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FAQ Clarifies Status of In-Network Providers, Facility Fees

The FAQ also strengthens the health care cost protections of the No Surprises Act.

Reported by PAUL MULHOLLAND

The Departments of Labor, Treasury and Health and Human Services issued an FAQ Friday covering the No Surprises Act and the Transparency in Coverage Final Rules. The FAQ clarifies when a health care provider is in-network for the purposes of reaching the maximum-out-of-pocket limit and how facility fees are to be disclosed.

Signed in 2020 and effective in 2022, the No Surprises Act regulates the billing practices of out-of-network medical providers and bans many forms of surprise medical billing. The FAQ clarified that a provider with a contractual relationship with a health plan will be considered in-network for the purposes of applying the MOOP limit, explains Roberta Casper Watson, a partner in Wagner Law Group and head of its welfare plans practice group.

Ryan Temme, a principal at Groom Law Group, clarifies that certain "single case agreements" probably would not "be pulled into the FAQ."

Temme explains that if a plan participant is treated by an out-of-network provider, that provider can collect the uninsured balance from the participant, known as "balance billing." By clarifying that a direct or indirect contractual relationship causes the provider to be in-network, the FAQ limits this practice.

According to Temme, balance billing was one of the key motivations for the No Surprises Act in the first place, because it enabled providers to pass large, and often unexpected, costs on to the participant. He describes the FAQ's clarifications as "commonsense."

The new final rules require health insurance plans to offer price comparison information and providers must provide a good faith estimate of out-of-pocket costs upon scheduling of a treatment or service or upon request.

The FAQ clarifies that these rules apply to facility fees as well, which Watson says are often used to sidestep legal requirements concerning billing.

The FAQ says, "The Departments are concerned that individuals are increasingly being charged facility fees for health care received outside of hospital settings, 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."

Facility fees cannot be left out of price estimates or MOOP calculations, according to the FAQ.

Tags Department of Labor (DOL), EBSA

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