October 18, 2021

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Attention: CMS-9907-P
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-9907-P; *Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement*

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 Proposed Rule, **Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement.** Along with the Part I interim final rule (IFR) published in July and the Part II IFR published earlier this month, this rule will take a crucial step in enforcing the No Surprises Act (NSA) and ensuring the law both meaningfully protects consumers and reins in health care costs. Importantly, this proposed rule will also strengthen mental health parity; provide for disclosure of agent and broker commissions in the individual and short term market that have been obscure to the public; and improve oversight of NSA compliance for both individual and group market plans as well as providers and facilities.

As a primary matter, our organizations offer our full support for the broad objectives of the NSA and the rulemaking the administration has published thus far, which will end the egregious practice of surprise billing in many situations. Out-of-network balance billing has plagued consumers for decades and has left families on the hook for hundreds, thousands, and tens of thousands of dollars for bills they did not have reason to expect and are often unable to pay.[1,2] There is also strong evidence that the abusive

[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.

practice of balance billing has contributed to higher premiums and health care costs for everyone with 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 to maximize profit margins.[4,5] If implemented well, this law will go a long way to provide 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

- **Air Ambulances:** In general, we support the proposed reporting requirements regarding air ambulances. We recommend that they be further strengthened to require the reporting of claims data in a disaggregated manner, include information about the cost and necessity of high-tech equipment, and how that cost is spread among patient runs and reflected in bills.

- **Disclosure of agent and broker commissions**: We support the rulemaking's required disclosure of agent and broker commissions. We recommend that HHS make agent and broker commission disclosures available to researchers and the public, provide additional context to help consumers understand and use the information, and require disclosure to shoppers well before a sale is finalized.

Comments Regarding Enforcement Standards Regarding Issuer, Plan, Facility and Provider Behavior

Our comments regarding enforcement of the NSA and of other standards regarding issuer, plan, facility and provider behavior center on the following 5 key areas:

- **Federal and State Enforcement**: We generally support the mechanisms these regulations provide for CMS enforcement, and CMS oversight of state enforcement, including through random market conduct investigations and in response to complaints. However, provider and facility billing practices are a new area for oversight, and it will be important for the federal government to determine that states not only designate an oversight entity but also that states are equipped with the tools and resources to engage in enforcement and oversight of the new regulations. If states do not adequately enforce the law, it is critical that the federal government step in to assume that role. We, therefore, urge CMS to publicly report data on the status and outcome of federal and state investigations and enforcement actions. Oversight and enforcement activities should apply to entities that bill on behalf of providers or buy debt from providers as well as to individual providers and facilities.
- **Enforcement with Respect to Telehealth:** We recommend further delineation of responsibilities for out-of-state telehealth services. CMS proposes that the state where the patient resides will

https://www.healthsystemtracker.org/brief/an-examination-of-surprise-medical-bills-and-proposals-to-protect-consumers-from-them-3/

[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

[4] Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services. Secretary of Health and Human Services' Report on: Addressing Surprise Medical Billing. 2020. https://aspe.hhs.gov/sites/default/files/private/pdf/263871/Surprise-Medical-Billing.pdf

[5] Spratt, Alexandra. "Part 3: As Purveyors of Surprise Medical Billing, Private Equity Has Fought Lawmakers' Attempts to Protect Patients," Arnold Ventures, September 9, 2020. https://www.arnoldventures.org/stories/part-3-as-purveyors-of-surprise-medical-billing-private-equity-has-fought-lawmakers-attempts-to-protect-patients/

enforce protections regarding out-of-network billing for telehealth, but we are concerned that the patient's home state may have no authority over an out-of-state telehealth provider.

- **Parity**: We strongly support the inclusion of nonquantitative treatment limits (NQTL) on mental health and substance use disorder services as an area for enhanced oversight, and request further clarity about this in the rules themselves. As recent cases have pointed out, non-quantitative limits (which include unequal reimbursement of mental health providers, inappropriate utilization criteria, and other non-numerical limits to reimbursable care) have "limited access to potentially life-saving mental health and substance use treatment."[6]
- **Coordination of Investigations Process with Consumer Complaint Process**: We seek clarification about how the investigation process described in these rules will interact with the consumer complaint process for surprise bills described in the earlier IFR. Specifically, how will consumers know where to file a complaint and with what agency to follow-up? How do the various investigation units coordinate with the consumer complaint system? What happens to the consumer's bill while a provider disputes an enforcement action?
- **Consumer Assistance**: We urge CMS to fund Consumer Assistance Programs as a vital part of the enforcement process for the NSA.

