from stakeholders to help people understand the law and promote compliance.

The No Surprises Act

Sections 102 and 103 of the No Surprises Act added section 9816 to the Internal Revenue Code (Code), section 716 to the Employee Retirement Income Security Act (ERISA), and section 2799A-1 to the Public Health Service Act (PHS Act). Section 104 of the No Surprises Act added sections 2799B-1 and 2799B-2 to the PHS Act. Section 105 of the No Surprises Act added section 9817 to the Code, section 717 to ERISA, and sections 2799A-2 and 2799B-5 to the PHS Act. These provisions provide protections against surprise medical bills for emergency services including those furnished by nonparticipating providers and nonparticipating emergency facilities,² non-emergency services furnished by nonparticipating providers with respect to a visit to a participating health care facility,³ and air ambulance services furnished by nonparticipating providers of air ambulance services.

The Departments and the Office of Personnel Management (OPM)⁴ issued interim final rules in July 2021 to implement certain of these provisions.⁵ The interim final rules generally prohibit

¹ The No Surprises Act was enacted as Title I of Division BB of the Consolidated Appropriations Act, 2021. Pub. L. 116-260, 134 Stat. 1182 (2020).

² A nonparticipating emergency facility means an emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to services that are included as emergency services pursuant to 26 CFR 54.9816-4T(c)(2)(ii), 2590.716-4(c)(2)(ii), and 45 CFR 149.110(c)(2)(ii)), that does not have a contractual relationship directly or indirectly with a group health plan or group or individual health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage, respectively. 26 CFR 54.9816-3T, 29 CFR 2590.716-3, and 45 CFR 149.30.

³ A health care facility, in the context of non-emergency services, is defined as (1) a hospital (as defined in section 1861(e) of the Social Security Act), (2) a hospital outpatient department, (3) a critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act), or (4) an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act. Code section 9816(b)(2)(A)(ii), ERISA section 716(b)(2)(A)(ii), and PHS Act section 2799A-1(b)(2)(A)(ii). 26 CFR 54.9816-3T, 29 CFR 2590.716-3, and 45 CFR 149.30.

⁴ The No Surprises Act also amended 5 U.S.C. 8902(p) to ensure that covered individuals enrolled in Federal Employees Health Benefits plans receive these protections. OPM regulations are set forth at 5 CFR 890.114.

⁵ 86 FR 36872 (July 13, 2021).

balance billing and limit cost sharing for emergency services, non-emergency services provided by nonparticipating providers with respect to a visit to a participating facility, and air ambulance services provided by nonparticipating providers of air ambulance services. However, if patients are provided notice and give consent to waive surprise billing protections consistent with applicable requirements, nonparticipating providers and nonparticipating emergency facilities may balance bill for certain post-stabilization services, and for certain non-emergency services furnished with respect to a visit to a participating health care facility, in limited circumstances.⁶

The regulations implementing the No Surprises Act define “participating provider,” “participating health care facility,” and “participating emergency facility” in terms of whether the provider or facility has a contractual relationship directly or indirectly with a group health plan or health insurance issuer offering group or individual health insurance coverage setting forth the terms and conditions on which a relevant item or service is provided to a participant, beneficiary, or enrollee under the plan or coverage, respectively.⁷ Similarly, the Departments consider a provider of air ambulance services to be a participating provider of air ambulance services if the provider of air ambulance services has a contractual relationship directly or indirectly with a plan or issuer, with respect to the furnishing of air ambulance services under the plan or coverage, respectively.⁸

Limitations on Cost Sharing under the Affordable Care Act

PHS Act section 2707(b), as added by the ACA, provides that all non-grandfathered group health plans, including non-grandfathered self-insured and non-grandfathered insured small and large group market health plans, shall ensure that any annual cost sharing imposed under the plan does not exceed the limitations provided for under ACA section 1302(c)(1). Under ACA section 1302(c)(1), an enrollee’s cost sharing for a plan year for essential health benefits is limited. This annual limitation on cost sharing also applies to non-grandfathered health insurance coverage offered in the individual and small group market through the essential health benefits requirements of PHS Act section 2707(a).

For plan or policy years beginning in 2014, the maximum annual limitation on an individual’s cost sharing under ACA section 1302(c)(1) (sometimes called the maximum out-of-pocket limit or MOOP limit) was set by reference to Code section 223(c)(2)(A)(ii). For plan or policy years thereafter, the MOOP limit is increased by the premium adjustment percentage described under ACA section 1302(c)(4).

⁶ 26 CFR 54.9816-4T(c)(2)(ii)(B) and 54.9816-5T(b); 29 CFR 2590.716-4(c)(2)(ii)(B) and 2590.716-5(b); and 45 CFR 149.110(c)(2)(ii)(B) and 149.120(b); 86 FR 36872, 36906 (July 13, 2021) (providing that individuals are allowed to waive their balance billing protections “only after receiving a written notice that includes detailed information designed to ensure that individuals knowingly accept out-of-pocket charges (including charges associated with balance bills) for care received from a nonparticipating provider or nonparticipating emergency facility”).

