December 6, 2021

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

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

The Honorable Martin Walsh, Secretary
Department of Labor
200 Constitution Ave, NW
Washington, DC 20210

The Honorable Janet Yellen, Secretary
Department of Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

The Honorable Kiran Ahuja, Director
Office of Personnel Management
1900 E Street, NW
Washington, DC 20415

Submitted via regulations.gov

RE: CMS-9908-IFC, Requirements Related to Surprise Billing; Part II (RIN 1210-AB00)

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

We, the undersigned organizations representing patients, consumers, and workers appreciate the opportunity to provide comments on the Interim Final Rule on "Requirements Related to Surprise Billing; Part II" (IFR) as released by the Office of Personnel Management; Internal Revenue Service; Employee Benefits Security Administration; and Centers for Medicare & Medicaid Services (the Departments). We thank the Biden Administration for their work on this IFR that builds upon the landmark passage of the *No Surprises Act,* and for finally protecting consumers from the harmful and unfair practice of out-of-network balance billing.

We support the broad objectives of the *No Surprises Act* and the IFR, which will end the egregious practice of surprise billing in many situations. Surprise medical bills have plagued consumers for decades and have left families on the hook for hundreds of thousands of dollars for bills they had no way to avoid and are often unable to pay.[1, 2] Millions of families who have insurance receive surprise out-of-network bills each year, often from providers — such as emergency room physicians and anesthesiologists — that the patient has no choice in selecting for care. There is also strong evidence that the abusive practice of balance billing has contributed to higher premiums and health care costs for everyone with

[1] New York State Department of Financial Services, "How New Yorkers Are Getting Stuck with Unexpected Medical Bills from Out-of-Network Providers." New York State. 2012. http://www.statecoverage.org/files/NY-Unexpected_Medical_Bills-march_7_2012.pdf

[2] Pollitz, Karen, Matthew Rae, Gary Claxton, Cynthia Cox, and Larry Levitt. "An Examination of Surprise Medical Bills and Proposals to Protect Consumers from Them." Peterson-KFF Health System Tracker, February 13, 2020. https://www.healthsystemtracker.org/brief/an-examination-of-surprise-medical-bills-and-proposals-to-protect-consumers-from-them-3/.

commercial insurance[3], and it is well-documented that private equity owned provider groups and facilities have used surprised billing as a business model to keep costs high.[4, 5] If implemented well, this law will go a long way in providing families with the financial security they need, and will make important strides toward reining in industry abuses that lead to inflationary health care costs.

Overall Considerations

The September IFR is a critical step towards ending surprise medical billing and protecting consumers from rising health care costs, and we are grateful to the Departments for their work drafting these regulations. **We would like to commend the Administration and highlight key components of the recent interim final rule, including the design of the independent dispute resolution (IDR) process that will settle payments between providers and insurers. Specifically, we appreciate that the primary consideration in the IDR process is based on local, in-network rates, through the qualifying payment amount (QPA) framework. Putting a market-driven value at the center of reimbursement negotiations will ensure fair payment to providers, while helping to reduce overall health care costs for patients.** Congress enacted the No Surprises Act to protect consumers and make access to health care more affordable, and we believe that the IFR's design of the IDR process will help achieve those goals.

The following recommendations in this comment letter will further strengthen the IFR and ensure that consumers are meaningfully protected from out-of-network balance bills. We ask that these comments, and all supportive citations referenced herein, be incorporated into the administrative record in their entirety. Our comments focus on the following areas of the interim final rule, as outlined in the preamble:

- Section III.C Overview of the Interim Final Rules Regarding the Federal Independent Dispute Resolution Process for Plans, Issuers, Providers, Facilities, and Providers of Air Ambulance Services—Departments of the Treasury, Labor, and HHS
- Section III.D.4.i Federal IDR Process Following Initiation, Submission of Offers
- Section III.D.4.ii Federal IDR Process Following Initiation, Selection of Offer for Qualified IDR Items or Services that are not Air Ambulance
- Section III.D.4.iii Federal IDR Process Following Initiation, Selection of Offer for Qualified Air Ambulance Services
- Section III.D.4.v Federal IDR Process Following Initiation, Written Decision
- Section IV. External Review and Section 110 of the No Surprises Act; and
- Section VI. Interim Final Rules Regarding Protections for the Uninsured—The Department of Health and Human Services

