No Surprises Act

Interim Final Rule Comparison

Detailed comparison of requirements previously established in the No Surprises Act and the new proposed requirements in the interim final rule issued on October 7, 2021.

ENSEMBLE® HEALTH PARTNERS

No Surprises Act

Interim Final Rule Comparison

On October 7, 2021, the Department of Health and Human Services (HHS), in conjunction with the Office of Personnel Management (OPM), Department of the Treasury (DOT), and Department of Labor, including the Internal Revenue Service (IRS) and Employee Benefits Security Administration (EBSA) (collectively "the Departments"), published the second iteration of the interim final rules implementing certain provisions of the No Surprises Act (NSA), which was enacted as part of the Consolidated Appropriations Act, 2021.

Below is a comparison between key NSA requirements previously established are the new proposed requirements in this IFR.

Federal Independent Dispute Resolution Process

Applies to Insured Patients and Out-of-Network Items and Services

Existing NSA Requirements	Proposed Additional NSA Requirements
Notice of Open Negotiation Period Before initiating the federal independent dispute resolution process, disputing parties must initiate a thirty-business-day open negotiation period to determine an agreed upon out-of-network-rate. The party initiating the open negotiation must provide written notice to the other party of its intent to negotiate. Negotiation during the open negotiation period will occur without the involvement of the Departments or a certified IDR entity.	The notice of intent to negotiate must include information sufficient to identify the items and/or services to be subject to the negotiation, including: 1. The date on which the items or services were furnished; 2. The applicable service code(s); 3. The initial payment amount(s) or notice of denial of payment(s); 4. A preliminary offer for the out-of-network rate; and 5. Contact information of the party sending the open negotiation notice. The notice must be delivered in writing to the other party within 30 business days of the initial payment or denial. Notice can be satisfied electronically by email if: 1. The party sending the notice has a good faith belief that the electronic method is readily accessible to the other party; and 2. The notice is provided in paper form free of charge upon request. For electronic notices, the date the notice is sent will also be considered the date it is received, but parties should make efforts to confirm contact information receipt. If the notice is not properly provided to the other party, and no reasonable effort has been made to ensure receipt, then the Departments may determine that the 30-business-day open negotiation period has not begun, potentially rendering any subsequent payment determination from an IDR entity unenforceable. The Departments have issued a standard notice form which can be found here.

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Duration of Open Negotiation Period During the 30-day negotiation period, beginning on the day the provider/ facility receives an initial payment or denial notice from the plan/patient regarding a claim, the provider, facility, plan, or coverage may initiate open negotiations to agree to an amount for payment (including any cost-sharing) for such item or service. [1]	The 30-business-day open negotiation begins on the day the open negotiation notice is sent by the party. The parties may discontinue the negotiation if they agree on an out-of-network rate before the last day of the thirty-business-day period.
Initiation of the Federal Independent Dispute Resolution (IDR) Process If the parties cannot agree on payment amount during the 30-day negotiation period, then the provider, facility, or plan may initiate the independent dispute resolution process within a 4-day period after end of the negotiation period (31-35 days from initial payment or denial).	A federal independent dispute resolution portal is being established and will be available at https://www.nsa-idr.cms.gov. The initiation period for the IDR process is four (4) business days, starting the day after the open negotiation ends. The initiation of the IDR process starts on the date of submission, or a date specified by the Departments. The entity initiating IDR must submit notice to the other party and the Departments. The notice may be electronically submitted and mustcontain the below: 1. Information sufficient to identify the items or services subject to the dispute (including whether they are batched items and services), the dates and locations of the items or services, the type of items or services (i.e., emergency services, post-stabilization services, professional services, or hospital-based services), service and place of service codes, the amount of cost sharing allowed, and the amount of the initial payment made by the plan or issuer; 2. The names and contact information of the parties involved; 3. The state where the items or services were furnished; 4. The starting date of the open negotiation period; 5. The initiating party's preferred certified IDR entity; 6. An attestation that the items or services qualify for utilization of the IDR process; 7. The qualifying payment amount (QPA); 8. Information about the QPA: 9. General information describing the IDR process, including a description of the scope of IDR processes.

