The No Surprises Act: Uninsured/Self-Pay Good Faith Estimate
Frequently Asked Questions
Last Updated: December 19, 2021

Below are a collection of frequently asked questions on the uninsured and self-pay good faith estimates, required as part of the No Surprises Act. The American Hospital Association (AHA) and Healthcare Financial Management Association (HFMA) will regularly update this document based on the latest information on these requirements and the biweekly implementation discussions that occur during the AHA-HFMA Office Hours, a new series of opportunities for members to ask questions about No Surprises Act implementation, with a specific focus on the uninsured and self-pay good faith estimates.

AHA-HFMA Office Hours occur every other Thursday, 3-4 PM ET. A new registration link and dial-in information for 2022 will be shared early in the new year.

Frequently Asked Question

1. **When do facilities and providers need to begin providing good faith estimates for patients scheduling or shopping for care?** Providers and facilities are required to provide ***uninsured or self-pay*** patients with good faith estimates for scheduled services (or upon request) beginning Jan. 1, 2022. The government has delayed implementation of the good faith estimates for ***insured*** patients until further rulemaking. AHA is seeking clarity from HHS on whether items/services scheduled in 2021 for a 2022 date require good faith estimates and, if yes, when such estimates would be due.

2. **Isn't the government delaying enforcement of these requirements?** In part. The government will delay enforcement of two components of the good faith estimates policies: 1) the requirement that the convening provider collect all components of an estimate from co-providers when providing a good faith estimate to an **uninsured or self-pay** patient, and 2) the requirement to provide good faith estimates for **insured** patients for use in the health plans' advanced explanations of benefits (AEOBs).

3. **Do these policies apply to all scheduled services?** Yes, this requirement applies to all scheduled services for patients who are uninsured, do not have coverage for the scheduled item/service, or do not plan to submit a claim for the scheduled item/service to their health plan, i.e., self-pay. In other words, providers and facilities are required to provide an estimate when: (i) a service is scheduled; (ii) a request for a good faith estimate has been made; or (iii) an inquiry as to the potential cost of a service or item has been made.

4. **How are the good faith estimates for uninsured and self-pay patients calculated?** The good faith estimates need to be the cash/self-pay rates, reflective of any discounts (e.g., financial aid) for which the patient would be eligible, even if the discount brings the patient's expected bill to $0. A patient-centered approach is advised when screening for financial assistance.

5. **Does this policy require a provider or facility to screen all uninsured or self-pay patients for financial assistance eligibility prior to scheduling?** Good faith estimates are expected to reflect financial assistance. The AHA and HFMA are seeking further clarification from the Department of Health and Human Services (HHS) on whether need-based financial assistance screening must occur for all patients prior to the issuance of a good faith estimate or whether providers can instead limit proactive financial assistance eligibility assessments only to patients who request one or those for which the hospital has a reasonable expectation of eligibility.

6. **What disclosures are required on the good faith estimate?** The convening provider must include the following types of disclosures on the good faith estimate:
    - a disclaimer informing the patient that there may be other items or services recommended by the convening or co-provider as part of the course of care that need to be scheduled separately; and
    - a disclaimer noting that the expected charges listed are only estimates and that the final billed charges may differ; and
    - a disclaimer on the patient's right to the patient-provider dispute resolution process, including information on how to initiate the process; and
    - a disclaimer that the estimate is not a contract and does not require the patient to obtain the items or services listed on the estimate. (This disclaimer is also required of all the co-providers and co-facilities.)

7. **Is there model language for the notification of rights and good faith estimate disclosures?** Yes. HHS provides model language for informing uninsured/self-pay patients of their right to good faith estimates and the patient-provider dispute resolution process; HHS provides a template of the comprehensive good faith estimate with model disclaimer language here.

8. **Are patients required to sign the good faith estimates to prove they received them?** No, the patients do not need to sign or otherwise verify that they received the good faith estimate.

9. **How does HHS define "self-pay?"** HHS defines "self-pay" patients as patients who may have health care coverage but do not have benefits for an item or service under the health plan *or* do not plan to submit a claim to their insurance for the scheduled item or service. If the patient does ultimately submit a claim for the item or service, they are no longer considered self-pay and are not eligible for the patient-provider dispute resolution process.

10. **What is the required method of delivery of the good faith estimate to the uninsured/self-pay patient?** The good faith estimates need to be delivered either electronically (e.g., secure email, patient portal message) or via paper mail, based on the patient's preference. If the estimates are delivered electronically, they must be provided in a manner that allows the patient to save and print the estimate.

11. **What items/services need to be included in the good faith estimate?** Good faith estimates need to include all items/services expected to be delivered during a period of care. In other words, good faith estimates should include the primary service (e.g., knee surgery), as well as all the items/services associated with the primary service that wouldn't be scheduled separately (e.g., physician professional services, anesthesiologist professional services, facility services, prescription drugs). The estimate does not need to include pre- or post-service estimates for items/services that would typically be scheduled separately (e.g., physical therapy), though the convening provider must include a list of typical pre- and post-service items or services on a good faith estimate.