Section III Overview of the Interim Final Rules Regarding the Federal Independent Dispute Resolution Process for Plans, Issuers, Providers, Facilities, and Providers of Air Ambulance Services—Departments of the Treasury, Labor, and HHS

Section III.C Open Negotiation and Initiation of the Federal IDR Process

[3] Congressional Budget Office (January 2021). Estimate for Divisions O Through FF H.R. 133, Consolidated Appropriations Act, 2021 Public Law 116-260 https://www.cbo.gov/system/files/2021-01/PL_116-260_div%20O-FF.pdf

In line with the *No Surprises Act* statute text, the Departments are proposing that providers and insurers have 30 days from the receipt of the initial claim to negotiate a payment rate between themselves. The Departments propose that the 30-day negotiation period begin on the day that one of the parties sends a notice to the other.

We applaud the Departments for codifying the 30-day negotiation period laid out in statute. However, the timeline proposed by the Departments could be strengthened and clarified. We believe that the 30-day negotiation period should begin when the receiving party receives notice of the negotiation invitation, not on the day that the negotiation invitation is sent.

We are concerned that parties could be incentivized to send notification via ground or traditional postage, which would lead to a shortening of the 30-day period for negotiation. This could especially disproportionately impact rural communities, where the United States Postal Service (USPS) anticipates significant delivery delays.[4] The Departments state repeatedly in the proposed rules that they are committed to limiting the use of the IDR process, and making it as predictable as possible. A key part of achieving this goal includes ensuring that the negotiation period is honored by both parties and a payment is negotiated in good faith.

We recommend the Departments change the proposed rule to state that the 30-day negotiation period should begin on the date of the receipt of the negotiation invitation. Further, we recommend that the receipt is of the invitation is documented in a formal way, so there is record of receipt of the notice to begin negotiation.

Section III. D Federal IDR Process Following Initiation

Section III.D.4.i Submission of offers

The Departments propose that when providers choose to batch claims in an arbitration case, the parties can provide different offers for the individual items that are batched, provided that the same offer apply to all items and services that have the same QPA.

We support the Departments in their creation of standards in regards to batching claims, and applaud the Departments for continuing to center the QPA in all cases of arbitration to ensure that health care costs are held down for consumers.

Section III.D.4.ii Selection of Offer for Qualified IDR Items or Services that are not Air Ambulance

We strongly support the Departments proposal to keep the QPA as the central point of consideration during the IDR process. As the Departments mention in the preamble, it is critical to anchor the IDR determination to the QPA in order to increase predictability of IDR outcomes, and keep overall health care costs un-inflated.

We also support the strict guidelines the Departments have proposed in the event that an arbiter would consider additional information (other than the QPA). We agree that credible information must clearly

[4] https://www.cbsnews.com/news/mail-delivery-slower-usps-october-1/

demonstrate that the QPA failed to take into account how the experience or level of training of a provider was necessary for providing the qualified IDR item or service to the patient or that the experience or training made an impact on the care that was provided. However, it should be made abundantly clear to the IDR entity that the qualified IDR items or services should not necessitate an out-of-network rate higher than the offer closest to the QPA, simply based on the level of experience or training of a provider, as this would lead to an increase in prices without a valid reason and does not align with the goals of the No Surprises Act. **The Departments express this view in the preamble, but we want to ensure that it is made very clear to IDR entities that a payment decision which is higher than the QPA should be supported by ample evidence and proof that the services rendered truly warrant a deviation from the QPA.**

Furthermore, we understand that monopolistic market dynamics stemming from consolidation in certain geographic regions can skew the QPA towards an artificially inflated rate. We submitted comments for the 'Part I' interim final rule, which detail our recommendations on how the QPA should be calculated in areas with high market concentration.[5] We would like to reiterate the recommendation here: In the case that a plan has multiple contracts with different providers housed under a single parent system, **the Departments should direct plans to treat these multiple contracts within the same parent system as a single contract when calculating the QPA.** This could be calculated by the taking the mean of the contracts, and using that mean as a single value in the median calculation for QPA. This method would reduce the impact of a consolidated system's unfair market power. We want to also make clear that these recommendations will not address the underlying cause of high health care prices, and urge the Administration to take additional action to regulate and monitor hospital consolidation in the health care market.