The Federal Independent Dispute Resolution Process

Once an IDR entity is chosen, the parties have 10 days to submit:

- An offer for payment for the item or service in question;
- Information relating to the offer as requested by the IDR entity; and
- Any information relating to the offers submitted by either party.

Agreement on a Certified Dispute Resolution Entity:

1. The initiating party will name a preferred certified IDR entity in the notice. The other party may agree or object to the selection within three (3) business days.
2. The IDR entity must not have any conflict of interest with either party.
3. If a party fails to object to the proposed IDR entity, then it will be assumed accepted. If they timely object, then they must state why and offer an alternate.

Notice of Certified Dispute Resolution Entity:

By the conclusion of the four (4) day IDR initiation period, the initiating party must notify the Departments electronically of the IDR entity selection or the failure to select one. .

Content of Notice:

If both parties agree on a certified IDR entity, the notice of the selection must include the following:

1. The name of the certified IDR entity;
2. The certified IDR entity number; and
3. An attestation by both parties (or by the initiating party if the other party has not responded) that the selected IDR entity does not have a conflict of interest.

If the parties cannot agree on an IDR entity, or if there is a conflict of interest, the Departments will randomly select an IDR entity within six (6) business days of the initiation period.

A conflict of interest, under this IFR, would be a material relationship, status, or condition of the party, or certified IDR entity that impacts its ability to make an unbiased and impartial payment determination.

Authority to Continue Negotiation:

If parties agree on a rate after IDR initiation but before the IDR determination, then the initiating party must notify the Departments and the IDR entity as soon as possible but no later than within 3 business days.

Submission of Offers to an IDR Entity:

After an IDR entity is selected, the parties must submit:

1. Their offers for payment along with supporting documentation;
2. Information requested by the IDR entity;
3. The size of their practice or facilities at the time the information is submitted; and
4. The practice or specialty type (if applicable).

Offer Submission Date

Offers and additional information are due ten (10) business days after the date of the IDR entity selection.

Certified Independent Dispute Resolution Entity Decision In general, the determination of the IDR entity is binding upon the parties (absent fraud/misrepresentation) and shall not be subject to judicial review. [1] [1] See exceptions in Paragraphs (1) through (4) of section 10(a) of title 9, United States Code – 9 U.S.C. §10(a)(1)-(4)	The IDR entity will issue a binding determination selecting one of the offers as the appropriate OON payment amount. Certified Independent Dispute Resolution Entity Criteria: The IDR entity should make its determination based on: 1. Default requirement is to begin with the presumption that the QPA is the appropriate out-of-network amount. 2. The IDR entity must select the offer closest to the QPA unless the IDR entity feels that information from either party clearly demonstrates that the QPA is materially different from the OON rate. 3. Additional information submitted by the parties must be treated as credible. 4. For the IDR entity to deviate from the offer closest to the QPA, any information submitted must clearly demonstrate that the value of the item or service is materially different from the QPA. Decision Date: Determination of payment will be made within 30 business days after the IDR is selected. Payment submitted to applicable party: Payment is due within 30 calendar days of the IDR's payment determination. Both parties must pay an administrative fee ($50 each for 2022) and an IDR entity fee (determined by the entity). Payment for these fees can be made in the federal IDR portal. Within 30 days of determination, the prevailing party will receive a refund of the IDR entity fee.
Effect of IDR Determination If a party initiates an IDR and loses, that party may not start another IDR against the same opposing party for the same item for 90 calendar days following the determination. Exception: However, once the 90-day period is over, then a clinician or facility may initiate an IDR for all claims that arose during the 90-day period for that item/service with that same opposing party.	Items that arise during this 90-calendar day suspension period will then be able to be batched together and submitted after the period ends. Normally, all batched items submitted must have occurred within the same 30-day period.