Our recommendations concerning specific sections of the rulemaking are detailed below.

Reporting Requirements for Plans and Issuers Regarding Air Ambulance Services (45 CFR 149.230); and Reporting Requirements Regarding Air Ambulance Services for Providers of Air Ambulance Services (45 CFR 149.460)

HHS proposes requiring submission of base-level and transport-level data on air ambulance services, as well as data on provider revenue for air ambulance services, the number and location of all air ambulance bases they operate, the number and type of aircraft they operate, cost data, and claims data, amongst other categories. These data are specified elements in the NSA, and codifying these requirements through rulemaking is aligned with the intent of Congress. Air ambulances are known to charge incomprehensibly high prices for their services, often amounting to tens of thousands of dollars.[7, 8, 9] Regulation over the air ambulance market is piecemeal across the country, and less than a quarter of air ambulances are in-network.[10] Limited information is known about where these services are provided, whether there is an over-abundance of providers in an area, or lack of sufficient coverage in an area. If the area has more air ambulance provider supply than demand requires, the companies will not have enough patients to cover their costs and high prices will seem "justified" to meet costs. The natural market forces of competition will not work to hold down prices due to consumer inability to shop for lower-cost options in emergency situations. In a different case, if there are not enough air ambulances to serve patient populations in an area (where demand is higher than supply), it is a flag for state health officials to seek to fill those gaps. These detriments have led to a serious dearth of data regarding air

[6] Complaint, People of the Stat of New York v. United Health, et al, Civil Action 21-e-v-4533, August 11, 2021.,
[7] Georgetown Center on Health Insurance Reforms. Air Ambulances. Protecting Patients From Surprise Medical Bills - Air Ambulances. Retrieved October 18, 2021, from https://surprisemedicalbills.chir.georgetown.edu/the-challenge/air-ambulances/.
[8] Chhabra, K. R., McGuire, K., Sheetz, K. H., Scott, J. W., Nuliyalu, U., & Ryan, A. M. (2020). Most patients undergoing ground and air ambulance transportation receive sizable out-of-network bills. Health Affairs, 39(5), 777–782. https://doi.org/10.1377/hlthaff.2019.01484
[9] Fuse Brown EC, Trish E, Ly B, Hall MA, Adler L. Out-of-Network Air Ambulance Bills: Prevalence, Magnitude, and Policy Solutions. *Milbank Q*. 2020;98(3):747-774. https://doi.org/10.1111/1468-0009.12464
[10] Ibid.

ambulances, their costs, and billing practices. The NSA requires plans, issuers, and air ambulance providers to report a certain level of data to HHS, finally filling a gap in data collection that has been sorely needed. **We strongly support HHS's direct enforcement of these data reporting requirements and subsequent civil monetary penalties for non-compliance. We urge HHS to issue guidance to states on how to use state regulatory authority to enforce these reporting requirements.**

HHS proposes to require air ambulance providers to report on claims data. Health outcomes have long been determined by race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location.[11] These factors have also been shown to have a significant impact on excess health care expenditures, proving that efforts to reduce health disparities could lead to immense savings. [12] Collection of and access to disaggregated data is essential to understanding how certain social factors play a role in perpetuating health disparities. **We recommend, where applicable, claims data be reported on a disaggregated basis, by race, ethnicity, primary language, geographic location, socioeconomic status, gender identity, sexual orientation, age, and disability status.** In regards to air ambulance reporting requirements, reporting disaggregated data will allow future policymakers to understand if there are certain groups of people who consistently and unfairly experience higher cost burdens.