Section III.D.4.iii Selection of Offer for Qualified IDR that are Air Ambulance Services

The Departments propose a similar process for an IDR entity to select an offer in a dispute related to air ambulance services as the process for services that are not air ambulance related. We applaud the Departments for once again holding the QPA as the central value in a dispute resolution process. However, due to skewed market forces, the median in-network rate for air ambulance services is not a good representation of efficient or fair rates.[6] Air ambulance markets across the country are both highly consolidated and largely out of network.[7,8] Though air ambulance services are often astronomical in price, they are rare services and therefore are only a small part of insurance spending.[9] For this reason, insurers spend very little resources on bringing these providers in network. Furthermore, because air ambulance markets tend to be highly concentrated, the negotiated rates of the few in-network providers tend to be inflated by their disproportionately large market power.[10] These factors lead air

[5] http://nosurprisescampaign.org/wp-content/uploads/2021/09/Sign-On-No-Surprises-Act-Part-I-Comments-Final-9.7.21.pdf
[6] https://www.healthaffairs.org/do/10.1377/hblog20210323.911379/full/
[7] https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/10/13/high-air-ambulance-charges-concentrated-in-private-equity-owned-carriers/
[8] https://onlinelibrary.wiley.com/doi/full/10.1111/1468-0009.12464
[9] https://www.ajmc.com/view/policies-to-address-surprise-billing-can-affect-health-insurance-premiums
[10] https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/10/13/high-air-ambulance-charges-concentrated-in-private-equity-owned-carriers/

ambulance prices to generally be artificially high, leading to a largely skewed QPA value. The prices are not only high, but also have been rising rapidly; from 2017 to 2020, the average estimated in-network amount for fixed-wing air ambulance transports rose by 76%.[11] However, this is not necessarily the case across all air ambulance entities. A recent study found that private equity-owned air ambulances receive higher payments and subsequently generate larger and more frequent surprise bills than their nonprofit-affiliated counterparts.[12] **We recommend the Departments ask IDR entities to take into account market concentration and prices charged by non-profit affiliated air ambulance providers when evaluating air ambulance disputes, and acknowledge that the QPA in this case, may represent an artificially inflated value.**

Section III.D.4.v Written Decision

The Departments propose that if a certified IDR entity does not choose the offer closest to the QPA, the written decision's rationale must include a detailed explanation of the additional considerations they relied upon, whether the information about those considerations submitted by the parties was credible, and the basis upon which the certified IDR entity determined that the credible information demonstrated that the QPA is materially different from the appropriate out-of-network rate. **We strongly support the Departments' proposed requirement for an IDR entity to provide a detailed explanation in the case that they select an offer farthest away from the QPA. We believe that having this information documented will help keep the IDR process predictable, and therefore used as sparingly as possible. We recommend that this information be publicly accessible to ensure transparency for providers and plans so they are able to learn from prior arbitration cases.**

Section IV. External Review and Section 110 of the No Surprises Act

Section IV. A. Scope of Claims Eligible for External Review

The Departments propose to give consumers the right to dispute whether a plan or issuer has complied with No Surprises Act billing rules by appealing to an external review entity. **We support the extension of external review to surprise billing issues, and urge further strengthening of external review rules.** Under the IFR, consumers will be able to appeal whether a claim is for emergency services; whether the plan has appropriately paid for a nonparticipating provider subject to the law; whether the plan is protecting a patient from out-of-network charges when they are not in a condition to give informed consent; whether coding is correct; and whether the plan is correctly applying patient cost-sharing for bills covered under the No Surprises Act. We support the addition of surprise billing issues and these examples to external review regulations. However, we agree with the comments[13] submitted by ten state-based consumer assistance programs that the external review rules should be further

[11] https://www.fairhealth.org/press-release/average-estimated-in-network-amount-for-fixed-wing-air-ambulance-transport-rose-76-percent-from-2017-to-2020

[12] https://www.brookings.edu/essay/private-equity-owned-air-ambulances-receive-higher-payments/

[13] Elisabeth Benjamin, Community Services Society of New York, et al, Letter from 10 State-based Consumer Assistance Programs (NY, MD, CT, ME, VT, MA, CO, DC, MS, and RI), commenting on the No Surprises Act Interim Final Rulemaking, November 8, 2021, https://www.regulations.gov/comment/CMS-2021-0156-0553.

strengthened to allow consumers to appeal other denied claims involving *both* contractual *and* medical issues.