Protections for Uninsured or Self-Pay Individuals: Good Faith Estimates (eff. January 1, 2022)

Applies to Uninsured/Self-Pay Individuals

Existing NSA Requirements	Proposed Additional NSA Requirements
Good Faith Estimate – Defined The NSA discusses "good faith estimate" in the context of the patient-provider dispute resolution process where a health care provider or health care facility must provide a good-faith estimate of expected charges for furnishing an item or service to an uninsured individual, where "uninsured" is defined as including a person who has health coverage but does not want it billed.	Good Faith Estimate means a notification of expected charges for a scheduled or requested item or service, including items or services that are reasonably expected to be provided in conjunction with such scheduled or requested item or service, provided by a convening provider, convening facility, co-provider, or co-facility.
Good Faith Estimate – Expected Charge	Expected charge means, for an item or service, the cash pay rate or rate established by a provider or facility for an uninsured (or self-pay) individual, reflecting any discounts for such individuals. This means that the good faith estimate can be the gross charges or chargemaster rates if that is the amount the individual is expected to pay, but HHS wants this estimate to be accurate so it should reflect any discounts that would be extended to uninsured or self-pay individuals, including any applicable financial assistance policy.
Good Faith Estimate – Items and Services	Good faith estimate applies to the "primary item or services" -- i.e., the initial reason for the visit. It also applies to items or services that are reasonably expected to be provided with care scheduled by all providers and facilities, like imaging and lab services. It does not apply to unanticipated or emergent care.

Good Faith Estimate – Period of Care Not discussed in the NSA.	A good faith estimate must reflect the expected charges during a "period of care." Period of care means the day or multiple days during which the good faith estimate for a scheduled or requested item or service (or set of scheduled or requested items or services) are furnished or are anticipated to be furnished, regardless of whether the convening provider, convening facility, co-providers, or co-facilities are furnishing such items or services, including the period of time during which any facility equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services that would not be scheduled separately by the individual, are furnished.
Convening Providers/Facilities Versus Co-Providers/Facilities	The "convening health care provider or health care facility" is the entity that receives the initial request for an estimate and is responsible for scheduling the primary item or service. The co-providers/facilities are those providers or facilities who are not the convening provider/facility but will furnish items or services that are customarily provided with the primary item or service.
Good Faith Estimate – Example Not discussed in the NSA.	Knee Surgery Example: A good faith estimate could include an itemized list of items or services in conjunction with and including the actual knee surgery (such as physician professional fees, assistant surgeon professional fees, anesthesiologist professional fees, facility fees, prescription drugs, and durable medical equipment fees) that occur during the period of care. An individual would not typically schedule days in the hospital post-procedure separately from scheduling the primary service of a knee surgery. HHS would therefore expect that all the items or services that are reasonably expected to be provided from admission through discharge as part of that scheduled knee surgery, from all physicians, facilities, or providers be included in the good faith estimate.
Notice of Availability of Good Faith Estimates – Uninsured (or self-pay) Not discussed in the NSA.	Convening providers/facilities must inform uninsured (or self-pay) individuals that good faith estimates of expected charges are available to individuals upon scheduling an item or service or upon request . This information must be provided in writing and orally during scheduling an item or service or when the individual has questions about the cost. Notice regarding the availability of good faith estimates: • Must be clear and understandable, and available in accessible formats and in the individual's language, • Prominently displayed, • Posted on the provider or facility's website, • Posted in the provider or facility's office, and on-site where scheduling or questions about the cost of items or services occur. HHS anticipates providing a model notice for notifying individuals of the availability of good faith estimates, but it is not yet available, and HHS will not require its use.

