



June 30, 2021

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

The Honorable Janet Yellen  
Secretary of the Treasury  
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

Dear Secretary Becerra, Secretary Yellen, and Secretary Walsh:

Nationally, one in five people (23 percent) report having unpaid medical bills.<sup>1</sup> Ample evidence shows that surprise medical bills are one of the key factors contributing to medical debt.<sup>2</sup> Although medical debt affects people across socioeconomic and demographic backgrounds, Black, Indigenous and people of color (BIPOC), and other historically oppressed and excluded populations incur substantial medical debt<sup>3</sup> and experienced long-lasting financial consequences compared with their white counterparts.<sup>4</sup> It is therefore critical that all solutions that aim to end surprise medical bills are developed through a racial justice and health equity lens.

Community Catalyst is a leading non-profit national health advocacy organization dedicated to advancing a movement for health equity and justice. We partner 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 we work 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.

---

<sup>1</sup> Judy T. Lin, Christopher Bumcrot, Tippy Ulicny, Gary Mottola, Gerri Walsh, Robert Ganem, Christine Kieffer, Annamaria Lusardi. The State of U.S. Financial Capability: The 2018 National Financial Capability Study. Finra Investor Education Foundation, June 2019.

[https://www.usfinancialcapability.org/downloads/NFCS\\_2018\\_Report\\_Natl\\_Findings.pdf](https://www.usfinancialcapability.org/downloads/NFCS_2018_Report_Natl_Findings.pdf).

<sup>2</sup> Lindsey Bomnin and Stephanie Gosk. "Surprise medical bills lead to liens on homes and crippling debt." *NBC News*, March 19, 2019. <https://www.nbcnews.com/health/health-news/surprise-medical-bills-lead-liens-homes-crippling-debt-n984371>

<sup>3</sup> Neil Bennett, Jonathan Eggleston, Laryssa Mykyta and Briana Sullivan. 19% of U.S. Households Could Not Afford to Pay for Medical Care Right Away. U.S. Census Bureau, April 7, 2021.

<https://www.census.gov/library/stories/2021/04/who-had-medical-debt-in-united-states.html>.

<sup>4</sup> Brianna Wells. Solving The Medical Debt Crisis. The Greenlining Institute, March 2021.

<https://greenlining.org/wp-content/uploads/2021/03/Greenlining-Medical-Debt-Crisis-Report-2021.pdf>.

Over the past six years, we have worked with state and local advocates to enact comprehensive protections against surprise billing in the states and were active in the Congressional debate that resulted in passage of the No Surprises Act. The new federal law will extend comprehensive protections for the first time to people living in the states without their own balance billing laws and to the nearly 135 million people in self-insured plans.

As you draft regulations to implement the No Surprises Act, first and foremost, we strongly encourage the Tri-agencies to undertake a broad, well-funded education campaign to inform people of their new rights under the No Surprises Act. We urge the Tri-agencies to incorporate racial equity into the regulations, consistent with the critical goals articulated in President Biden's Executive Order 13985.<sup>5</sup>

We urge the Tri-agencies to keep in mind two key principles that reflect Congress' intent in enacting the law:

- First, the law must be implemented in a way that provides individuals and their families 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 dispute resolution process does not contribute to higher health care costs.

**1. Ensuring that people know their rights - Protections against surprise medical bills must be clearly communicated to everyone in a way that is easy-to-read and understandable. We recommend the following strategies:**

***a. Invest in education campaigns to notify people of new protections under the NSA***

In order to successfully utilize the new protections under the NSA, people need trusted resources they can rely on for information and support. We strongly urge the Tri-agencies to invest in education campaigns focusing on raising awareness of new protections under the NSA. Education efforts should use a mix of paid advertising (including advertisements on broadcast, digital, and earned media) and direct education to communities. Education efforts should be done in cooperation with community-based organizations and stakeholder organizations, such as community health workers, community health centers, navigators, enrollment assisters. We believe that allocating grant funding to these organizations will help accelerate these efforts.

