

# No Surprises Act / Good Faith Estimate



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# Price Transparency in Health Care

“Readily available information on the price of health care services that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare, and choose providers that offer the desired level of value.” – Association of American Medical Colleges (AAMC)














# Increased Pressure on the Industry

- National health expenditures in 2021 - \$4.3 trillion
  - Drastic increases year after year
  - Not necessarily because patients are receiving more services
  - Price transparency exists in other industries – why not health care?
- Significant increases in patient out-of-pocket costs
  - Copays, coinsurance, and deductibles has made patients more attentive to the costs of services

## The U.S. Has the Lowest Life Expectancy Among Large, Wealthy Countries While Far Outspending Them on Health Care

Life expectancy (2021) and per capita healthcare spending (2021 or nearest year)

Country	Life expectancy	Health spending, per capita
 United States	76.1	\$12,318
 United Kingdom	80.8	\$5,387
 Germany	80.9	\$7,383
 Austria	81.3	\$6,693
 Netherlands	81.5	\$6,190
 Belgium	81.9	\$5,274
Comparable Country Average	82.4	\$6,003
 France	82.5	\$5,468
 Sweden	83.2	\$6,262
 Australia	83.4	\$5,627
 Switzerland	84.0	\$7,179
 Japan	84.5	\$4,666

Potomac RFP  
Health System Tracker



# Theoretical Impacts

## Put Pressure On:

- Insurers
- Providers



## Intended to Help:

- Patients by making them more informed consumers and empowering them to “shop” for health care services in non-emergent situations.
- Belief that “price-conscious consumers” will seek low cost and high-quality care.



Which, in turn, stimulates greater competition amongst plans and providers based on their cost and value.



# No Surprises Act – Balance Billing

- Federal legislation passed in December 2020 establishing policies for balanced billing for services provided by an out-of-network provider in:
  - Out-of-network Emergency Department, or
  - In-network facility
- A “facility” is:
  - Hospital
  - Hospital outpatient department
  - Critical Access Hospital (CAH)
  - Ambulatory surgical center

**RHCs are NOT classified as qualified facilities for purposes of these provisions.**





# No Surprises Act – Good Faith Estimate

- The price transparency provision that DOES apply to **providers** (including those that work in RHCs) is the Good Faith Estimate (GFE)



# Required Notice

## You have the right to receive a “Good Faith Estimate” explaining how much your health care will cost

Under the law, health care providers need to give **patients who don't have certain types of health care coverage or who are not using certain types of health care coverage** an estimate of their bill for health care items and services before those items or services are provided.

- You have the right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- If you schedule a health care item or service at least 3 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 1 business day after scheduling. If you schedule a health care item or service at least 10 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after scheduling. You can also ask any health care provider or facility for a Good Faith Estimate before you schedule an item or service. If you do, make sure the health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after you ask.
- If you receive a bill that is at least \$400 more for any provider or facility than your Good Faith Estimate from that provider or facility, you can dispute the bill.

For questions or more information about your right to a Good Faith Estimate, visit [www.cms.gov/nosurprises/consumers](https://www.cms.gov/nosurprises/consumers), email [FederalPPDRQuestions@cms.hhs.gov](mailto:FederalPPDRQuestions@cms.hhs.gov), or call 1-800-985-3059.



# What is a GFE?

- An **estimate** of the charges associated with items and services **expected** to be furnished to:
  - Uninsured patients
  - Self-pay patients (patients with health insurance who do not wish to have a claim submitted to their insurer for these specific items/services)





# When do GFEs need to be issued?

- Beginning January 1, 2022, providers must issue a GFE to uninsured or self-pay patients that:
  - Request a GFE, OR
  - Schedule an appointment 3+ days in advance
- Does not apply to beneficiaries in Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE.

Appointment Scheduled:	GFE Required:
10+ business days in advance	Within 3 business days of scheduling
3-9 business days in advance	Within 1 business day of scheduling
Less than 3 business days in advance	No GFE required

When a patient requests a GFE, it must be issued within 3 business days of the request.



# Are GFEs optional?

- No, when a patient schedules an appointment within the timeframe where they're eligible for a GFE, **they must be provided with a GFE**
  - In writing, either on paper or electronically
  - Orally, if the patient requests it in this method



# What must be included in the GFE?

- A GFE must list, and provide charge information for:
  - The primary service that the RHC expects to provide to the patient (the initial reason for the visit)
  - The items and/or services that are “reasonably expected” to be provided “in conjunction with the primary service” during a “period of care”
    - Encounters, procedures, tests, supplies, prescription drugs, other fees associated with providing care, etc.
- Separate GFEs would be provided when other items or services beyond the period of care are scheduled