12. **Does this requirement apply only to facility-based care?** No, this requirement applies to all services in any setting (e.g., hospital, clinic, urgent care) that are scheduled 3+ days in advance. This includes pre-paid, elective services (e.g., elective cosmetics).

13. **Do these requirements apply to out-of-network patients?** These requirements only apply to out-of-network patients if the patient does not plan to have a claim for coverage submitted to their insurance. If the patient does plan to have an out-of-network claim submitted to their insurance, then these requirements do not apply.

14. **How do these good faith estimates relate to the notice and consent estimates?** These good faith estimates must be provided to any *uninsured or self-pay patient prior to any scheduled item or service*. The notice and consent estimates are required specifically when an out-of-network provider or facility seeks to balance bill certain *insured out-of-network* patients for scheduled or post-stabilization care, consistent with other requirements in the No Surprises Act. As noted above, there may be some instances in which an out-of-network patient may seek care as a self-pay patient. In those instances, the good faith estimate requirements apply and not the notice and consent requirements.

15. **HHS defines the convening provider as the provider/facility responsible for scheduling the primary item/service or that receives the request for an estimate. In practicality, does this mean the convening provider is the physician who requests a procedure to be scheduled at a hospital or the hospital that schedules it?** The regulations are not clear on this point. The AHA is seeking clarity from HHS.

16. **Can the convening provider simply utilize the required machine-readable files posted on each hospital's website (as required under the Hospital Price Transparency rule) to gather the co-facility estimate information?** No. The good faith estimates need to be the cash/self-pay rates, reflective of any discounts (e.g., financial aid) for which the patient would be eligible. The machine-readable files include general rates and would not allow a convening provider to derive a patient-specific estimate.

17. **How quickly does the co-provider or co-facility need to return expected charges and additional information to the convening provider?** The regulation allows the convening provider or facility to set a deadline for co-providers/co-facilities such that they can meet the deadline for returning the good faith estimate to the patient. The deadline must be included in the request for expected charges that the convening provider or facility sends to the co-providers/co-facilities. The co-provider's response also must include the patient's name and date of birth; an itemized list of expected items and services to be provided by the co-provider; applicable diagnosis and service codes; the co-provider's name, NPI, and TIN; and a disclaimer that the good faith estimate is not a contract.

18. **How quickly does the convening provider or facility need to return the consolidated good faith estimate to the patient?** The convening provider or facility must provide a consolidated good faith estimate of expected charges for all items and services to an uninsured or self-pay patient within the following timeframes:
    - if a service is scheduled at least 3 days in advance, the good faith estimate must be provided no later than 1 business day after the date of scheduling; or
    - if a service is scheduled at least 10 days in advance, the good faith estimate must be provided no later than 3 business days after the date of scheduling; or
    - if an estimate of expected costs is otherwise requested by an uninsured or self-pay individual, the good faith estimate must be provided no later than 3 business days after the request.

19. **Is the co-provider/co-facility any provider or facility outside of the convening provider/facility?** A co-provider/co-facility is any provider or facility that will provide care for the patient as part of a scheduled service for whom the convening provider does not bill. In other words, co-providers/co-facilities are the other providers/facilities delivering items/services during the period of care covered by the good faith estimate that would bill separately from the hospital.

20. **Do these policies apply to patients with short-term, limited-duration plans, liability insurance/workers compensation plans, or health sharing ministries?** Patients enrolled in these types of coverage, absent enrollment in

other forms of comprehensive coverage, are considered uninsured for the purpose of this regulation, as these types of coverage are not recognized as group health insurance. Therefore, these patients should receive uninsured/self-pay good faith estimates prior to scheduled care.

21. **Do these policies apply to reference-based pricing plans?** Reference-based pricing plans that are offered as part of ERISA-regulated group health insurance are subject to these regulations. Therefore, patients with reference-based pricing plans are considered insured, and therefore do not need to receive an uninsured/self-pay good faith estimate for scheduled services.

22. **[NEW] Do these policies apply to federal health care programs coverage?** Items and services covered under a federal health care program, such as Medicare, Medicaid, Indian Health Service, or Tricare are considered insured. Therefore, unless they have otherwise indicated a desire to self-pay, these patients do not need to receive an uninsured/self-pay good faith estimate for scheduled services.

23. **If a patient that requested a good faith estimate goes on to schedule a procedure, does the provider need to provide a new good faith estimate?** Yes, if the patient schedules the service following a request for a good faith estimate, a new estimate is required.

24. **What content is required to be included on the good faith estimate in instances when the final code is unknown at the time of scheduling (e.g., E&M CPT codes, Dx codes) Would a standard menu of all possible codes and their corresponding charges suffice?** Providers should use their best efforts to provide a good faith estimate that is reflective of what the final bill will include. Though additional services that are unknown at the time of scheduling are often unavoidable and to be expected, the regulation leaves additional costs exceeding $400 from the good faith estimate (including additional, unexpected services) to be subject to the patient dispute resolution processes. We recommend that providers develop a policy on how to handle additional services in advance of Jan. 1, 2022. We also recommend that providers adjust their processes to ensure that good faith estimates are properly created by people with knowledge of billing processes. Additional training for front office and finance staff will likely be required in order to achieve compliance with the regulation.