Specifically, we believe that Consumer Assistance Programs (CAP) are well-positioned to offer this direct assistance and one-on-one guidance. They offer essential language translation services, have systems and resources in place to explain complex billing processes, and have existing relationships with communities. Trusting relationships, in combination with their existing infrastructure to offer support around medical bill, will allow CAPs to quickly relay information to people in the communities they serve regarding changes under the NSA. Robust, long-term funding will be vital to ensuring these programs are able to support people at the offset and give them the stability to extend

---

<sup>5</sup> The White House. Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government. Executive Order 13985. January 20, 2021. <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/>.

outreach and programming to reach new communities. For more information on the CAPs, please see the Community Catalyst resource: *Overview of Consumer Assistance Programs* outlining the need for these programs, the solutions they provide, and how they coordinate with other forms of consumer assistance.<sup>6</sup>

***b. Protect patients from unknowingly waiving the new protections guaranteed under the NSA***

The NSA protects patients from balance billing except where they have knowingly and voluntarily agreed to receive care from certain out-of-network providers in certain settings. Providers must notify patients of their network status and obtain their signed consent to receive non-emergency care out-of-network, thereby waiving their balance billing protections. However, protections cannot be waived in certain circumstances: when there is no in-network provider available, for urgent or unforeseen care, or for certain specialty providers (e.g., anesthesiologists, pathologists, radiologists and neonatologists, and others that may be identified in federal regulations). How this notice is provided, and consent is obtained will be critical to ensuring that patients don't unknowingly waive their protections.

In order to implement this provision in a manner that ensures patients are knowingly and voluntarily agreeing to receive care out-of-network, where permitted, we recommend the following:

- The notice and consent form must comply with Section 1557 and other federal language access requirements and provide information on how to file a complaint and request an appeal (including under the NSA's provision expanding external review to include the applicability of the NSA). The notice should also provide information on how to access assistance services (for example, from a Consumer Assistance Program or a trusted legal aid organization). These assistance services should be available in the language requested by the patient.
- The content of the notice and consent form must be provided as a stand-alone document. It should not be buried among a package of other documents a patient may have to review and sign in advance of scheduling and receiving care. It must be clear, easy-to-read, understandable and available in the language spoken by the patients as well as in accessible formats for people with disabilities.
- Regulations should prohibit blanket waivers that would apply to multiple or potential providers or an episode of care that involves multiple procedures or services, and the cost-estimate must be specific to the provider and procedure or service.
- Regulations must give clear guidance on the circumstances under which patients can voluntarily give consent to out-of-network care and waive their protection from balance billing. For example, Texas law says patients must have "meaningful choice" to give signed consent, which is deemed impossible if the out-of-network provider was assigned to or selected for the patient by another provider or the health plan, or if the patient was coerced, for example, if the provider requires payment of a non-refundable fee, deposit or cancellation fee.

---

<sup>6</sup> Community Catalyst. Finance & Sustain Consumer Assistance for Health Care. June 3, 2021. <https://www.communitycatalyst.org/resources/publications/document/Consumer-Assistance-Programs-Overview.pdf>.

Furthermore, in order to comply with the NSA's requirement to update the notice as necessary, the Tri-agencies should utilize consumer testing and complaint data to identify areas where improvements are needed to ensure consent is given knowingly and without coercion.

Federal regulators should also confirm that state laws that do not allow patients to waive state balance billing protections exceed the standards laid out in the NSA as more protective of patients and thus are not preempted by federal notice and consent requirements. Similarly, regulations should confirm that state laws that require notice further in advance of a procedure would be more protective of patients. For example, Michigan requires 14 days' notice and Texas requires 10 days' notice prior to receiving non-emergency care. To do otherwise would result in patients from those states losing existing protections.

*c. Ensure patient-friendly complaint process*

The federal complaint system should operate with a “no wrong door” policy that will receive complaints from any source (including Consumer Assistance Programs, community health workers, community health centers, navigators, enrollment assisters), and route complaints to the appropriate state or federal agency for further action. To do otherwise may discourage complaints and limit the potential of the complaint system to inform enforcement, oversight and future rulemaking. One potential example of a patient-friendly complaint system is the one operated by the Consumer Financial Protection Board (CFPB), found here: <https://www.consumerfinance.gov/complaint/process/> The CFPB complaint system allows patients to track the status of their complaint; be notified if their complaint was routed to another government agency; and be notified of the likely timeframe for getting a response.

*d. Ensure provider directories are up-to-date and accurate at all times*

We strongly support the requirement that health plans and insurers keep provider directories up-to-date and accurate, and the requirement that providers report information to health plans and insurers to assist in regular directory updates. We urge regulators to conduct regular audits and secret shopper studies to confirm that health plans and insurers are complying with this critical consumer protection.