Gathering the Good Faith Estimates from Co-Providers and Co-Facilities The NSA requires that the good faith estimate include any item or service that is reasonably expected to be provided in conjunction with or in support of the primary service or item by another provider or facility ("co-provider" or "co-facility").	The convening provider/facility must contact all applicable co-providers and co-facilities to request their good faith estimates no later than 1 business day after the request for the good faith estimate is received or after the primary item or service is scheduled. This request must include a date that their good faith estimate is due back.
New Good Faith Estimates – Uninsured (or self-pay) Not delineated in the NSA.	New (i.e., updated) good faith estimates are due to the individual when information used to create the original good faith estimate changes. The new estimate must be issued no later than one (1) business day before the item or service is scheduled. The same applies if there are any changes in the expected providers or facilities who will be providing the items or services. In situations where an individual only requests a good faith estimate but does not schedule the service until after receiving that estimate, then a new estimate must be provided to the individual upon scheduling the item or service. In these situations, HHS encourages reviewing any previously issued good faith estimates before issuing a new one, and then communicating to the individual any changes between the two.
Good Faith Estimates for Recurring Items or Services – Uninsured (or self-pay) Not discussed in the NSA.	Good faith estimates may be issued for recurring primary items or services if the following are met: • Clearly states the expected scope of the recurring items or services (such as timeframes, frequency, and total number of recurring items or services); and • Does not exceed 12 months. Anything items or services beyond 12 months require a new good faith estimate with an explanation of any changes.

Content of a Good Faith Estimate for an Uninsured (or Self-Pay) Individual Not discussed in the NSA.	A good faith estimate issued by the convening provider/facility to the uninsured (or self-pay) individual must include: 1. Patient name and date of birth; 2. Description of the primary item or service in clear and understandable language (and if applicable, the date the primary item or service is scheduled); 3. Itemized list of items or services, grouped by each provider or facility, reasonably expected to be furnished for the primary item or service, and items or services reasonably expected to be furnished in conjunction with the primary item or service, for that period of care including: a. Items or services reasonably expected to be furnished by the convening provider or convening facility for the period of care; and b. Items or services reasonably expected to be furnished by co-providers or co-facilities); 4. Applicable diagnosis codes, expected service codes, and expected charges associated with each listed item or service; 5. Name, National Provider Identifier, and Tax Identification Number of each provider or facility represented in the good faith estimate, and the State(s) and office or facility location(s) where the items or services are expected to be furnished by such provider or facility; 6. List of items or services that the convening provider or convening facility anticipates will require separate scheduling and that are expected to occur before or following the expected period of care for the primary item or service. The good faith estimate must include a disclaimer directly above these required items. Separate good faith estimates will be issued upon scheduling or upon request of the listed items or services; notification that for items or services included in this list, information such as diagnosis codes, service codes, expected charges and provider or facility identifiers do not need to be included as that information will be provided in separate good faith estimates upon scheduling or upon request of such items or services; and include instructions for how an uninsured (or self-pay) individual can obtain good faith estimates for such items or services; 7. A disclaimer that informs the individual that there may be additional items or services the convening provider or convening facility recommends as part of the course of care that must be scheduled or requested separately and are not reflected in the good faith estimate; 8. A disclaimer that informs individual that the information provided in the good faith estimate is only an estimate regarding items or services reasonably expected to be furnished at the time the good faith estimate is issued to the individual and that actual items, services, or charges may differ from the good faith estimate; and *(continued on next page)*