Consumers are not sufficiently protected under current external appeal regulations. In 2010, federal rules provided for external appeals of *all* adverse benefit determinations by health plans; however, those rules were "temporarily suspended" in 2011 and have since only allowed appeals of denials of care based on "medical judgement." The experience of consumers and their advocates shows that many other disputes between consumers and their insurers need resolution and review by a party that has no financial interest in the matter. The rules should explicitly provide for external review to consumers denied care due to all of their plan's medical management techniques, including step therapy and quantity limits, and should provide external appeal rights for disputes over whether a benefit is covered under the plan's contract. It is such a common practice for plans to assert that denials are purely contractual that some providers and disease advocacy associations have developed template letters to help patients assert that these denials are actually appealable medical disputes under the Affordable Care Act.[14] In Washington State, 46 decisions that were overturned by the independent review organization in 2020 were contractual coverage disputes, and their successful appeal resulted in patients receiving services ranging from cancer treatment to a protective helmet for someone with epilepsy.[15]

Experience from states whose laws enable consumers to appeal a broader scope of issues demonstrates that the appeal rights are important. For example, in health plans regulated by the District of Columbia, consumers can seek internal review of "any adverse benefit determination" and can then appeal externally if "the subject of the appeal reasonably appears to be a benefit or service covered by the health benefits plan."[16] In Maryland, consumers can appeal determinations regarding "contractual exclusions."[17] Maine allows external review of "any adverse treatment decision" and the Crohn's and Colitis Foundation is among those that advocated for Maine's state law to explicitly provide for appeals of step therapy; it is similarly advocating for a nationally transparent step therapy appeals process. [18] Such provisions have helped consumers gain payments for surgeries, nutrition and services for infants failing to thrive, and medications, and to address disputes about whether treatment is cosmetic or medical. States are not able to regulate self-insured employer sponsored plans nor federal government plans. It is therefore essential that the federal government amend external appeal regulations to provide consumers with similar protections, as required by the Affordable Care Act.

We further recommend that external appeal rules require federal or state government to pick the external review entity or entities that will hear disputes and determine whether a claim is eligible for external review. Currently, group plans that are federally regulated (and not subject to state regulation) contract with three external review entities that are assigned cases on a rotating basis. This does not provide for a fair and unbiased process. It must be changed. Plans could be required to pay the cost of

[14] https://www.urmc.rochester.edu/encyclopedia/content.aspx?contenttypeid=34&contentid=20275-1
[15] Washington Office of the Insurance Commissioner, "Look Up an Independent Review Decision" https://fortress.wa.gov/oic/consumertoolkit/Search.aspx?searchtype=indrev
[16] DC Code 44-301.06 and 44-301.07.
[17] https://www.marylandattorneygeneral.gov/CPD%20Documents/HEAU/Anual%20Reports/HEAUannrpt17.pdf
[18] https://www.crohnscolitisfoundation.org/sites/default/files/2019-09/step-therapy-providers-maine.pdf; https://www.crohnscolitisfoundation.org/get-involved/be-an-advocate/steptherapy

external review, but they should never pick the reviewer or themselves determine which claims are appealable.

The Departments propose to make No Surprises disputes subject to review in grandfathered plans, as required by the Act. We support this, and urge that for grandfathered plans as well as other group plans, the federal government contract with and choose the external review entities. Plans should still be required to pay the cost of external review.

Section VI. Interim Final Rules Regarding Protections for the Uninsured—The Department of Health and Human Services

The IFR allows uninsured and self-pay individuals to receive a good faith estimate of charges in advance of medical care. If their final bills are significantly higher than the good faith estimates, the rules provide a dispute resolution process. **We urge the departments to lower the dollar threshold for patients to dispute bills higher than the good faith estimate, and to coordinate this billing protection with requirements for nonprofit health facilities to provide financial assistance programs to low-income uninsured patients.**

Section VI. A. Good Faith Estimates for Uninsured (or Self-Pay Individuals)

Under the IFR, one provider (the "convener") would coordinate getting estimates from other providers involved (the "co-providers"). We support this provision, which will make it easier for consumers to get an estimate from all the providers involved in their care. Since consumers may not otherwise know who will be involved in their care, the responsibilities of a convening provider to gather estimates are especially important.