In order to enhance the usability of provider directories, we recommend regulators consider strengthening this requirement to also require provider directories to indicate which providers are accepting new patients, languages spoken (including American Sign Language and Braille), access for people with disabilities and providers' race, ethnicity and LGBTQ+ status. There should also be a clear way for patients to report any inaccuracies in provider directories. Doing so would assist regulators in their oversight of this critical provision.

**2. Holding down health care cost for patients - It is critical to put in place sufficient guardrails on the Independent Dispute Resolution (IDR) Process that limit the criteria arbitrators can use in their consideration for final payment determinations.**

Regulations should be drafted to at least meet, if not exceed, the savings projected by the Congressional Budget Office, which estimated premiums could be reduced by one percent. To do so, we urge you to develop a system that first encourages the parties to resolve out-of-network billing disputes through negotiation rather than the full IDR process. For disputes that do go to IDR, regulations should ensure the process limits administrative costs, produces consistent results (which will likely further encourage negotiations) and enables efficient and strong federal oversight.

One way to ensure IDR produces consistent results is to require the QPA, which is based on the median contracted rate, to be the primary consideration for arbitrators' decisions. The parties to the dispute should be required to submit their proposals relative to the QPA, and only if there is compelling data would an arbitrator consider an amount that exceeds the QPA. In particular, regulations should direct arbitrators to consider non-QPA permitted factors only in very limited circumstances. The parties to the arbitration should be required to demonstrate why any given factor is not already recognized by broadly used bases for payment, including diagnosis-related groups (DRGs) or CPT codes. Regulations should also ban considering billed charges including any reference to bill charges, for example, 80 percent of billed charges.

The IDR process must also allow for strong federal oversight of certified IDR entities and the outcomes of those proceedings. This monitoring and evaluation of IDR entities should inform the reports that the secretaries must regularly produce and make public. Certified IDR entities must also produce, and the secretaries must collect, other data needed to monitor effects on provider payments, provider networks and health care costs. Not only will this help establish an efficient and cost-effective IDR process, it will also be necessary to inform future rulemaking that adjusts for any unintended outcomes, including cost impacts.

### **3. Additional Protections under the NSA**

#### *a. Defer to state laws only where there is a demonstrated benefit to patients*

Our work with state advocates has included efforts to pass comprehensive balance billing protections for patients in state-regulated plans. We therefore support the NSA's recognition of state efforts with the federal law's deferral to "specified state laws," including those that rely on a set payment amount to resolve billing disputes between insurers and providers. With regard to other NSA provisions, federal law should defer to state laws where there is a demonstrated benefit to patients, as with the examples shared above regarding state law on notice and consent. People in states that have enacted balance billing protections should not have less than the full protections previously enacted under state law.

#### *b. Develop dispute resolution for uninsured*

The NSA requires providers to give uninsured patients a good faith estimate of the cost of their care. We believe that this requirement is not strong enough to protect uninsured patients from exorbitant medical bills. First, it would be impossible to require a patient to demonstrate the cost "substantially exceeds" the estimate in the absence of any estimate. Ample evidence shows hospitals frequently charge uninsured patients two to four times what health insurers and public programs actually pay for hospital services.<sup>7,8&9</sup> Second, requiring a fee to access IDR will pose a financial barrier for millions

<sup>7</sup> Gerard Anderson. From 'Soak The Rich' To 'Soak The Poor': Recent Trends In Hospital Pricing. *Health Affairs* 26, no. 4 (May 2007): 780-789. <https://doi.org/10.1377/hlthaff.26.3.780>

<sup>8</sup> Stacie Dusetzina, Ethan Basch, and Nancy Keating. For Uninsured Cancer Patients, Outpatient Charges Can Be Costly, Putting Treatments out of Reach. *Health Affairs* 34, no. 4 (April 2015): 584-591. <https://doi.org/10.1377/hlthaff.2014.0801>

<sup>9</sup> Rachel Garfield, Kendal Orgera and Anthony Damico. The Uninsured and the ACA: A Primer - Key Facts about Health Insurance and the Uninsured amidst Changes to the Affordable Care Act. Kaiser Family Foundation, January 25, 2019. <https://www.kff.org/uninsured/report/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act/view/footnotes/#footnote-389478-2>

of people. Most of the nearly 29 million uninsured have low income, many of them are people of color, immigrants and people with income at or below the poverty level in states that haven't expanded Medicaid.<sup>10</sup> Requiring a fee to access IDR will pose a substantial barrier for millions of people.