⁷ 26 CFR 54.9816-3T, 29 CFR 2590.716-3, and 45 CFR 149.30. Note that under these regulations, a single case agreement between a health care facility or emergency facility and a plan or issuer that is used to address unique situations in which a participant, beneficiary, or enrollee requires services that typically occur out-of-network constitutes a contractual relationship for purposes of the definitions of “participating emergency facility” and “participating health care facility,” and is limited to the parties to the agreement with respect to the particular individual involved. *See* 86 FR 36882 (July 13, 2021).

⁸ *See also* FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 55 (Aug. 19, 2022), fn 4, available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-55.pdf> and <https://www.cms.gov/files/document/faqs-part-55.pdf>.

Pursuant to ACA section 1302(c)(3), cost sharing includes deductibles, coinsurance, copayments, or similar charges, and any other expenditure required of an individual that is a qualified medical expense (within the meaning of Code section 223(d)(2)) with respect to essential health benefits covered under the plan, except that cost sharing does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services. Under HHS regulations at 45 CFR 156.130 implementing ACA section 1302(c)(1), in the case of a plan using a network of providers, cost sharing paid by, or on behalf of, an enrollee for benefits provided outside of such network is not required to count toward the annual limitation on cost sharing. Previous FAQs also provided guidance on the MOOP limit under PHS Act section 2707. One of these FAQs explained that PHS Act section 2707 sets limits on cost sharing with reference to the limitations set forth in ACA section 1302(c); therefore, the FAQs clarified that if a plan includes a network of providers, the plan may, but is not required to, count an individual's out-of-pocket spending for out-of-network items and services toward the MOOP limit.⁹

For purposes of the MOOP limit under PHS Act section 2707 and ACA section 1302(c), an out-of-network provider is a provider or facility with which the plan or issuer does not have a contractual arrangement directly or indirectly with respect to the applicable plan or coverage.¹⁰ In contrast, an in-network provider is a provider or facility with which the plan or issuer has a contractual arrangement directly or indirectly with respect to the applicable plan or coverage.

Q1: Is cost sharing for services furnished by a nonparticipating provider, facility, or provider of air ambulance services (as defined for purposes of the No Surprises Act) considered cost sharing for benefits provided outside of a plan's network for purposes of the MOOP limit?

Yes. Cost sharing for services furnished by a provider, facility, or provider of air ambulance services that is “nonparticipating” for purposes of the No Surprises Act is considered “cost sharing paid by, or on behalf of, an [individual] for benefits provided outside of such network” for purposes of the MOOP limit under PHS Act section 2707 and ACA section 1302(c), as implemented at 45 CFR 156.130. Additionally, cost sharing for services furnished by a provider, facility, or provider of air ambulance services that is “participating” for purposes of the No Surprises Act is considered cost sharing for benefits provided within a plan's network for purposes of the MOOP limit. That is, cost sharing for services provided by participating providers is considered to be in-network cost sharing for purposes of the MOOP limit, and cost sharing for services provided by nonparticipating providers is considered to be out-of-network cost sharing for purposes of the MOOP limit.¹¹

⁹ See FAQs about Affordable Care Act Implementation (Part XVIII) and Mental Health Parity Implementation (Jan. 9, 2014), Q4, available at www.dol.gov/sites/dolgov/files/EBSA/about-ebbsa/our-activities/resource-center/faqs/aca-part-xviii.pdf and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs18.

¹⁰ See 78 FR 12833, 12847 (Feb. 25, 2013) (“We [consider] an out-of-network provider to be a provider with whom the issuer does not have a contractual arrangement with respect to the applicable plan.”).

¹¹ Cost sharing attributable to benefits provided by nonparticipating providers generally is not required to be counted toward the MOOP limit under PHS Act section 2707 and ACA section 1302(c). However, under the No Surprises Act, a plan or issuer must count any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to certain services subject to the surprise billing protections of the No Surprises Act toward any in-network deductible or in-network out-of-pocket maximums (including the MOOP limit) (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

Q2: The Departments are aware that some plans and issuers have contractual relationships with providers, facilities, or providers of air ambulance services that the plans and issuers do not consider to be part of their network. May a plan or issuer treat a provider, facility, or provider of air ambulance services with which it has a contractual relationship as out-of-network for purposes of the MOOP limit under PHS Act section 2707 and ACA section 1302(c), while also treating them as participating for purposes of the No Surprises Act?