HHS proposes that data reported by plans, issuers, and air ambulance providers, for the calendar year, includes both data relevant to air ambulance services furnished within the calendar year, as well as data relevant to services for which payments were made within the calendar year (even if the services was provided in a different calendar year). **We strongly support this provision, as it will improve upon the overall lack of data and information regarding air ambulance services, and allow for swifter release of data to inform future regulatory or legislative solutions to the high cost of ambulance services.**

HHS proposes requiring air ambulance providers to report on the type of aircraft they operate, as well as certain equipment. However, air ambulance providers are not required to report specifically on the type and quantity of medical equipment aboard their aircraft, which could drive up costs. The average estimated in-network amount for fixed-wing air ambulance transports rose by 76% from 2017 to 2020.[13] This type of arbitrary increase in costs harms consumers immensely, and shows a need for evaluation. **Therefore, we recommend that HHS require air ambulance providers to disclose the type of medical equipment and quantity of such equipment on board the given aircraft; and for plans and issuers to similarly report the level of equipment used in transport.** These data would allow researchers, consumers, and policymakers to analyze the relationship between cost and equipment for air ambulances, and identify how this relationship might lead to price gouging or otherwise unexplained increases in costs. Collecting this data would allow policymakers to address the underlying drivers of cost amongst air ambulance providers. The data can also be used to determine how and if the cost of such equipment should be attributed to various bills.

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[11] Office of Disease Prevention and Health Promotion, Department of Health and Human Services. Disparities | Healthy People 2020. Retrieved October 18, 2021, from https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities.
[12] Harvard Business Review. (2017, May 8). The costs of racial disparities in health care. Retrieved October 18, 2021, from https://hbr.org/2015/10/the-costs-of-racial-disparities-in-health-care.
[13] FAIR Health. "Air Ambulance Services in the United States: A Study of Private and Medicare Claims." September 28, 2021. https://s3.amazonaws.com/media2.fairhealth.org/whitepaper/asset/Air%20Ambulance%20Services%20in%20the%20United%20States%20-%20A%20Study%20of%20Private%20and%20Medicare%20Claims%20-%20A%20FAIR%20Health%20White%20Paper.pdf

Disclosure of Agent and Broker Compensation to Individuals in Individual Health Insurance Coverage and Short-Term, Limited Duration Insurance (45 CFR 148.410(c)(2)(i) and (ii) and (c)(3) and (4))

HHS is proposing to codify disclosure requirements set out in the Consolidated Appropriations Act of 2021 (CAA) which would require health insurance issuers that offer individual health insurance coverage or short-term, limited duration insurance, to make certain disclosures to enrollees. These disclosures include compensation provided by the issuer to an agent or broker associated with enrolling individuals in such coverage, prior to when the individual finalizes their plan selection, as well as any documentation confirming the individual's enrollment. HHS also proposes codification of requirements for issuers to provide data regarding agent and broker compensation prior to open enrollment. **We applaud CMS for their rulemaking on this issue, and believe that information about compensation will be valuable to the public and to policymakers. However, we suggest some modifications to the rule to ensure that the disclosures will hold meaning for consumers, researchers and policymakers.**

In 2020, the House Energy and Commerce Committee found that brokers received ten times the compensation rate for selling short term plans than for ACA compliant plans – they received 23% commissions on short term plans, and 2% commissions on ACA compliant plans.[14] Consumers may wish to avoid plans in which so little of their premiums go into medical care, but in order to comparison shop, they need additional context to determine whether the commission for the plan they are considering is unusually high. Since the Consolidated Appropriations Act also requires issuers to report agent and broker compensation schedules to HHS prior to open enrollment, HHS should be able to use that compensation information to provide consumers with information about typical compensation ranges. **We recommend that HHS use this agent and broker compensation data to create explainers for consumers about the range of agent/broker compensation, and about what is typical in a market, so that consumers can be on the lookout for high rates.** Without any analysis or guidance on what may be considered egregious or superfluous compensation on the part of an issuer to a broker, compensation information holds little value to the consumer.

The Consolidated Appropriations Act requires that issuers provide their agent and broker compensation schedules to individuals prior to consumers' finalizing plan selection, but gives HHS discretion to further define when issuers will disclose this compensation to consumers. **We recommend that the rule require agent/broker compensation information to be available on any agent or broker websites before the consumer discloses personal information**. While the majority of consumers might not use this information in their shopping decisions, it is important that the information be available to consumers who wish to compare the amount of their premium that will be spent for agent and broker compensation in various health plans – and consumers should be able to access that information without subjecting themselves to sales calls and emails. **We further recommend that CMS develop a simple standard format for disclosure of agent/broker commissions to ensure that consumers are able to easily understand and access the information being presented to them. For example,** "Your premium in this plan will be $X. Of this amount, $Y or Z percent is the agent or broker commission."