# “Reasonably Expected”

- The services to included on the GFE are to be based on the information the RHC has *at the time the appointment was scheduled or the GFE requested*.
  - The GFE is not required to account for unanticipated care that is not reasonably expected or results from unforeseen events.
- Highlights importance of **documentation** but also the significant flaws with this policy -
  - Non-clinical scheduling staff are expected to gather the information necessary to generate a GFE





# Expected Charges

- Cash pay rate
- “True” anticipated charges including discounts or adjustments typically offered to uninsured or self-pay patients
  - FAQ #4 released by CMS provides more detail regarding incorporating sliding fee scales



# Sample GFE

[NAME OF CONVENING PROVIDER OR CONVENING FACILITY]  
Good Faith Estimate for Health Care Items and Services

<b>Patient</b>		
Patient First Name	Middle Name	Last Name
Patient Date of Birth:      /      /		
Account Number (last four digits) (optional):		
<b>Patient Mailing Address, Phone Number, and Email Address</b>		
Street or PO Box		Apartment
City	State	ZIP Code
Phone		
Email Address		
Patient's Contact Preference: <input type="checkbox"/> By mail <input type="checkbox"/> By email <input type="checkbox"/> By phone		
<b>Patient Diagnosis (if determined)</b>		
Primary Service or Item Requested/Scheduled		
Patient Primary Diagnosis	Primary Diagnosis Code	
Patient Secondary Diagnosis	Secondary Diagnosis Code	
If scheduled, list the date(s) the Primary Service or Item will be provided:		
<input type="checkbox"/> Check this box if this service or item is not yet scheduled		

Date of Good Faith Estimate:      /      /	
<b>Summary of Expected Charges</b> (See the itemized estimate attached for more detail.)	
Provider Name	Estimated Total Cost
Provider Name	Estimated Total Cost
Provider Name	Estimated Total Cost
<b>Total Estimated Cost: \$</b>	

The following is a detailed list of expected charges for [LIST PRIMARY SERVICE OR ITEM], scheduled for [LIST DATE(S) OF SERVICE, IF SCHEDULED] [[ADD IF ADDITIONAL ITEMS/SERVICES ARE BEING INCLUDED], as well as for items or services reasonably expected to be furnished in conjunction with the primary item or service as part of the period of care]. [Include if items or services are reoccurring. "The estimated costs are valid for 12 months from the date of the Good Faith Estimate."]



# Sample GFE

[Provider/Facility 1] Estimate

Provider/Facility Name		Provider/Facility Type	
Street Address			
City		State	ZIP Code
Contact Person	Phone	Email	
National Provider Identifier		Taxpayer Identification Number	

Details of Services and Items for [Provider/Facility 1]

Service/Item	Address where service/item will be provided	Diagnosis Code (if required for the calculation of the GFE)	Service/Procedure Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service/Procedure Code Type: Service/Procedure Code Number]		
Total Expected Charges from [Provider/Facility 1]				\$	
Additional Health Care Provider/Facility Notes					

Health Care Items/Services Expected to Be Separately Scheduled with Another Provider or Facility

**DISCLAIMER:** For health care items/services listed below, separate good faith estimates will be issued upon scheduling or upon request. Specific information such as the names and identifiers for the providers or facilities that may furnish the services, diagnosis codes (if required for the calculation of the GFE), service codes, and expected charges will be provided in separate good faith estimates once these items or services are scheduled (or upon request).

Service/Item	Provider/Facility [Instructions for obtaining a good faith estimate for the service/item, such as provider/facility name, address, phone number, and email]



# Disclaimers Required

#1: There may be additional items/services the provider recommends during the course of care that are not reflected in the estimate

- Separate GFEs will be issued upon scheduling of an additional services if patient is eligible

#2: The information provided in the GFE is only an estimate, services and charges may differ

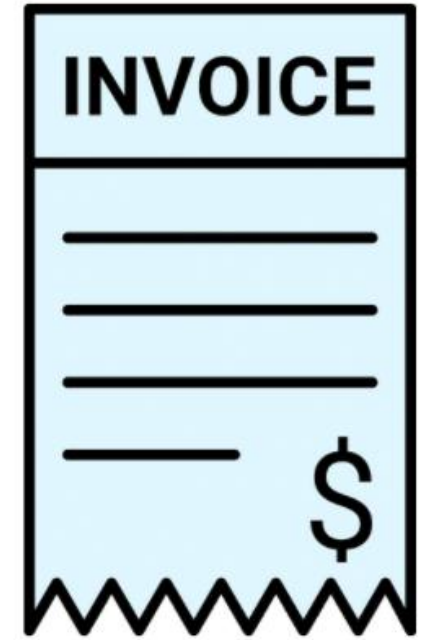
#3: The individual has the right to initiate the dispute resolution process; instructions for initiating that process

#4: The GFE is not a contract, patients don't need to obtain the services included





# GFE Enforcement



- Patient initiated “[dispute resolution process](#)”
  - If after getting a bill the patient realizes they’ve been billed for an amount that’s \$400 or more than what was included or GFE, they can request that an independent third-party, called a dispute resolution entity, review the case and determine an appropriate payment.