No. If a plan or issuer has a direct or indirect contractual relationship with a provider, facility, or provider of air ambulance services that sets forth the terms and conditions on which a relevant item or service is provided to a participant, beneficiary, or enrollee under the plan or coverage, the provider, facility, or provider of air ambulance services is considered participating for purposes the No Surprises Act and is also considered in-network for purposes of the MOOP limit under PHS Act section 2707 and ACA section 1302(c).

Thus, for emergency services, non-emergency services furnished by a provider with respect to a visit to a participating health care facility, and air ambulance services, either (1) the balance billing and cost-sharing protections under the No Surprises Act will apply because the items and services are furnished by a nonparticipating provider, emergency facility, or provider of air ambulance services; or (2) the MOOP limit under the ACA will apply (if the plan or coverage is non-grandfathered) because the items or services are furnished by an in-network provider, facility, or provider of air ambulance services.

For example, under no circumstance can an emergency facility providing emergency services to a participant, beneficiary, or enrollee be “out-of-network” for purposes of the MOOP limit under PHS Act section 2707 and ACA section 1302(c) and simultaneously be a “participating” emergency facility for purposes of the balance billing and cost-sharing protections under the No Surprises Act.

The No Surprises Act and Transparency in Coverage with Regard to Facility Fees

The Transparency in Coverage (TiC) Final Rules require plans and issuers to make price comparison information available to participants, beneficiaries, and enrollees through an internet-based self-service tool and in paper form, upon request.¹² This information must be available for plan years (in the individual market, policy years) beginning on or after January 1, 2023, with respect to the 500 items and services identified by the Departments in Table 1 in the preamble to the TiC Final Rules,¹³ and with respect to all covered items and services, for plan or policy years beginning on or after January 1, 2024.¹⁴

cost-sharing payments were made with respect to items and services furnished by a participating provider or a participating emergency facility. *See, e.g.*, Code section 9816(a)(1)(C)(v); ERISA section 716(a)(1)(C)(v); PHS Act section 2799A-1(a)(1)(C)(v); 26 CFR 54.9816-4T(b)(3)(v); 29 CFR 2590.716-4(b)(3)(v); and 45 CFR 149.110(b)(3)(v).

¹² 26 CFR 54.9815-2715A2(b), 29 CFR 2590.715-2715A2(b), and 45 CFR 147.211(b).

¹³ 85 FR 72158, 72182 (Nov. 12, 2020).

¹⁴ 26 CFR 54.9815-2715A2(c)(1); 29 CFR 2590.715-2715A2(c)(1); and 45 CFR 147.211(c)(1). *See also* FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49 (Aug. 20, 2021) (FAQs Part

Section 112 of the No Surprises Act added section 2799B-6 to the PHS Act. This section requires providers and facilities, upon an individual's scheduling of items or services, or upon request, to inquire if the individual is enrolled in a health plan or health insurance coverage or certain other types of coverage, and to provide a notification of the good faith estimate (GFE) of the expected charges for furnishing the scheduled item or service and any items or services reasonably expected to be provided in conjunction with those items and services, including those provided by another provider or facility, with the expected billing and diagnostic codes for the items and services. If the individual is enrolled in a health plan or coverage (and is seeking to have a claim for the item or service submitted to the plan or coverage), the provider must provide this notification to the individual's plan or coverage. If the individual is not enrolled in a health plan or coverage or does not seek to have a claim for the item or service submitted to the plan or coverage, the provider must provide this notification to the individual.¹⁵ These provisions apply with respect to plan years (in the individual market, policy years) beginning on or after January 1, 2022.

Section 111 of the No Surprises Act also added section 9816(f) to the Code, section 716(f) to ERISA, and section 2799A-1(f) to the PHS Act, which require plans and issuers, upon receiving a GFE regarding an item or service as described in PHS Act section 2799B-6, to send a participant, beneficiary, or enrollee an Advanced Explanation of Benefits (AEOB) notification in clear and understandable language. The notification must include, among other information: (1) the network status of the provider or facility; (2) the contracted rate for the item or service or, if the provider or facility is not a participating provider or facility, a description of how the individual can obtain information on providers and facilities that are participating; (3) the GFE received from the provider; and (4) a GFE of the amount the plan or coverage is responsible for paying, and the amount of any cost sharing for which the individual would be responsible for paying with respect to the GFE received from the provider. These provisions apply with respect to plan years (in the individual market, policy years) beginning on or after January 1, 2022. However, previous FAQs stated that HHS will defer enforcement of the requirement that providers and facilities send a GFE to plans and issuers and stated that the Departments will defer enforcement of the requirement that plans and issuers provide an AEOB.¹⁶

The Departments are concerned that individuals are increasingly being charged facility fees for

49), Q3, available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf> and <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf>.

