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Compliant good faith estimates for uninsured ambulatory care patients

by Robyn Hoffmann

The No Surprises Act required that healthcare facilities and providers give good faith estimates (GFEs) to uninsured and self-pay patients starting January 1, 2022. To provide guidance about GFEs for healthcare facilities (which include Federally Qualified Health Centers (FQHCs), FQHC Look-Alikes (LALs), Tribal/Urban Indian Health Centers, Rural Health Clinics (RHCs), hospitals, hospital outpatient departments, critical access hospitals, and Title X Family Planning Clinics) and healthcare providers who serve uninsured and self-pay patients, the Centers for Medicare & Medicaid Services (CMS) produced the first of a series of FAQs on December 21, 2021.[1]

What is a GFE?

A GFE lists the expected charges for scheduled items or services that your clinical practice or facility will provide.[2] Because the GFE is based on information known at the time when it was created, it does not include any unknown or unexpected costs.

The purpose of a GFE is to help protect an uninsured or self-pay individual from unexpected healthcare charges; it allows individuals to compare prices for nonemergency healthcare goods or services. Examples of nonemergency ambulatory services are:

- Behavioral healthcare
- Dental and oral healthcare
- Family planning services
- Imaging services
- Laboratory services
- Outpatient physical, occupational, or speech therapy services
- Prenatal and postpartum care
- Primary healthcare
- Vision services

Who needs to receive a GFE in ambulatory care settings?

To comply with federal requirements, healthcare facilities and ambulatory clinical practices must offer GFEs to two categories of individuals:

- Those who have no health insurance coverage (defined as "uninsured"), or
- Those who do have health insurance coverage but do not want to have a claim submitted to their insurer (defined as "self-pay")

How HHS defines uninsured and self-pay individuals

The U.S. Department of Health and Human Services (HHS) defines the uninsured as individuals who do not have coverage for healthcare items or services under any of the following arrangements:

- Commercial health coverage, such as a group health plan or a group or individual health insurance that a health insurance issuer offers
- A federal employee health benefits plan (FEHBP)
- A federal or federal/state healthcare program, such as Medicare, Medicaid, Medicare Advantage, or TRICARE

In August 2022, the U.S. Assistant Secretary for Planning and Evaluation, Office of Health Policy released its analysis of data about the number of uninsured individuals based on findings from the National Health Interview Survey.[3] While the rate of uninsurance varies by age and state of residence, the Office of Health Policy reported that approximately 8% of U.S. residents were uninsured.

HHS defines self-pay as individuals who have commercial health insurance or FEHBP coverage but who choose not to have a claim submitted to their insurer for the service. Two self-pay examples are:

- A new patient contacts your behavioral health practice to book counseling services. The caller, who has employer-based health insurance, states they do not want their health plan billed. The individual should be given a GFE.
- An established patient contacts your family practice, requesting testing for a possible sexually transmitted infection. The caller, covered by an FEHBP carrier, states they want to pay out of pocket for this service. This individual should receive a GFE.