In addition, we recommend disclosure reports be categorized by health plan, and distinguish between commissions paid for short-term limited duration insurance, Qualified Health Plans (QHPs) sold on the

[14] House Energy and Commerce, Press Release, E&C INVESTIGATION FINDS MILLIONS OF AMERICANS ENROLLED IN JUNK HEALTH INSURANCE PLANS THAT ARE BAD FOR CONSUMERS & FLY UNDER THE RADAR OF STATE REGULATORS, June 25, 2020. https://energycommerce.house.gov/newsroom/press-releases/ec-investigation-finds-millions-of-americans-enrolled-in-junk-health

marketplace, and QHPs sold off the marketplace. HHS should publicly post this information so that it can be used by researchers, and consider sharing this data with state insurance regulators and regulators within CMS's Center for Consumer Information and Insurance Oversight (CCIIO). Providing researchers and state regulators with this information would enable these entities to track trends and analyze relationships which could improve the health insurance market in the country.

We also offer one additional recommendation for consideration. Agents and brokers may be selling fixed indemnity or dread disease plans along with short term limited duration insurance. Since the statute does not require disclosure of commissions for these other products, a company could easily attach a high commission to the combined sale without attributing it to the short-term plan, and this is not yet addressed in the proposed rule. HHS should assure that the commission issuers' report to regulators is not hidden in one of these other products. **At a minimum, the extent of these stacked sales should be reported to HHS so that regulators can determine whether further oversight is warranted. Further, HHS should require reporting of commissions for the sale of stacked products.**

Enforcement of Group and Individual Insurance Market and Provider and Facility Requirements (45 CFR Part 150)

Definitions (45 CFR 150.103)

We have commented previously that HHS should broadly construe the provisions of the NSA that protect patients who, while using an in-network non-emergency facility for care, are served by out-of-network ancillary providers. Consumers could experience surprise bills in facilities ranging from urgent care, to "primary and immediate care facilities," to in-network physician offices that also house out-of-network providers. The CAA statute includes in its definition of health facility, "(V) Any other facility, specified by the Secretary, that provides items or services for which coverage is provided under the plan or coverage, respectively." **We recommend HHS broadly define "any other facility subject to the requirements." The Secretary should specify that ''facility" includes all sites of care in which a patient is treated by an in-network provider yet receives ancillary services from providers who might not participate in the same networks.** Further, if a facility or provider is using a billing entity, that entity should also be subject to enforcement actions.

State Enforcement; Circumstances Requiring CMS Enforcement (45 CFR 150.201-150.203)

We generally support these sections, which would enable CMS to determine if federal enforcement is warranted both when a state notifies CMS that it does not have statutory authority to enforce the law with respect to insurers, providers or facilities, and when CMS determines that a state is not *in fact* enforcing the law. Some states that have authority to enforce the law will also have direct knowledge of insurer and provider behavior; but we agree that it is essential for federal regulators to step in when states are not staffed or otherwise able to carry out this job. CMS's determination of whether federal enforcement is warranted should include whether the state periodically examines posted and mailed notices to patients; whether complaint systems are in place, used, and generate corrective action; and whether the oversight agency is in fact taking enforcement action. States that are enforcing the law should demonstrate their authority, ability, and freedom from conflicts of interest. **We urge HHS to add factors to examine state enforcement, provide clear information about enforcement entities for self-insured non-federal governmental plans, and set clear enforcement authority for out-of-state telehealth providers.**

The preamble to the rule (p. 51747) states that CMS will be the primary enforcer with respect to non-federal government plans. **HHS should clarify whether that includes self-insured non-federal governmental plans.** The preamble provides a separate email address, PHIG@cms.hhs.gov, for consumers to use in complaining about those plans**. We request that the agencies publish and maintain a list of all non-federal government plans (including those that are self-insured) and the applicable enforcement authority, and customize notices, summaries of benefits, and other documents to ensure that consumers and their representatives know who to call regarding issues**. **Further, complaint systems should ensure that if a consumer complains to the state or to** MarketConduct@cms.hhs.gov**, the complaint is routed to the appropriate place without delay.**

We recommend that enforcement authority regarding out-of-state telehealth services be demonstrated either through an agreement among states, or an agreement between a state and CMS. The preamble of the rule (p. 51745) proposes that a state would be the primary enforcer of the Public Health Service Act requirements for providers or facilities that furnish services via telehealth to individuals located in the state, even in circumstances where the provider or facility is located in a different state. However, the state where the patient is located may have no power to revoke a license or impose a fine on an out-of-state provider. CMS should require interstate agreements for telehealth enforcement, or step in as the enforcement entity for telehealth services if there is no such enforcement arrangement.

