



September 7, 2021

The Honorable Janet Yellen  
Secretary  
U.S. Department of the Treasury  
1500 Pennsylvania Avenue, NW  
Washington, DC 20220

The Honorable Martin Walsh  
Secretary  
U.S. Department of Labor  
200 Constitution Avenue, NW  
Washington, DC 20210

The Honorable Xavier Becerra  
Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

RE: Requirements Related to Surprise Billing: Part I (CMS-9909-IFC)

Dear Secretary Yellen, Secretary Walsh, and Secretary Becerra:

Thank you for the opportunity to submit comments on the Requirements Related to Surprise Billing; Part I, issued by the Office of Personnel Management and the Departments of Health and Human Services (“HHS”), Labor, and the Treasury (collectively, the “Departments”).

The undersigned organizations represent millions of patients and consumers who face serious, acute, and chronic health conditions across the country. Our organizations have a unique perspective on what patients need to prevent disease, cure illness, and manage chronic health conditions. Our diversity enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource in this discussion.

In March of 2017, our organizations agreed upon three overarching principles<sup>1</sup> to guide any work to reform and improve the nation’s healthcare system. These principles state that: (1) healthcare should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare must be adequate, meaning healthcare coverage should cover treatments patients need, including all the services in the essential health benefit (EHB) package.

Many of the individuals we represent are among the one in six Americans who have received a surprise bill.<sup>2</sup> Numerous studies and media accounts have documented the financial implications of surprise bills resulting in devastating out-of-pocket costs for those consumers directly affected and in higher premiums for all privately insured consumers.<sup>3</sup> Consequently, we worked alongside Congress to develop the bi-partisan, bi-cameral legislation to provide protections for patients from receiving unexpected medical bills that was enacted at the end of last year.

As we stated in comments<sup>4</sup> submitted on June 9, 2021, in advance of this IFR, we ask that you keep in mind two principal goals of the legislation – and Congress’ intent —when drafting regulations.

- First, the law must be implemented in a way that provides consumers with clear, comprehensive protections against surprise bills where they have not knowingly obtained out-of-network care.
- Second, the law must be implemented in a way that ensures the independent dispute resolution (IDR) process does not lead to higher costs for patients.

In addition, we must emphasize again our strong recommendation that the Departments undertake a broad, well-funded education campaign to notify consumers of their new rights under the No Surprises Act (NSA). The vast majority of the privately insured, including the nearly 135 million people in self-insured plans, will newly gain these comprehensive protections when the law takes effect on January 1, 2022. Investing in consumer education will help ensure more patients are aware of their rights under federal law before being presented with a form seeking their consent to waive these protections. We must also restate our recommendation that the Departments put in place robust oversight and enforcement of the new law to ensure patients are protected as Congress intended.

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<sup>1</sup> Healthcare Reform Principles. Available at:

<https://cgrcengage.com/mda/file/kSgnXK91pJZ/052820%20Healthcare%20Principles42logos.pdf>.

<sup>2</sup> <https://www.kff.org/health-costs/poll-finding/data-note-public-worries-about-and-experience-with-surprise-medical-bills/>

<sup>3</sup> <https://www.ajmc.com/view/policies-to-address-surprise-billing-can-affect-health-insurance-premiums>, [https://www.cbo.gov/system/files/2021-01/PL\\_116-260\\_div%20FF.pdf](https://www.cbo.gov/system/files/2021-01/PL_116-260_div%20FF.pdf), <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/09/26/california-saw-reduction-in-out-of-network-care-from-affected-specialties-after-2017-surprise-billing-law/>, <https://aspe.hhs.gov/sites/default/files/private/pdf/263871/Surprise-Medical-Billing.pdf><https://www.arnoldventures.org/stories/part-3-as-purveyors-of-surprise-medical-billing-private-equity-has-fought-lawmakers-attempts-to-protect-patients/>, <https://www.ineteconomics.org/perspectives/blog/private-equity-and-surprise-medical-billing>, <https://www.newsweek.com/health-lobbyist-spent-75-million-kill-surprise-medical-bills-reform-1559065>, <https://khn.org/news/investors-deep-pocket-push-to-defend-surprise-medical-bills/>, <https://www.nytimes.com/2019/09/13/upshot/surprise-billing-laws-ad-spending-doctor-patient-unity.html>

<sup>4</sup> <https://www.cff.org/About-Us/Our-Approach-to-Federal-State-and-Local-Policy/Our-Policy-Priorities/Briefings-Testimonies-and-Regulatory-Comments/PPC-Letter-to-Administration-on-No-Surprises-Act.pdf>

With the above two goals in mind, we respectfully offer the following comments and recommendations addressing specific provisions of the proposed rule. Please see our June 9 comments for a more detailed discussion of many of the below provisions.