The preamble clarifies that this protection also applies to people in short-term limited duration insurance plans, since these plans are not included in the definition of individual health insurance. **Please also clarify that this protection applies to people in fixed indemnity plans and other excepted benefits plans.** These plans similarly omit coverage for many medical procedures and conditions, leaving consumers effectively uninsured.

We strongly urge the Department of Health and Human Services (HHS) to lower the dollar threshold for estimates subject to dispute. Currently, the rule provides that in order to be subject to dispute, the final billed charge from a particular provider must be at least $400 higher than the good faith estimate. Moreover, as drafted, the $400 applies to *each* provider's bill instead of allowing appeals if the total charges of the convening plus co-providers is $400 higher. For example, a patient receiving a procedure involving three providers might not be able to dispute bills that total an $1196 excess cost. These single estimate and combined estimate thresholds will create hardships for many consumers who rely on the estimates to determine if they can afford care. They would leave many consumers unprotected by the new law.

A recent JAMA study showed that the mean amount of medical debt in collection in 2000 was $429, and that nearly 80% of medical debt is held by households with zero or negative net worth.[19] Research from

[19] Kluender, et al, Medical Debt in the US, 2009-2020, JAMA, July 20, 2021, https://jamanetwork.com/journals/jama/article-abstract/2782187.

the Urban Institute recently found that even before the pandemic, an estimated 45 percent of New Yorkers could not pay for a $400 emergency expense with cash, 30%could not come up with money for such an expense at all, and communities of color were twice as likely to have debt in collections as majority white communities.[20] A 2021 survey showed that half of households earning less than $30,000 have no emergency savings.[21] In states around the country, medical debts result in wage garnishments, liens, foreclosures, denials of future medical treatment, and even arrests.[22]

To protect consumers from unforeseen bills they cannot afford, we strongly recommend that either a) the federal government establishes a no-minimum threshold for disputes unless and until it determines from experience that the dispute mechanism is overused; or b) the threshold be set at 10% higher than the combined estimate from all providers or $400, whichever is *lower*. Ten percent is a threshold used for disputing some other bills, such as auto repairs and home loans.[23] Such a threshold would better protect consumers who anticipate and are prepared to pay a small charge, such as $15 for a COVID test, when they instead receive a $380 bill.[24] If final rules set a threshold for uninsured and self-pay payment disputes, the Departments should study the dollar amount and scope of disputes received under the No Surprises Act in order to determine if thresholds should be further adjusted.

We recommend that good faith estimates, billing, and the patient-provider resolution process coordinate with federal and state rules governing financial assistance programs especially when a hospital facility is the provider,. This should be reflected in both IRS rules governing nonprofit hospitals at 26 CFR 1.501r(6) and in HHS rules. In particular, good faith estimates and bills should be accompanied by information about available financial assistance programs. If a patient applies for financial assistance, the amount written off as a charitable expense should never be higher than the allowed charges. Conversely, for patients who have been found eligible for financial assistance, patients' good faith estimates should not exceed the amount that the hospital is allowed to charge them under the financial assistance policy. A hospital should not be allowed to take extraordinary collection action during the time that *either* a patient is disputing a charge under the No Surprises Act *or* the patient is entitled to apply for financial assistance. Once a bill is final, information about the final billed amount and how much of that bill a financial assistance program will pay should be clear and distinguishable for patients, for auditors who are determining the integrity of a financial assistance program, and for the agencies overseeing the No Surprises Act.