25. **Are insured patients that do not have coverage for a particular item or service considered uninsured for the purpose of this requirement?** Yes, patients that are not covered for a particular item or service are considered uninsured for the purpose of these requirements. The AHA and HFMA are seeking further clarification from HHS on how providers should proceed when determining an insured patient's coverage for an item or service is not feasible in the short good faith estimate timeline.

26. **Is it still acceptable to require a point of service collection for a self-pay scheduled service?** There is nothing in this regulation that would prevent a provider from requiring point of service payments from a patient. However, if the point of service collection is associated with any type of prompt pay discount, the good faith estimate should reflect the discounted amount.

27. **Are there penalties for non-compliance with these requirements?** If a provider does not comply with these requirements and the uninsured/self-pay patient's bill is over $400, then the patient can initiate a patient-provider dispute resolution process. In addition, any provider or facility found to be in violation of the new requirements established under the No Surprises Act (including the good faith estimates for insured or uninsured patients, once they are both in effect) could be subject to penalties under state and federal law, including civil monetary penalties. (*Citation: Section 2799B-4*)

28. **How long do providers need to store the good faith estimates?** The good faith estimates are considered part of a patient's medical record and should be stored in the same manner as other items in the patient's medical record. The convening provider must be able to provide a patient a copy of any previously issued good faith estimate furnished within the previous six years.

29. **Can providers give patients one good faith estimate for a series of visits?** Yes, for recurring items or services, providers/facilities can deliver patients a single good faith estimate, as long as the estimate clearly identifies the scope of the estimate (e.g., timeframe, frequency, total number of visits). In addition, the good faith estimate would need to be updated annually and/or whenever there is a change to the estimated charges or scope.

30. **[NEW] Do the good faith estimates need to include line item estimates, or can they be bundled under one code?** HHS is clear in the regulation that facilities or providers should use the most comprehensive service code available. In other words, if a single service code captures multiple components of an item or service that is the service code and corresponding charge that should be used. In instances when a comprehensive code is used, the comprehensive service code should be used for billing purposes as well.

31. **[NEW] Are providers/facilities required to provide patients good faith estimates for same day services or for services scheduled less than 3 days in advance?** No, good faith estimates are only required for services scheduled at least 3 days in advance.

32. **[NEW] What should providers/facilities do about unexpected additional services during a scheduled health care visit, such as consultation with an outside provider?** Providers should include charges for all services for which they are aware at the time of scheduling. To the extent that additional medically necessary services are performed, providers may charge for these services, though such charges would potentially be subject to a patient dispute resolution process if in excess of $400. We recommend that providers create policies to prepare for such scenarios.

33. **[NEW] Can patients decline the good faith estimates at the time that they are notified of their rights to receive the good faith estimates?** No, patients are not required to sign good faith estimates, so therefore, cannot decline them. In other words, facilities/providers are always required to give uninsured/self-pay patients good faith estimates for services scheduled 3+ days in advance and whenever requested during the shopping process.

34. **[NEW] Are retail services, such as acupuncture, included in these requirements?** Yes, good faith estimates are required for all items/services scheduled by an uninsured or self-pay patient 3+ days in advance or by request when shopping for care. HHS defines *items and services* very broadly to mean "all encounters, procedures, medical tests, supplies, prescription drugs, durable medical equipment, and fees (including facility fees), provided or assessed in connection with the provision of health care." In the regulation, HHS notes that this definition is inclusive of those items and services related to dental health, vision, substance use disorders and mental health.

35. **[NEW] If a patient presents with insurance for a scheduled procedure but at a future date we find out that the insurance retroactively terminated and the patient is deemed self-pay/no-insurance at that time, how should the provider/facility proceed given that no good faith estimate would have been generated at admission?** If a provider learns that a scheduled patient's insurance has been retroactively terminated prior to the provision of care, they should provide the patient with a good faith estimate upon learning. The regulation is unclear as to how providers that learn of a patient's lapse in coverage after care is provided should proceed when a good faith estimate was not produced due to a prior indication that the patient was insured. We recommend that providers review their eligibility batching process to assure payer coverage is validated 3 days prior to scheduled services to minimize surprises. The AHA/HFMA have requested clarification on this issue from CMS and will provide an update once we have additional information.

DISCLAIMER: *To help address basic questions regarding the No Surprises Act, implementing regulations and guidance, the AHA has prepared several member*

resources found at Surprise Billing | AHA. These resources, including these FAQs, summarize and answer basic questions about the implementing regulations and guidance. These resources are not intended as legal advice from AHA. Hospitals should consult with their own counsel for their individual organization's needs.