## **Scope of Protections**

### ***Emergency Services***

We appreciate the Departments' strong standards to ensure patients retain their protection against balance billing for emergency services unless and until a patient can knowingly and without coercion provide consent to be safely transferred to an in-network facility using non-medical or non-emergency transportation within a reasonable distance and without unreasonable travel burden. We applaud the thoughtful and extensive discussion of the potential circumstances and context for any given patient's potential transfer, with their attending physician's approval and the patient's consent. We therefore ask that the Departments include that discussion from the preamble into the rule itself, at a minimum as examples of the greater threshold to be met before transferring a patient at this particularly vulnerable time. Regarding what constitutes unreasonable travel distance or unreasonable travel burden, that will, as the IFR notes, very much depend on individual circumstances. However, we recommend the Departments define those terms broadly, and include, at a minimum, a lack of accessible transportation in the definition of unreasonable travel burden.

We also recommend, as we did in our comments<sup>5</sup> on the model notices submitted August 12, that the Departments develop and require a separate notice and consent form for patients being asked to waive their balance billing protections following emergency care. As the IFR notes, there are greater considerations and additional criteria that must be met before a patient can be asked to waive their protections when they seek emergency care. It would be appropriate to have these criteria and considerations reflected in the notice and consent given patients in these circumstances.

### ***Non-Emergency Services***

We strongly support the inclusion of single case agreements in the definition of in-network facilities. This is particularly important for people with complex conditions that require specialized care that may not be available in their health plan's network. People with complex or rare conditions should not be forced to waive balance billing protections due to a failure of network adequacy or single case agreements offered by their health plans to meet their needs. This should include people with disabilities who are unable to find accessible providers in-network.

As noted in our June comments, we urge the Departments to take a more expansive view of facilities, recognizing that patients are receiving both emergency and non-emergency care in many different settings. One approach to more broadly defining health care facilities to which the NSA protections apply would be to include any and all in-network facilities where a physician or provider may bill independent of the facility, which would include urgent care centers as well as labs, imaging facilities, rehabilitation and physical therapy clinics, behavioral health and substance use disorder treatment facilities and potentially other facilities. Doing so is consistent with Congress' intent to provide comprehensive protections for surprise billing.

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<sup>5</sup> <https://www.cff.org/About-Us/Our-Approach-to-Federal-State-and-Local-Policy/Our-Policy-Priorities/Briefings-Testimonies-and-Regulatory-Comments/PPC-Letter-to-CMS-and-HHS-on-No-Surprises-Act-Implementation.pdf>

We are also concerned that neither the statute nor the IFR defines hospital outpatient department within the definition of facilities. Leaving this term undefined will lead to confusion and uncertainty for consumers about when they can depend on the law's protections. It will also likely result in balance billing in circumstances and settings Congress intended to capture in the prohibition on surprise bills. We therefore recommend that the Departments define "hospital outpatient department" and to do so as broadly as possible, in order to meet Congressional intent to ban balance billing in all settings where consumers do not knowingly choose to receive out-of-network care.

### **Notice and Consent**

The NSA garnered bipartisan support because far too often, patients have been hit with financially devastating costs when, through no fault of their own and without their knowledge, they received care from an out-of-network provider. The NSA's notice and consent provisions are critical to ensuring consumers and patients do not unknowingly waive their balance billing protections or do so unwillingly or under duress. As our earlier comments noted, one of the most vulnerable times for a patient is right before a procedure. In addition to navigating their actual care (which might require lab tests, consults, and other steps that must be taken directly in advance of a procedure), patients must also make arrangements for follow-up care, child care, transportation, and work. This is a stressful time for even the most prepared and well-resourced patients. We strongly believe that most patients, if they truly understand the law's protections, will not want to waive those protections. We have provided extensive comment on these critical provisions in our June 9 comments<sup>6</sup> as well as the comments we submitted on the model notice and disclosure and focus here on particular provisions of the IFR.

