May 06, 2022

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

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

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

The Honorable Chiquita Brooks-LaSure, Administrator
Center for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS - 9908 - IFC
P.O. Box 8016
Baltimore, MD 21244-8016

Dear Secretary Becerra, Secretary Yellen, Secretary Walsh, and Administrator Brooks-LaSure:

Thank you for meeting us to discuss ways to strengthen patient protections under the final rule to implement the No Surprises Act (NSA). Community Catalyst and U.S. PIRG are writing to follow up on some of the issues that we discussed, as well as others that we did not have time to raise during the meeting.

Community Catalyst is a leading non-profit national health advocacy organization dedicated to advancing a movement for health equity and justice. The organization partners with local, state, and national advocates to leverage and build power so all people can influence decisions that affect their health. Health systems will not be accountable to people without a fully engaged and organized community voice. That's why Community Catalyst works every day to ensure people's interests are represented wherever important decisions about health and health care are made: in communities, state houses, and on Capitol Hill. Community Catalyst's mission is to build the power of people to create a health system rooted in race equity and health justice and a society where health is a right for all.

U.S. PIRG is a federation of independent, state-based, citizen-funded Public Interest Research Groups in 25 states, whose role is to find common ground around the solutions that will make our future healthier, safer and more secure.

In general, we strongly encourage the Tri-Agencies to develop the NSA final rule to be consistent with the critical goals articulated in President Biden's Executive Order 14009[1] to review regulations to make high quality health care accessible and affordable; and to ensure the NSA rules align with Vice President Harris's announcement on improving oversight on medical billing and collection actions to address the burden of medical debt.[2]

To that end, we urge you to keep in mind three key principles:

(1) To ensure that the process used to reach final payment by private insurance plans avoids inflating costs to the overall health care system, costs which will likely be passed on to consumers in increased premiums.
(2) To strengthen protections for patients enrolled in private insurance plans and those patients without coverage or who opt to pay for care without using their insurance, ensuring balance bills are prohibited and patients aren't cajoled into waiving their protections with the "Surprise Billing Protection Form."
(3) To effectively inform patients, regardless of insurance status, about their rights guaranteed under the NSA and help them find the help they need to fight any illegal bills, stay out of collections and protect their credit.

Specifically, we recommend the following:

RECOMMENDATION # 1: Standing firm on the priority of the Qualifying Payment Amount (QPA)

We thank the Tri-Agencies for the strong provisions included in the interim final rules that ensure privately insured patients will never have to worry about receiving exorbitant surprise medical bills from most out-of-network providers for hospital visits or emergency department treatments.

Unfortunately, numerous lawsuits and challenges to both the NSA itself and the rules from the Tri-Agencies threaten to end those crucial patient protections or weaken the reforms of the law that aim to reduce health care inflation. We previously expressed our concerns in a letter signed by 70 diverse organizations representing patients, consumers, employers, and labor unions who have long paid the price for surprise medical billing. In it we noted that the decision rendered in Texas Medical Association v. Department of Health and Human Services, et al. would result in changes to federal rules that could raise costs for consumers/patients. Without the guardrails necessary to make decisions by arbiters' independent dispute resolution (IDR) predictable, hospital-based providers will have a green light to use IDR routinely, hoping to win oversized payment, rather than joining health plan networks. Without the guardrails pointing to the primacy of the Qualifying Payment Amount (QPA) in payment decisions in the interim final rules, some providers will try to obtain higher, inflated rates, leading to increased health care costs and higher premiums for consumers.

With hundreds of thousands of consumers/patients already protected from surprise bills so far in 2022, we write to reiterate our support and urge you to stand firm in the wake of attacks on the NSA that if successful will harm consumers/patients. The ban on balance billing is vital for individual

[1] The White House. Executive Order on Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage. Executive Order 14009. April 5, 2022.
[2] The White House. FACT SHEET: The Biden Administration Announces New Actions to Lessen the Burden of Medical Debt and Increase Consumer Protection. Statements and Releases. April 11, 2022.

patients, but the guardrails established for the IDR process will bring out-of-network provider payments back in line with in-network payments and result in cost-savings for all insured patients.

RECOMMENDATION #2: Improving Surprise Billing Protection Form

The rules recommend a model form to be used by some providers who seek consent from patients to allow balance-billing. The model form is unfortunately misnamed and the title of the document should make it clear that this form is not giving patients protections from surprise bills, but rather is requesting patients to allow balance billing to occur. The title and the language used in the form should be as clear as possible to alert the consumer that they do not have to sign the form, and should they do so, they will be responsible for much higher out-of-pocket costs. We also recommend that the form require a physician signature and printed name so there is a specific individual to hold accountable for the estimate of charges provided in the form. By requiring this signature, it will ensure providers are fully away of the charges the patient is being asked to pay, and it gives regulators a specific person to hold accountable to the estimate. Without this identifier, it will be easier for health care providers to point the blame at billing clerk errors or other obfuscation, making it difficult for patients to challenge bills that go above the estimate.

The waiver form is part of the law that worries consumer advocates because we know it has the potential to open a wide gap in the important patient protections of the NSA. Tightening up the language of the model form and ensuring accountability for the estimate of charges could minimize the potential adverse consequences of the form.

RECOMMENDATION # 3: Informing <u>all</u> patients of their rights to be screened for hospital financial assistance as well as all applicable public health insurance programs to help reduce their medical bills. Specifically, we suggest including both the NSA protections and the availability of hospital financial assistance programs to the notice and consent form.