## Medical bill disagreements if you're uninsured

### Resolving billing disagreements between consumers and providers

Starting in January 2022, if you're uninsured or self-pay (insured but not planning to use your insurance to pay for your care), health care providers and facilities must give you a [good faith estimate](#) before you get care. If after getting your bill you realize that any of your providers or facilities billed you for an amount that's \$400 or more than what's on your good faith estimate, you can use a new dispute resolution process to request that an independent third-party, called a dispute resolution entity, review your case and determine an appropriate payment. This process is referred to as "patient-provider dispute resolution." The dispute resolution entity will review the good faith estimate, your bill, and information submitted by your provider or facility to determine if you should pay the amount on your good faith estimate, the billed charge, or an amount in between the two. There's a \$25 non-refundable administrative fee to start this process.

You'll be eligible to use this process if:

- You're uninsured or self-pay (you have insurance but didn't use it to pay for your health care item or service).
- You scheduled and received the medical items or services on or after January 1, 2022.
- You have a good faith estimate from your provider.
- You have a bill dated within the last 120 calendar days (about 4 months).
- The difference between the good faith estimate and the bill from any single provider or facility is at least \$400.

**Note:** The good faith estimate may have expected costs from more than one provider. You're eligible for the patient-provider dispute resolution process only if your bill from an individual provider or facility is at least \$400 more than the total expected costs on the good faith estimate from that provider or facility. View an example of what a [good faith estimate \(PDF\)](#) may include.

#### How to start the billing dispute process

If you meet all of the conditions above, you're eligible for the dispute resolution process. You'll need a copy of your good faith estimate and a copy of your bill to begin the process. We'll ask you to provide copies of these documents and to pay an administrative fee.

A \$25 non-refundable administrative fee is required to start the patient-provider dispute resolution process. If the dispute resolution entity decides in your favor, this amount will be deducted from the amount you owe your provider. You can pay this fee online, or you can mail a money order or cashier's check when you submit your dispute form through the mail. Personal checks aren't accepted. If you mail your dispute form but pay online, you'll get an email with information on how to complete your payment online once we get your dispute form.

[Start a dispute online](#)[Start a dispute by mail or fax \(PDF\)](#)

Your protections during the patient-provider dispute resolution process

# GFE Enforcement

- Complaint process: if a patient believes they should have received a GFE, but did not.
- <https://www.cms.gov/medical-bill-rights/help/submit-a-complaint>



# Documentation

- GFEs must be included in the patient's medical record and available upon request for a minimum of 6 years





# Good Faith Estimate Phase II and III

- In the current 'Phase 1' of No Surprises Act regulation, convening providers are required to provide a GFE inclusive of their own charges. Regulators have deferred enforcement of the mandate to include “co-provider” estimates indefinitely, pending future rulemaking.
- The statute also establishes a 3<sup>rd</sup> phase to this, in which every patient would have the ability to receive an Advanced Explanation of Benefits (AEOB)
  - This provision has not yet had an effective date established
  - CMS expected to release a proposed rule with AEOB requirements in March 2024



# Impacts of Price Transparency Policy and Where It's Headed

- This continues to be a bipartisan focus
- September 2022 Congressional Budget Office (CBO) [report](#):
  - ...." adopting **all** of the price-transparency policies **would reduce prices by a very small amount (0.1 percent to 1 percent)**. Those amounts reflect anticipated effects in a given year once policies had been fully implemented and stakeholders had fully adjusted to them."



# Do Patients Care?

## Yes

- “It’s now our right by law to see upfront prices in healthcare, so we can compare and save. But most hospitals are still hiding their prices. So, we must demand them. It’s our health. It’s our money to save. [Power to the Patients.](#)”
- PatientsRightsAdvocates.com survey [data](#) claims:
  - 87% of patients would shop around if they had posted prices
  - 91% of patients support price transparency in health care

## No

- Recent KFF poll:
  - 1/10 aware of hospital disclosure requirements
  - 85% of respondents don’t shop around for best-priced care



# NARHC Resources

- [Webinars](#) (December 2021 and December 2022)
- [Resource Guide](#)

NARHC continues to work with CMS to obtain additional guidance and advocate for more reasonable and less burdensome price transparency measures that achieve the initial, positive intent.



# Good Faith Estimate Resources (CMS)

[Regulations](#)

[CMS Overview](#)

[Patient Initiated Independent Dispute Resolution Process](#)

[Templates](#)

[CMS Webinar](#)

CMS FAQs: [1](#) and [2](#) and [3](#) and [4](#)



# Questions?

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