We strongly support the requirement that a patient cannot be coerced into signing a waiver of their protections, which would include subjecting the patient to a non-refundable or cancellation fee, and that consent cannot be given if a notice is not provided in their preferred language. This should include, as the IFR does, compliance with Section 1557 and the accessibility requirements of Section 504 of the Rehabilitation Act and the Americans with Disabilities Act.

As noted above, we also strongly support the inclusion of single case agreements in the definition of health care facility, but not all individuals are aware of their right to request coverage of an out-of-network provider or know how to access those rights. In implementing the prohibition against balance billing where there is no in-network provider available, the obligation to find an in-network provider must fall to the health plan or insurer – not the patient – and must include notice of the right to request a single case agreement that would ensure in-network cost-sharing and protection from balance billing.

We are also pleased that the IFR recognizes that state laws that do not allow providers to request that patients waive state surprise billing protections are more protective of consumers than the NSA and thus are not preempted by federal notice and consent requirements. We urge the Departments to conduct a close review of state laws to determine which are more consumer protective – for example, those that require notice further in advance of a procedure – and to require that those protections be made clear in the notices and disclosures provided to patients.

Finally, while we recognize and appreciate the Departments' intent to set a floor on notice required in advance of same-day procedures, we are concerned that allowing providers to give notice and seek

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<sup>6</sup> <https://www.cff.org/About-Us/Our-Approach-to-Federal-State-and-Local-Policy/Our-Policy-Priorities/Briefings-Testimonies-and-Regulatory-Comments/PPC-Letter-to-Administration-on-No-Surprises-Act.pdf>

consent to balance bill a patient just 3 hours prior to their scheduled procedure opens the door to abuse of the notice provisions and coercion of consent. We believe a clearer line that would minimize confusion for consumers and protect against providers misinterpreting or misapplying the notice provisions would be to disallow out-of-network providers from seeking consent to waive protections once a patient arrives at a facility for their scheduled procedure or service.

### **Determination of Patient Cost-Sharing Amount**

We strongly support limiting patient cost-sharing to the lesser of the qualifying payment amount (QPA) or the billed charge. We encourage the Departments to go further by limiting patient cost-sharing to the lesser of the QPA or the amount negotiated or determined in the dispute resolution. We also ask that consumers in states where the recognized amount (i.e., the amount that is the basis for calculating the consumer's cost-sharing) is defined under state law be guaranteed the same protection. If a state law would require consumers to pay more out-of-pocket than would apply if their cost-sharing was calculated using the QPA, the lower amount should apply.

### **Methodology for Calculating the Qualifying Payment Amount**

Consumers who receive out-of-network care to which the NSA applies will be directly affected by the QPA if their plan requires them to meet a deductible or bases their out-of-pocket cost on coinsurance rather than fixed dollar copays. We therefore strongly support the Departments' approach to defining the methodology used to determine the QPA in a manner that minimizes the inclusion of outliers that would skew the QPA higher, such as rates paid in single case agreements or bonuses paid under alternative payment arrangements. We also support a broad definition of geographic region and minimizing the need to use alternative methods to calculate the QPA. Any inputs that would skew the QPA higher will increase costs for the patients and consumers we represent. We therefore ask that the Departments closely monitor the QPAs produced under their methodology, through the audits required under the NSA, in order to identify the need for future rulemaking or legislation to address factors that may contribute to a higher QPA.

### **State Law Interaction with ERISA**

The Departments seek comment on whether an insurer, health care provider, or facility should be allowed to opt into a state law that would not otherwise apply because it fails to meet the IFR's test for deferral to state law for determining the "recognized amount," which determines patient cost-sharing, or the out-of-network rate. We do not believe providers and facilities should be allowed this discretion. Doing so would mean treatment of providers would be inconsistent, creating confusion for patients and consumers. It would also likely result in higher costs over time, as providers and facilities are likely to choose the process and payment methodology – state or federal – that is more favorable to them.