The notice and consent form is a perfect avenue to educate patients about the availability of financial assistance and opportunity to be screened for financial support to pay for their medical treatment. The Affordable Care Act has expanded health insurance coverage to millions of people across the nation. However, 30 million people remain uninsured. While the No Surprises Act provides necessary protections for privately insured patients from the most pervasive types of surprise out-of-network bill, many individuals continue to face high out of pocket cost sharing (i.e. deductibles, coinsurance, copayments) if illness or injury strikes. When a person's medical bills exceed what they can pay, they are saddled with medical debt. U.S. Census Bureau data estimate that 17 percent of U.S. households held at least $195 billion in medical debt in 2019.

To achieve the goals of improving health care affordability and reducing the burden of medical debt for all patients set forth by the White House, we recommend the Tri-Agencies include requirements for health care providers and facilities that mirror all applicable federal and state laws on free and discounted care programs for uninsured and underinsured[3] patients.

[3] In the Commonwealth Fund's latest Biennial Health Insurance Survey, patients who were considered underinsured were:

- individuals with income greater than 200% of the Federal Poverty Level (FPL) who had out-of-pocket costs, excluding premiums, of at 10% or more of their household income over the prior 12 months;
- individuals with income less than 200% of FPL who had out-of-pocket costs, excluding

For instance, at the federal level, under the ACA and IRS Section 501(r),[4] non-profit hospitals are required to establish and publicize financial assistance programs for low-income patients. In addition, hospitals are prohibited from charging patients who are eligible for financial assistance more than the amounts generally billed to insured patients. Finally, before engaging in extraordinary collection actions, hospitals must make reasonable efforts to determine whether a patient is eligible for financial assistance.

At the state level, many states have gone beyond federal requirements mandating that both nonprofit and for-profit hospitals provide financial assistance. Often this includes a 100% discount, or "free care," for low-income patients who fall at or below a specific income requirement. California mandates general or acute care hospitals to provide free or reduced care for uninsured patients, or patients with high medical costs who have incomes at or below 400% FPL. Connecticut mandates that all hospitals screen for eligibility for financial assistance and provide free care or discounted care for uninsured or underinsured individuals who are unable to pay.[5]

Because there are already some requirements for the provision of financial aid and eligibility screening by federal and some state laws, with more being passed, the notice and consent form as well as the "Surprise Billing Protection Form" required under the NSA offer more opportunity for consumers to learn about how to access support that could reduce their medical debt burden. Including hospital-specific information on these forms, with phone numbers to call, would be a timely way for patients now facing the need for care to learn and understand their ability to access financial aid.

RECOMMENDATION # 4: Requiring all health care providers to pause all debt collection actions at the time patients notify their intent to dispute their medical bills until the dispute resolution process has ended. We recommend applying this protection to both uninsured or cash-paying patients and insured patients who initiate internal claims with their health plans.

We appreciate the prohibitions on collections while the patient-provider dispute resolution process is pending. This provides an important protection for uninsured patients since medical bills in collection cause the individuals stress, anxiety, and poor health. We strongly urge the Tri-Agencies to apply the same protection to insured patients who initiate appeals to dispute denials of claims with their health plans. With the time limits imposed by the NSA to file a surprise billing claim, we are concerned that patients may not have exhausted their internal insurance claim appeals and might forfeit their opportunity to challenge a surprise bill. We recommend that the 120-day surprise billing complaint only starts after the insured patient has exhausted their internal appeals process with their health plan.

We also request that the Tri-Agencies strengthen the above requirement by prohibiting providers and facilities from employing collection practices that impoverish patients and worsen economic

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premiums, of 5% or more of their household income over the prior 12 months; or
- individuals who were responsible for deductibles totaling 5% or more of their household income.

https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial

[4] 26 CFR Parts 1, 53, and 602 https://www.govinfo.gov/content/pkg/FR-2014-12-31/pdf/2014-30525.pdf

[5] The National Consumer Law Center (November 2021). An Ounce of Prevention: A Review of Hospital Financial Assistance Policies in The States. https://www.nclc.org/images/pdf/medical-debt/Rpt_Ounce_of_Prevention.pdf

inequities. These practices include taking such legal actions as freezing of bank accounts, garnishing wages, or placing a lien on property, vehicles, or other personal possessions. In New Mexico, for example, health care facilities and third-party health care providers and medical creditors are prohibited from pursuing collection actions, i.e., selling debt and filing lawsuits to collect medical debt against patients who are determined to be indigent patients (patients with income at or below 200% FPL) over charges for health care services and medical debt.[6]

All patients should receive confirmation when entering appeals or the patient-provider dispute process, which includes:

- notice of debt collection pause; and
- advising patients to contact the Consumer Financial Protection at (855) 411-2372 or submit a complaint at https://www.consumerfinance.gov/complaint/ if the collections continue.

RECOMMENDATION # 5: Improving language translation services to support patients who speak a language other than English

We have run a test for non-English, non-Spanish speakers to use the surprise billing hotline number. We found it lacking because there is only an English speaker to handle all non-English, non-Spanish questions. Callers were put on hold and then disconnected. We urge you to revisit the system currently being used.

Thank you for the opportunity to provide this additional information. We are happy to address any questions you may have. Please contact: Quynh Chi Nguyen at qnguyen@communitycatalyst.org or Patricia Kelmar at pkelmar@pirg.org

Sincerely,

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[6] Chapter 31 (SB 71) https://www.nmlegis.gov/Sessions/21%20Regular/final/SB0071.pdf