**FAQS ABOUT CONSOLIDATED APPROPRIATIONS ACT, 2021 IMPLEMENTATION – GOOD FAITH ESTIMATES (GFEs) FOR UNINSURED (OR SELF-PAY) INDIVIDUALS – PART 5**

**Q1: Are providers and facilities required to provide uninsured (or self-pay) GFEs to individuals who are members of health care sharing ministries and not enrolled in other health coverage?**

A1: In general, yes. Section 2799B-6 of the Public Health Service (PHS) Act (as added by section 112 of the No Surprises Act) and 45 CFR 149.610 generally require a provider or facility to provide a GFE to an uninsured (or self-pay) individual. An individual is considered uninsured for this purpose if they are not enrolled in a group health plan, group or individual health insurance coverage, federal health care program, or Federal Employees Health Benefits (FEHB) plan. Individuals who are members of health care sharing ministries and not enrolled in one of these other types of health coverage are considered uninsured for GFE purposes, and providers and facilities must provide them with a GFE for uninsured (or self-pay) individuals if otherwise required.

Other plans or coverage that an individual may have and still be considered uninsured for GFE purposes are short-term, limited-duration insurance, self-funded student health plans, and farm bureau plans. In general, an individual enrolled in one of these types of coverage (and not also enrolled in a group health plan, group or individual health insurance coverage, federal health care program, or FEHB plan) is considered uninsured for purposes of the GFE requirements, and providers and facilities must give them an uninsured (or self-pay) GFE, if otherwise required.

**Q2: Are providers and facilities required to verify with an individual's plan or issuer whether the individual is enrolled in a group health plan, group or individual health insurance coverage, federal health care program, or FEHB plan?**

A2: 45 CFR 149.610(b)(1)(i)-(ii) requires providers and facilities to determine if an individual is uninsured (or self-pay) by inquiring if they are enrolled in a group health plan, group or individual health insurance coverage, federal health care program, or FEHB plan and are seeking to have a claim submitted to their plan or coverage. As part of that inquiry, providers and facilities must take reasonable steps to determine if the individual is enrolled in such plan or coverage.

Taking reasonable steps may include educating staff about the types of plans and coverage that are, and are not, considered group health plans, group or individual health insurance coverage, federal health care programs, or FEHB plans. For individuals who represent themselves as insured, taking reasonable steps may include asking them for the name and policy number of the product they are enrolled in and reviewing their insurance card for key terms that suggest they may not be enrolled in a group health plan, group or individual health insurance coverage, federal health care program, or FEHB plan. Providers are encouraged, but not required, to verify the individual's enrollment by contacting the plan, issuer, or other organization listed on the card to determine whether the product is a group health plan, group or individual health insurance coverage, federal health care program, or FEHB plan. For more information about determining

whether an individual is considered insured, uninsured, or self-pay for GFE purposes, see the fact sheet *What is Considered "Health Insurance"? Determining When Uninsured (or Self-Pay) Good Faith Estimate Rules Apply,* available at https://www.cms.gov/files/document/fact-sheet-what-is-considered-health-insurance.pdf.

**Q3: Does the requirement to provide GFEs to uninsured (or self-pay) individuals apply to dental and vision providers and facilities?**

A3: Yes. Dental and vision providers and facilities are generally subject to the requirement to provide GFEs to uninsured (or self-pay) individuals.[1]

**Q4: Are GFEs required when students who are not licensed providers furnish health care items or services under the supervision of a licensed provider or facility (such as a university clinic)?**

A4: Yes. Where a licensed provider or facility supervises an unlicensed student in furnishing health care items or services, such as in a university clinic, the responsibility to provide a GFE lies with the licensed provider or facility. If an uninsured (or self-pay) individual schedules an item or service to be furnished by (or requests a GFE from) the licensed provider or facility, including through supervision of an unlicensed student, the licensed provider or facility must provide a GFE (either directly or through a representative, such as their administrative staff or the unlicensed student), as otherwise required.

GFEs in this situation must include the name, National Provider Identifier, and Tax Identification Number of the licensed provider or facility that would be billing the uninsured (or self-pay) individual. If the licensed provider or facility does not expect to bill the uninsured (or self-pay) individual for items and services, it may provide an abbreviated GFE as outlined in *FAQs about Consolidated Appropriations Act, 2021 Implementation – Good Faith Estimates (GFEs) for Uninsured (or Self-pay) Individuals – Part 4*, available at https://www.cms.gov/files/document/faqs-good-faith-estimate-uninsured-self-pay-part-4.pdf.