	9. A disclaimer that informs the uninsured (or self-pay) individual of the individual's right to initiate the patient-provider dispute resolution process if the actual billed charges are substantially in excess of the expected charges included in the good faith estimate; this disclaimer must include instructions for where information about how to initiate the patient-provider dispute resolution process can be found, and state that the initiation of the patient-provider dispute resolution process will not adversely affect the quality of health care services furnished to an uninsured (or self-pay) individual by a provider or facility; and 10. A disclaimer that the good faith estimate is not a contract and does not require the individual to obtain the items or services from any of the providers or facilities identified in the good faith estimate.
Requirements for Co-Providers and Co-Facilities Submitting Good Faith Estimate Information – Uninsured (or self-pay) Not discussed in the NSA.	The good faith estimate information submitted by co-providers or co-facilities must include: 1. Patient name and date of birth; 2. Itemized list of items or services expected to be provided by the co-provider or co-facility that are reasonably expected to be furnished in conjunction with the primary item or service as part of the period of care; 3. Applicable diagnosis codes, expected service codes, and expected charges associated with each listed item or service; 4. Name, National Provider Identifiers, and Tax Identification Numbers of the co-provider or co-facility, and the State(s) and office or facility location(s) where the items or services are expected to be furnished by the co-provider or co-facility; and 5. A disclaimer that the good faith estimate is not a contract and does not require the uninsured (or self-pay) individual to obtain the items or services from any of the co-providers or co-facilities identified in the good faith estimate.
Separately Scheduled Items and Services Impact to Good Faith Estimate – Uninsured (or self-pay) Not discussed in the NSA.	For situations where certain items or services will need to be separately scheduled, the good faith estimate must include a list of those items or services which will require separate scheduling. The good faith estimate must also include a disclaimer that notifies the uninsured (or self-pay) individual that: 1. Separate good faith estimates will be issued to an individual upon scheduling of the listed items or services or upon request; 2. For items or services included in this list, information such as diagnosis codes, service codes, expected charges, and provider or facility identifiers may not be included as that information will be provided in separate good faith estimates upon scheduling of such items or services or upon request; and 3. Include instructions for how an individual can obtain good faith estimates for such items or services.

Required Methods for Providing Good Faith Estimates for Uninsured (or Self-Pay) Individuals Not discussed in the NSA.	The good faith estimate must be provided in written form either on paper or electronically, pursuant to the uninsured (or self-pay) individual's requested method of delivery. For good faith estimates provided electronically, they must be provided in a manner that the individual can both save and print and must be use clear and understandable language in a manner calculated to be understood by the average individual. If an uninsured (or self-pay) individual requests a good faith estimate be provided orally, the convening provider/facility may discuss the information included in the good faith estimate but it will also issue the good faith estimate in written form. The good faith estimate may be issued to the authorized representative to the extent not prohibited under state law. There are additional requirements to use clear and understandable language recognizing communication, and literacy barriers, and providers and facilities should also take into account any vision, hearing, or language limitations; communication needs of underserved populations; individuals with limited English proficiency; and persons with health literacy needs.
Good Faith Estimates Recordkeeping Not discussed in the NSA.	A good faith estimate is considered part of the patient's medical record and must be maintained in the same manner. Convening providers/facilities must provide a copy of any previously issued good faith estimate furnished within the last six (6) years to an uninsured (or self-pay) individual upon request.
Errors or Omissions in Good Faith Estimate Not discussed in the NSA.	In circumstances in which a provider or facility, acting in good faith, makes an error or omission in a good faith estimate, a provider or facility must still comply with this section despite acting in good faith and with reasonable due diligence. If the provider or facility makes an error or omission in a good faith estimate, they must correct it as soon as practicable. However, if the services are furnished before the error in the good faith estimate is addressed, the provider or facility may be subject to patient-provider dispute resolution if the billed charges are substantially in excess of the good faith estimate. The provider or facility will not be in violation if it relied in good faith on information from another entity, unless the provider or facility knows, or reasonably should have known, that the information is incomplete or inaccurate.
Complaints Against Other Providers Not discussed in the NSA.	HHS notes that providers and facilities (including convening providers/facilities or co-providers/co-facilities) who experience other providers' or facilities' failures to comply with the requirements in these interim final rules may file a complaint for enforcement investigation.

Enforcement Discretion in 2022 Not discussed in the NSA.	HHS understands that it may take time for providers and facilities to develop systems and processes for receiving and providing the required information from co-providers and co-facilities. Therefore, for good faith estimates provided to uninsured (or self-pay) individuals from January 1, 2022 through December 31, 2022, HHS will exercise its enforcement discretion in situations where a good faith estimate provided to an uninsured (or self-pay) individual does not include expected charges from co-providers or co-facilities.
Good Faith Estimate Variations	Where good faith estimates are also required in other provisions of the NSA: HHS recognizes that providers and facilities have some discretion in the assumptions that they make regarding which items or services to include in a good faith estimate, and that some natural variation may occur across providers and facilities in terms of which items or services they would include in an estimate. However, HHS is of the view that it is critical for providers and facilities to apply the same process and considerations in developing the good faith estimate required under other sections of the NSA to avoid consumers receiving two different estimates describing care from the same provider or facility for the same care.