¹⁵ The GFE for an individual who is not enrolled in a health plan or coverage or does not seek to have a claim for the item or service submitted to the plan or coverage must include estimates from a convening provider or convening facility, which is the provider or facility that receives the initial request for a GFE from an uninsured (or self-pay) individual and that is or, in the case of a request, would be responsible for scheduling the primary item or service. The GFE for an uninsured (or self-pay) individual must also include estimates from co-providers or co-facilities, which are providers or facilities other than a convening provider or a convening facility that furnish items or services that are customarily provided in conjunction with a primary item or service. 45 CFR 149.610. However, HHS is exercising enforcement discretion, pending future rulemaking, for situations where GFEs for uninsured (or self-pay) individuals do not include expected charges from co-providers or co-facilities. *See* FAQs about Consolidated Appropriations Act, 2021 Implementation - Good Faith Estimates (GFEs) for Uninsured (or Self-pay) Individuals – Part 3 (Dec. 2, 2022), available at <https://www.cms.gov/files/document/good-faith-estimate-uninsured-self-pay-part-3.pdf>.

¹⁶ FAQs Part 49, Q5 and Q6, available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf> and <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf>.

health care received outside of hospital settings,¹⁷ which increases health care costs. When facility fees are covered by the individual’s plan or coverage in connection with essential health benefits provided in-network, cost sharing for those fees is subject to the MOOP limit. However, when not covered by the individual’s plan or coverage in connection with the provision of essential health benefits, those fees expose patients to financial risk. They are also likely to come as a surprise to the individual. Several states have taken or are considering taking action to prohibit, limit, or increase transparency around facility fees.¹⁸ The Departments are monitoring this issue, and encourage plans and issuers, and providers and facilities to minimize the burden to participants, beneficiaries, and enrollees that result from imposing facility fees.

Q3: Are facility fees included in the definition of items and services for purposes of the TiC Final Rules and the GFE requirements of the No Surprises Act?

Yes. For purposes of the TiC requirements and the uninsured (or self-pay) GFE requirements, “items and services” are explicitly defined to include facility fees.¹⁹ Therefore, plans and issuers are required to make price comparison information for covered facility fees available to participants, beneficiaries, and enrollees through an internet-based self-service tool and in paper form, upon request.²⁰ In addition, providers and facilities are required to provide GFEs to uninsured (or self-pay) individuals in connection with facility fees.²¹

In addition, while the Departments have not yet issued regulations implementing the No Surprises Act’s AEOB and GFE provisions for individuals who are enrolled in a health plan or coverage (and who are seeking to have a claim for scheduled or requested items or services submitted to the plan or coverage), the Departments anticipate that future proposed rules would address facility fees with respect to these provisions.

¹⁷ Health Care Cost Institute. Facility Fees and How They Affect Health Care Prices: Policy Explainer (Jun. 2023), available at https://healthcostinstitute.org/images/pdfs/HCCI_FacilityFeeExplainer.pdf.

¹⁸ See, e.g., Conn. Gen. Stat. § 19a-508c; Minn. Stat Ann. § 62J.824; Tex. Health & Safety Code Ann. § 254.156; and Wash. Rev. Code § 70.01.040. See also, Goodland, Marianne, Hospitals Decry Bill Banning ‘Facility Fees,’ Supporters Call it More ‘Surprise Billing,’ Colorado Politics, (Feb. 24, 2023), available at https://www.coloradopolitics.com/legislature/hospitals-decry-bill-banning-facility-fees-supporters-call-it-more-surprise-billing/article_37169ae0-b466-11ed-8c61-3bab9b968163.html.

¹⁹ See 26 CFR 54.9815-2715A1(a)(2)(xiii); 29 CFR 2590.715-2715A1(a)(2)(xii); 45 CFR 147.210(a)(2)(xiii); and 45 CFR 149.610 (cross-referencing 45 CFR 147.210(a)(2)).

²⁰ 26 CFR 54.9815-2715A2(b), 29 CFR 2590.715-2715A2(b), and 45 CFR 147.211(b). Facility fees are not included in the 500 items and services identified by the Departments in the TiC Final Rules. However, plans and issuers will be required to make pricing information available for covered facility fees through the TiC tool once they are required to make pricing information available for all covered items and services beginning on or after January 1, 2024.

²¹ Due to the exercise of enforcement discretion in situations where an uninsured (or self-pay) GFE does not include expected charges from co-providers or co-facilities, HHS will not take enforcement action where a GFE for an uninsured (or self-pay) individual does not include expected charges from a co-provider or co-facility charging facilities fees. In these situations, uninsured (or self-pay) individuals are encouraged to request a GFE directly from the co-provider or co-facility. FAQs about Consolidated Appropriations Act, 2021 Implementation - Good Faith Estimates (GFEs) for Uninsured (or Self-pay) Individuals – Part 3 (Dec. 2, 2022), available at <https://www.cms.gov/files/document/good-faith-estimate-uninsured-self-pay-part-3.pdf>.