**Q5: Are uninsured (or self-pay) GFEs for items or services scheduled fewer than 3 business days before the date of service eligible for the patient-provider dispute resolution (PPDR) process?**

A5: No. Pursuant to section 2799B-6 of the PHS Act and 45 CFR 149.610, a provider or facility is not required to provide a GFE to an uninsured (or self-pay) individual who schedules an item or service fewer than 3 business days before the date the item or service is expected to be furnished, such as in the case of walk-in appointments and emergencies. A provider or facility who provides such a GFE does so voluntarily.

Section 2799B-7 of the PHS Act establishes the PPDR process that allows an uninsured (or self-pay) individual who receives a GFE from a provider or facility pursuant to section 2799B–6 of the PHS Act to challenge a bill that is substantially in excess of the GFE. Because voluntary GFEs are not provided pursuant to the requirements in section 2799B-6 of the PHS Act, they are

[1] See definition of "health care provider" and "health care facility" at 45 CFR § 149.610(a)(2)(vii-viii)

not eligible for the PPDR process. This is true regardless of whether the individual's final bill exceeds the voluntary GFE by $400 or more.

**Q6: Should a provider or facility reschedule an appointment for an individual if the provider or facility is unable to provide a required uninsured (or self-pay) GFE within the timeframes set forth in section 2799B-7 of the PHS Act and implementing regulations?**

A6: Providers and facilities are required under section 2799B-6 of the PHS Act and 45 CFR 149.610(b)(1)(vi) to provide uninsured (or self-pay) GFEs within certain specified timeframes. For an item or service scheduled between 3 and 9 business days in advance, a GFE must be provided no later than 1 business day after the date of scheduling. For an item or service scheduled 10 or more business days in advance, a GFE must be provided no later than 3 business day after scheduling. When a GFE is requested by an uninsured (or self-pay) individual, the GFE must be provided no later than 3 business days after the date of the request. Delaying care does not relieve a provider or facility of its obligation to provide a GFE within these timeframes.

As such, HHS strongly encourages providers or facilities not to delay patient care solely because the provider or facility is unable to provide a required GFE within the timeframes set forth in section 2799B-6 of the PHS Act and implementing regulations, or solely because the patient has not received their GFE by the date of service (such as in the case of delayed paper mail), unless the delay is requested by the patient.

**Q7: What does "business day" mean?**

A7: As described in Q6 above, a GFE generally must be provided within either 1 or 3 business days after an individual schedules an item or service or requests a GFE. HHS considers "business days" for GFE purposes to include Monday through Friday, not including federal holidays. The GFE must be provided by 11:59PM on the business day that it is due pursuant to 45 CFR 149.610(b)(vi). For example, if an uninsured (or self-pay) individual schedules an item or service on Monday, January 3 at 3:00PM to be provided on Thursday, January 6 at 12:00PM, the provider or facility must provide a GFE no later than 11:59PM on Tuesday, January 4 because the item or service was scheduled between 3 and 9 business days in advance, requiring the provider or facility to provide the GFE within 1 business day after the date of scheduling.

States that are primary enforcers of GFE requirements may exclude both state and federal holidays from the definition of "business days" for GFE purposes. HHS will not determine that a state is failing to substantially enforce GFE requirements if it takes such an approach.

**Q8: If a consumer requests a GFE from the wrong point of contact in a provider's office or facility, is the provider or facility responsible for ensuring the consumer is directed to the right point of contact?**

A8: Yes, if it would be reasonable for the consumer to expect that they have made a valid request for a GFE and that the person receiving the request would be an appropriate agent of the provider or facility. Section 2799B-6 of the PHS Act requires a provider or facility to provide a GFE "if requested by the individual." HHS expects providers and facilities to make good faith efforts to satisfy this requirement and not impose an unreasonable burden on an individual seeking to

obtain a GFE. For example, if an individual requests a GFE from someone whose position with a provider or facility relates to patient care, scheduling, billing, or other similar functions, it would be reasonable for the patient to expect that they have made a valid request for a GFE and that the person receiving the request would be an appropriate agent of the provider or facility. In that case, the person receiving the request must transmit the request, or direct the requesting individual, to the appropriate person or department responsible for providing GFEs, in a manner sufficiently timely for the GFE to be provided under the timeframes specified in Q6.