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[20] Urban Institute, Tracking the Credit Health of New York City Residents, 2021, (powerpoint) https://www.urban.org/sites/default/files/publication/103663/tracking-city-credit-health_nyc.pdf

[21] https://www.bankrate.com/banking/savings/emergency-savings-survey-july-2021/

[22] Giacomo Bologna, Mississippi Center For Investigative Reporting, "St. Dominic Knew Patients Couldn't Afford Care. It Sued Them Anyway." August 6, 2021, https://www.mississippicir.org/news/st-dominic-knew-patients-couldnt-afford-care-it-sued-them-anyway, Wendi Thomas, Methodist Le Bonheur Makes Millions, Owns a Collection Agency and Relentlessly Sues the Poor, June 27, 2019, https://mlk50.com/2019/06/27/methodist-le-bonheur-makes-millions-owns-a-collection-agency-and-relentlessly-sues-the-poor/; Elisabeth Ryden Benjamin, Amanda Dunker, Dishcharged Into Debt: Nonprofit Hospitals File Liens on Patients' Homes, November 2021, https://smhttp-ssl-58547.nexcesscdn.net/nycss/images/uploads/pubs/Liens.pdf

[23] https://www.consumerfinance.gov/rules-policy/regulations/1024/7/; https://law.justia.com/codes/maryland/2010/commercial-law/title-14/subtitle-10/14-1002/

[24] https://www.nytimes.com/2021/09/26/upshot/cost-of-covid-rapid-test-prices.html

Section VI B. Patient Provider Dispute Resolution

The rule provides consumers 120 days (excluding weekends and holidays) to dispute a bill that is significantly higher than a good faith estimate. Consumers would pay an administrative fee of about $25 to the dispute resolution entity, and would get this back if they won. For a provider to prevail, the provider would need to show that there was good reason for unforeseen costs. **We generally support this timeline and process, but recommend good cause exceptions to the 120 day filing deadline that allow patients more time to dispute a bill, for example, that arrived during a long hospitalization or while they were awaiting a retroactive Medicaid eligibility determination.**

To initiate patient-provider dispute resolution, CMS proposes that consumers be required to submit information, including copies or images of the estimated bill, through a portal, electronically, or on paper. We appreciate these multiple formats but note that this process may still be very difficult for someone with limited English and/or limited computer skills. **We urge CMS to make the portal and explanation available in multiple languages, make it possible to submit documentation via mobile phones, provide helpline staff that can enter information for consumers, and fund Consumer Assistance Programs to assist with this process.**

CMS intends to contract with national firms to hear patient-provider disputes. **We recommend that dispute resolution firms have no financial interest in any provider, and that they become knowledgeable about federal and state financial assistance laws as well as public program screening and eligibility requirements that would affect their handling of a bill for uninsured patients.**

Consumer Assistance Programs will play a vital role in helping insured consumers with external appeals, as well as helping uninsured and self-pay consumers with the dispute resolution process. HHS should provide them with funding, training, and sample outreach and education materials in English and in other languages to assist them with this increased workload. **Other community-based organizations and social service providers – including groups that serve immigrants and communities of color, should also receive outreach and training about new patient rights,** including materials and videos in other languages.

Conclusion

Congress enacted the *No Surprises Act* to protect consumers from balance billing while at the same time creating downward pressure on health care costs. This rulemaking honors that Congressional intent by centering the interests of consumers: holding families harmless from surprise medical bills and minimizing the inflationary impact of provider-insurer payment disputes so that families do not face higher health care costs as a result.

On behalf of our organizations representing consumers, patients, and workers, we appreciate the opportunity to provide the above recommendations and feedback. We offer our support in providing additional feedback and technical assistance as you are developing subsequent rulemaking in the coming weeks and months. Please contact Jane Sheehan, Director of Federal Relations at Families USA, at JSheehan@familiesusa.org for further information.

Sincerely,

Families USA Action
ACA Consumer Advocacy
Arthritis Foundation
Center for Independence of the Disabled, NY
Colorado Consumer Health Initiative
Community Catalyst
Consumers for Affordable Health Care
Every Texan
Georgia Watch
Georgians for a Healthy Future
Health Access California
Health Care Voices
Kentucky Voices for Health
Medicare Rights Center
National Alliance on Mental Illness
National Consumer Law Center, on behalf of our low-income clients
National Consumers League
New Jersey Appleseed Public Interest Law Center
New Jersey Citizen Action
New Jersey Health Care Quality Institute
Northwest Health Law Advocates
Office of the Health Care Advocate / Vermont Legal Aid
Pennsylvania Health Access Network
Tennessee Health Care Campaign
The Leukemia & Lymphoma Society