### **Disclosure**

As we recommended in our comments on the model disclosure, providers and facilities should be required to provide the model disclosure of the NSA's protections at the earliest possible point in their interaction with a patient. Doing so will increase the likelihood that patients will understand their protections well in advance of being asked to provide their consent to be balance billed. We also believe that relying on the disclosures alone, or primarily, will have limited reach and effect. As noted above and in our previous comments, a broad, well-funded public education campaign is essential and may well do

more to educate consumers on their rights than a notice provided with other health care documents that patients are given when they consult a provider or schedule an appointment.

## **Complaints**

As noted in our earlier comments, patients typically do not know which federal or state agency has jurisdiction over their coverage. We are therefore pleased that the Departments have sought to provide a seamless process for consumers to file complaints and seek help with a disputed balance bill. However, we believe the Departments must provide far greater detail on the operation of the complaint system and tighter timeframes for responding to complainants in order to ensure consumers' complaints are resolved in a timely manner and to minimize problems that can occur while they are waiting for a resolution.

We highly recommend the federal complaint system be modeled after the Consumer Financial Protection Board (CFPB) process.<sup>7</sup> The CFPB complaint system is clearly accessible from the homepage and allows consumers to track the status of their complaint; be notified if their complaint was routed to another government agency; know the likely timeframe for getting a response; and access published de-identified complaints through a publicly-available database.

Furthermore, the federal complaint system should be required to respond to a complaint in 30 days, down from 60 days in the IFR. Consumer bills may go to collections in as few as 30 days. When a complaint is received, the federal complaint system should notify the provider involved and bar them from sending a bill while the charges are in dispute. Any late payment penalties should be prohibited while a complaint is pending. Moreover, once a complaint is made, the complainant should receive an official acknowledgement that can be used as evidence that they have filed a complaint in the event the provider sends a bill.

The Departments seek comment on whether there should be a limit on the time allowed for consumers to file a complaint. We strongly oppose limiting the time allowed for consumers to file a complaint. Consumers may experience delays because the provider or facility has not sent their bill in a timely way, or because they are waiting to learn more about what their insurer or health plan will pay or potentially what may be covered under a hospital charity program.

It will also be important to require states to share their complaint data with federal regulators, including states that have responsibility for enforcement of the provisions that apply to providers. Doing so will allow federal regulators to get a more complete picture of NSA implementation and enforcement and will be essential to informing any needed revisions to the regulations.

## **Provider Directories**

The IFR and the Departments' recently issued set of frequently asked questions (FAQs) note that there will not be further guidance on implementation of the NSA's provider directory provisions before the NSA's effective date. The FAQs say the Departments will rely instead on insurers' and plans' good faith, reasonable interpretation of the provisions that require health plans and insurers to keep directories up-to-date.<sup>8</sup> Under the NSA, consumers are protected from surprise billing by a non-participating provider if

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<sup>7</sup> <https://www.consumerfinance.gov/complaint/process/>

<sup>8</sup> <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebbsa/our-activities/resource-center/faqs/aca-part-49.pdf>

the consumer relied on inaccurate provider directory information. Given the recently issued FAQs, we must affirm our earlier comments recommending that federal rules place the burden on the plan to demonstrate the directory was accurate at the time of the patient's search.

### **Conclusion**

Our organizations thank you for the opportunity to provide comments on the Requirements Related to Surprise Billing: Part I issued by the Departments. If you have any questions, please contact Theresa Alban ([talban@cff.org](mailto:talban@cff.org)) at the Cystic Fibrosis Foundation.

Sincerely,

Alpha-1 Foundation  
ALS Association  
American Cancer Society Cancer Action Network  
American Heart Association  
American Kidney Fund  
American Lung Association  
Arthritis Foundation  
Asthma and Allergy Foundation of America  
Cancer Support Community  
*CancerCare*  
Cystic Fibrosis Foundation  
Epilepsy Foundation  
Family Voices  
Hemophilia Federation of America  
JDRF  
Mended Hearts & Mended Little Hearts  
Muscular Dystrophy Association  
National Eczema Association  
National Hemophilia Foundation  
National Kidney Foundation  
National Multiple Sclerosis Society  
National Organization for Rare Disorders  
National Patient Advocate Foundation  
Susan G. Komen  
The AIDS Institute  
The Leukemia & Lymphoma Society  
WomenHeart: The National Coalition for Women with Heart Disease