August 12, 2021

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244–1850

Dear Secretary Becerra and Administrator LaSure:

Thank you for the opportunity to submit comments on the documents (CMS-10780) related to implementation of the No Surprises Act (NSA), including the standard notice and consent documents, the model disclosure notice, the complaints processes, and their supporting documents**.**

Nationally, one in five people (23 percent) report having unpaid medical bills.[1] Ample evidence shows that surprise medical bills are one of the key factors contributing to medical debt.[2] 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[3] and experienced long-lasting financial consequences compared with their white counterparts.[4] 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

[1] 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.
[2] 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
[3] 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.
[4] 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.

wherever important decisions about health and health care are made: in communities, state houses and on Capitol Hill.

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.

Notice and Consent Documents

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. The content of the standard notice and consent form and the circumstances under which patients must make a decision about whether to waive their protections and knowingly and voluntarily obtain care out-of-network is a critical component of the NSA. We are pleased that the instructions require non-participating providers at participating health care facilities to provide the document separate from any other documents, and to make available in person or by phone a representative of the provider or facility to explain the documents and cost estimates to the patient and to answer questions. We also support the requirement that the document meet applicable language access requirements and be translated or available through a qualified interpreter, if needed. However, **we believe that the instructions and forms should be strengthened to ensure no patient feels coerced into signing away their protections or pressured to do so without a full understanding of the costs and consequences of doing so**. We therefore offer the following recommendations for the content of the form:

- "More details about your estimate" (page 4): Providers should be required to provide complete and accurate information to help patients assess their potential costs if they waive their protections.
    - The form instructs the provider or facility to provide a good faith estimated cost for the items and services to be furnished, "plus the cost of any items or services *reasonably expected to be provided* in conjunction with such items or services" [emphasis added]. If actual costs substantially exceed the estimate, patients should be able to file a complaint and the form should provide information on how to do that. Also, if there is any item or service not included on the list but furnished by the provider, federal regulations should recognize that as a cost for which the patient did not waive their protections and the provider must be barred from sending a balance bill for that item or service.
    - The form instructs the patient to contact their health plan to find out how much their plan will pay. This should be the responsibility of the in-network facility to obtain that information and there should be an additional column added to the table with a heading like the one included in the Texas notice and consent standard form ("You may need to pay").[5]
- Choice to obtain care from an in-network provider or facility: The following text on the bottom of page 1 should be amended to read [new text in italics]: "You shouldn't sign this form if you didn't have a choice of providers when receiving care. For

[5] See https://www.tdi.texas.gov/forms/lhlifehealth/ah025.pdf

example, if a doctor was assigned to you with no opportunity to make a change *or when your health plan couldn't arrange for an in-network provider in time for your scheduled procedure."* Patients should be able to proceed with their procedure as scheduled. It should be considered coerced consent if a patient must reschedule their procedure – and likely the arrangements they made to make that procedure possible, including time off from work, childcare, and transportation to and from the procedure – in order to obtain care from an in-network provider. Furthermore, we recommend the following text be deleted from the bottom of page 1: "If there isn't one, your health plan might work out an agreement with this provider or facility, or another one." This could lead the patient to think they can avoid the out-of-network charges. It also suggests the patient should consider signing away their protections without full and final information.

- Signature page (page 3): This is the page where a patient would provide signed consent to be balance billed and should therefore include more information to ensure their choice is made voluntarily and with full and complete understanding of the consequences. We therefore recommend this page be amended to include the following:
    - The out-of-network provider's signature, in addition to the patient's signature.
    - An amendment to the statements to which the patient consents to include [new text in italics]: "I got the notice either on paper or electronically, consistent with my choice, *and in the language of my choice."*
    - In addition to the statement, "I can end this agreement by notifying the provider or facility in writing before getting the services," a place for the patient to sign that they are revoking their consent and information on where to send their notice of revocation, as is done on the Texas form. This makes it more likely that the patient can act on this protection if they choose to do so.
    - Rather than suggest the patient take a picture of their signed consent, include a statement on the form advising the patient that the provider or facility must provide a copy of the signed consent, consistent with the instructions for the form.
    - In order to reinforce for patients that they must be able to make this choice of their own free will and without coercion or pressure, include a statement similar to: "If you feel you had no choice but to sign this form in order to get your care as scheduled, you can file a complaint at…."

In addition, we believe there should be a separate form for notice and consent for patients asked to waive their post-stabilization protections. The preamble to the Interim Final Rule (IFR) includes a robust discussion of circumstances under which patients may be unable to provide clear consent, free from coercion or in compromised state. Without that consent, the patient would continue to be protected from balance billing under the NSA's emergency services provisions. Providers therefore have additional conditions to meet to eliminate those protections and subject the patient to balance billing. We believe the concerns and additional considerations articulated in the IFR would be best served by requiring providers to use a different form for notice and consent in post-stabilization circumstances so that these additional considerations can be captured on the form, including whether a patient's ability to understand the notice and waiver

is compromised by medication or other substances, and to travel without undue burden to another facility.

Model Disclosure Notice

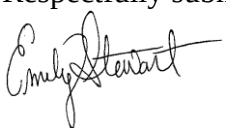
Providers and facilities are instructed to provide the disclosure notice no later than the date and time on which they request payment from the individual, or, if the provider doesn't seek payment from the individual, when the provider submits a claim to the health plan or insurer for payment. We believe notice should be provided at the earliest possible point in the patient's interaction with the provider or facility and no later than the date and time when a procedure is scheduled. Notice should also be provided when billing the patient or submitting a claim, but to rely on either as the earliest point at which a patient is notified of their rights risks undermining compliance with the law. We also recommend notice be provided with the individual's explanation of benefits.

We also have the following recommendations for the content of the model disclosure:

- Amend the form to include information on where to file a complaint and how to contact a consumer assistance program for help with a complaint or appeal.
- Add to page 2 to the text that begins, "You're never required to give up your protections from balance billing" [new text in italics]: "You can choose a provider or facility in your plan's network *and if no in-network provider is available, you can't be balance billed."*
- Move to the beginning of the notice the following, now at the bottom of page 2: "If you believe you've been wrongly billed, you may contact ….. "

Thank you for your consideration of our comments. If you have any questions, please contact Quynh Chi Nguyen at qnguyen@communitycatalyst.org

Respectfully submitted,



Emily Stewart
Executive Director