Protections for Uninsured or Self-Pay Individuals: Patient-Provider Dispute Resolution Process

Applies to Uninsured/Self-Pay Individuals

Existing NSA Requirements	Proposed Additional NSA Requirements
Eligibility for Patient-Provider Dispute Resolution Process The NSA states that an uninsured (or self-pay) individual may seek a determination from a selected dispute resolution entity when they are billed charges that are substantially in excess of the good faith estimate.	A patient's bill will be eligible for the patient-provider dispute resolution process if the following conditions are met: 1. The patient received a good faith estimate; 2. The process is initiated within 120 calendar days of the patient receiving the bill; and 3. The bill is "substantially in excess of the good faith estimate" - defined as at least $400 more than the total amount of expected charges listed on the good faith estimate. Note that payment of all or part of the billed charges by the uninsured (or self-pay) individual (or by another party on their behalf) does not demonstrate agreement by the individual to settle at that amount or any other amount and the individual may still pursue the dispute resolution process.

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Initiation of Patient-Provider Dispute Resolution The NSA states that the process would be initiated by the uninsured (or self-pay) individual only.	The Patient-Provider Dispute Resolution (PPDR) process can only be initiated by an uninsured (self-pay) individual by providing notice to HHS within 120 calendar days of receiving the bill containing charges for the items or services that is substantially in excess of the expected charges. HHS selects the dispute resolution entity if the eligibility factors are met. The selected dispute resolution entity will provide notice to all parties with information identifying the item or service under dispute and various other related information. No later than ten (10) business days after the receipt of notice from the selected dispute resolution entity a provider or facility must submit information, including: 1. A copy of the good faith estimate (the copy can be a photocopy or an electronic image so long as the document is readable); 2. A copy of the billed charges; and 3. Documentation demonstrating that the difference between the billed charges and the expected charges in the good faith estimate reflected the cost of a medically necessary item or service and is based on unforeseen circumstances that could not have reasonably been anticipated by the provider or facility when the good faith estimate was provided.
Provider Rules During the Patient-Provider Resolution Not discussed in the NSA.	All collection efforts must cease when a PPDR is pending, including the accrual of any late fees. Retributive action against an uninsured (self-pay) individual is prohibited
Dispute Resolution Entity Determination Not discussed in the NSA.	The SDR entity should use the expected charges in the good faith estimate as the presumed appropriate amount and unless the provider or facility provides credible information justifying the difference between the total billed charges and the good faith estimate by demonstrating that the difference between the billed charges and the expected charges in the good faith estimate for the item or service reflects the costs of a medically necessary item or service and is based on unforeseen circumstances that could not have reasonably been anticipated by the provider or facility when the good faith estimate was provided. For this purpose, information is credible if critical analysis the information shows it is worthy of belief and consists of trustworthy information. SDR determinations are binding and not subject to judicial review.
Administrative Fee The NSA states the Secretary shall establish a fee to participate in the patient-provider dispute resolution process in such a manner as to not create a barrier to an uninsured individual's access to such process.	The IFR provides that the administrative fee may be no more than $25.00 assessed to the non-prevailing party.

Settlement Not discussed in the NSA.	The parties may agree to resolve the dispute by settling on a payment amount at any point after the PPDR has been initiated but before the date on which a determination is made by the dispute resolution entity. The parties can settle the payment amount through either an offer of financial assistance, an offer to accept a lower amount, or via an agreement by the individual to pay the billed charges in full. In the event that the parties agree to settle on a payment amount, the provider or facility should notify the dispute resolution entity through the Federal IDR Portal, electronically, or in paper form, as soon as possible, but no later than 3 business days after the date of the agreement. The settlement notification must contain at a minimum, the settlement amount, the date upon which settlement was reached, and documentation demonstrating that the provider or facility and uninsured (or self-pay) individual have agreed to the settlement. The settlement notice must also document that the provider or facility has applied a reduction to the uninsured (or self-pay) individual's settlement amount that is equal to at least half the amount of the administrative fee paid.