We strongly urge the Tri-agencies to include regulations that:

- Automatically qualify uninsured patients' bill for IDR and allow uninsured patients to enter the IDR process at no cost, if providers fail to provide a cost estimate.
- Require health care providers to screen all uninsured patients, regardless of immigration status, for eligibility for hospital financial assistance programs (such as free care or discounted care) that may lower their medical bill, and for public health coverage programs, particularly given the American Rescue Plan's expanded eligibility for premium tax credits. In addition, health care providers should be discouraged from employing collection practices that impoverish patients and worsen economic inequities. These practices include taking legal actions such as freezing of bank accounts, garnishing of wages, or placing a lien on property, vehicles, or other personal possessions.
- Prohibit health care providers from imposing excessive charges on uninsured patients. The Tri-agencies should put limitations on charges for uninsured patients, ideally using the Medicare rate or Medicaid rate as a base to calculate uninsured patients' medical bills and defer to more consumer protective state laws that cap hospital charges for uninsured patients. For instance, under New Jersey law, uninsured patients with incomes less than 500% of the federal poverty level cannot be charged more than 15% above the Medicare payment rate.<sup>11</sup> In California, hospitals are prohibited from charging patients with income not exceeding 350% of the federal poverty level more than Medi-Cal program, Medicare or another federal or state government-sponsored health care program in which the hospital participates, whichever is greatest.<sup>12</sup>

***c. Ensure continuity of coverage***

We strongly support the requirement that health plans and insurers allow patients in certain circumstances to continue to receive care from their providers in the event that their provider's network status has changed. Specifically, we recommend specifying the following circumstances: pregnant people who are in their second or third trimester of pregnancy through the postpartum period (commonly defined as the six weeks after birth); people with terminal illnesses; and patients being treated for a life-threatening condition, a serious acute condition, or another health condition (such as severe depression or a mental health condition).

To effectively implement this provision, regulations should require health plans and insurers to provide notice of these protections that comply with the same requirements we note above for notice and consent of out-of-network care, including that notice must be provided as a separate document, be available in the patient's preferred language, and include information on how to appeal and access consumer assistance.

<sup>10</sup> Jen Tolbert and Kendal Orgera, "Key Facts About the Uninsured Population," Kaiser Family Foundation, November 6 2020. <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/>

<sup>11</sup> [N.J. Stat. Ann. § 26:2H-12.52 \(West\)](#)

<sup>12</sup> [Cal. Health & Safety Code §12705](#)

*d. Require robust disaggregated data collection to track impact of NSA provisions*

Health justice and equity cannot be achieved without complete and transparent data collection and the disaggregation of data.<sup>13</sup> We urge the Tri-agencies to use the work with the Consumer Financial Protection Bureau to collect and analyze data on the number of uninsured patients using the IDR process and the number of patients using the complaint system. To better address health disparities, it is imperative to collect not just aggregated data, but detailed data on race, ethnicity, primary language, sex, gender identity, sexual orientation, age, socioeconomic status, disability status, and other demographic information as required under the Affordable Care Act, Section 4302. We also recommend that the Tri-agencies work with the Internal Revenue Service (IRS) to require health care providers to report disaggregated data regarding their financial assistance activities since these programs are a particularly important protection for uninsured patients. Findings from data collection and analysis should be included in the three mandatory reports issued by the Government Accountability Office, as well as made available to the public and policy makers to aid future policy improvements.

Thank you for the opportunity to submit these above recommendations. Please do not hesitate to contact Quynh Chi Nguyen, Senior Policy Analyst at [qnguyen@communitycatalyst.org](mailto:qnguyen@communitycatalyst.org) if you have any questions or if you would like additional information.

Respectfully submitted,



Emily Stewart  
Executive Director

---

<sup>13</sup> APIAHF, ACCESS, National Urban League, UNIDOS US, National Congress of American Indians. Policy Recommendations: Health Equity Cannot Be Achieved Without Complete and Transparent Data Collection and the Disaggregation of Data. February 2021. <https://www.apiahf.org/resource/policy-recommendations-health-equity-cannot-be-achieved-without-complete-and-transparent-data-collection-and-the-disaggregation-of-data/>.