How to Take Action

CMS is accepting comments to the proposed IFR until December 5, 2021. Utilize this template to submit your comments. Comments can be submitted online here.

Concerned about navigating this complexity on your own? You don't have to.

At Ensemble Health Partners, we help providers manage complex regulations and adapt to evolving trends by empowering them with the data and operational expertise they need to remain compliant, avoid lost revenue, and continue to deliver on their missions of providing quality care to their communities.

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Additional Resources:

Federal Register: https://www.govinfo.gov/content/pkg/FR-2021-10-07/pdf/2021-21441.pdf

Regulations.gov: https://www.regulations.gov/document/CMS-2021-0156-0001

[1]Unless the state has applicable laws regarding the OON rates. new secs. 2799A-1(c)(1) of the PHS Act, 716(c)(1) of ERISA; 9816(c)(1) of IRC.

[2]Additionally, a conflict is when:

1. An IDR entity is, or is an affiliate or subsidiary of, a group health plan, a health insurance issuer offering group health insurance coverage, individual health insurance coverage or short-term, limited-duration insurance, an FEHB carrier, or a provider, a facility, or a provider of air ambulance services. (While the NSA does not specify that the independent dispute resolution entity must not be a health insurance issuer offering short-term, limited-duration insurance, the Departments have determined that would also be prohibited);
2. An IDR entity is an affiliate or subsidiary of a professional or trade association representing group health plans, health insurance issuers offering group health insurance coverage, individual health insurance coverage or short-term, limited-duration insurance, FEHB carriers, or providers, facilities, or providers of air ambulance services;
3. An IDR entity has, or any personnel assigned to a determination have, a material familial, financial, or professional relationship with a party to the payment determination being disputed, or with any officer, director, or management employee of the plan, issuer or carrier offering a health benefits plan, the plan administrator, plan fiduciaries, or plan, issuer, or carrier's employees, the health care provider, the health care provider's group or practice association, the provider of air ambulance services, the provider of air ambulance services' group or practice association, or the facility that is a party to the dispute.

[3]Batched items and services are qualified IDR items or services that are considered jointly as part of a single payment determination.

[4]Uninsured (or self-pay) individual means:
(A) An individual who does not have benefits for an item or service under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, Federal health care program (as defined in section 1128B(f) of the Social Security Act), or a health benefits plan under chapter 89 of title 5, United States Code; or
(B) An individual who has benefits for such item or service under a group health plan, or individual or group health insurance coverage offered by a health insurance issuer, or a health benefits plan under chapter 89 of title 5, United States Code but who does not seek to have a claim for such item or service submitted to such plan or coverage.
Note here that persons enrolled only in a short-term limited duration insurance policy would be considered uninsured for purposes of the good faith estimate.

[5]IFR definition of health care provider (provider) means a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law, including a provider of air ambulance services.

[6]The IFR definition of Health care facility (facility) means an institution (such as a hospital or hospital outpatient department, critical access hospital, ambulatory surgical center, rural health center, federally qualified health center, laboratory, or imaging center) in any State in which State or applicable local law provides for the licensing of such an institution, that is licensed as such an institution pursuant to such law or is approved by the agency of such State or locality responsible for licensing such institution as meeting the standards established for such licensing. Note that "facility" is defined more broadly for purposes of the good faith estimate than for non-emergency services under the NSA because "facility" includes any state- or locally-licensed health care institutions.

[7]HHS notes that uninsured (or self-pay) individuals may use different terminology other than "good faith estimate" when requesting a good faith estimate. Convening providers and convening facilities shall therefore consider any discussion or inquiry regarding the potential cost of items or services under consideration as a request for a good faith estimate.