Sources of Information Triggering an Investigation of State Enforcement (45 CFR 150.205)

We recommend HHS add additional items to the listed sources of information that would trigger an investigation of state enforcement. Under the proposed rule, an investigation could be triggered by information provided by governors, commissioners, directors of public health, and other state agencies with oversight authority. **We recommend HHS add state attorneys general to the list of sources of information that would trigger an investigation of state enforcement, especially since some have designated health care bureaus**. **Second, Consumer Assistance Programs (CAPs) (whether within or outside of government) should be able to report patterns of complaints that trigger an investigation. Third, we recommend that when consumers submit complaints through the CMS complaints system, and CMS in turn refers the complaint to a state entity for investigation, CMS should track actions taken by the state entity. If the state agency fails to follow up on complaints, that should also trigger an investigation of state enforcement.**

As currently written, section 150.205 provides broad authority to the federal government to investigate state enforcement (including based on "any other information") but does not set up a regular schedule or system for collecting and reporting data. **We recommend that HHS establish a system and target number of reviews that will enable the agency to secure adequate staffing for this function in the years to come.**

HHS, together with states, should systematically collect data and *publicly* report it. We recommend HHS lay out a process for collecting and publishing data, regarding:

- complaints, including the number, nature, provider/facility/insurer involved, and resolution;
- the availability of consumer assistance programs in each state to help consumers with complaints;
- the availability of information for consumers whose primary language is not English;

- appeal, issues involved, and their resolution;
- state and federal oversight actions; and
- enforcement action.

Data should be publicly reported on the CMS website so that researchers, advocates, and lawmakers will learn how the system is working and what further oversight or improvement is warranted.

Notice to the State (45 CFR 150.211)

Subsection (d) of 150.211 states that if an alleged failure to enforce involves a provider or facility, the official responsible for regulating such provider or facility receives notice from CMS. We are concerned about the lack of clarity in many states about what department or board has such responsibility. **As HHS gathers information about oversight responsibilities, and assumes oversight for states that are not enforcing this aspect of the law, we recommend that HHS provide a public, state-by-state list of provider and facility oversight agencies or entities on the HHS website.** Consumers and consumer representatives will need to know who has authority in order to successfully follow-up on complaints.

Basis for Initiating an Investigation (45 CFR 150.303)

We support the proposed changes that add providers and facilities to the list of reporters that can trigger an investigation of issuer and health plan compliance with the Public Health Service Act, and that provide for random and targeted investigations. We seek further public analysis of internal and external appeals data as part of an investigation. We recommend that nonquantitative treatment limits also be specifically referenced in this section.

45 CFR 150.303 provides that a history of substantiated complaints may trigger a compliance investigation. Data on health plan internal and external appeals determinations could be key in providing such a history, but appeals rules must be strengthened to assure consumers the right to appeal a broader scope of issues that adversely affect them.

As we will detail in our comments on the second Interim Final Rule[15], we support the broadening of issues subject to external appeal to include surprise billing. However, HHS has not yet published rules that require reporting of external appeals to HHS, and they should. **We recommend that HHS require reporting on all external appeals (including for self-insured and employer-based plans**). Data on the subject and outcome of appeals should be part of the determination of whether plans and issuers have a history of substantiated complaints.

The preamble to this proposed rule lists several email addresses that can be used, in place of regional CMS offices, for complaints about issuers and health plans. However, these are not listed in the regulation itself so it will be difficult for complainants to locate the appropriate entity for follow-up. Further, the July IFR set forth a one-stop complaint system regarding surprise billing, and it is unclear how that interacts with the offices described in the preamble to this proposal. **In regulation and on its website, HHS should list both the one-stop complaint entity and the other entities or agencies to**

[15] No Surprises Campaign. Comments to Biden Administration re: "CMS-9909-IFC- Requirements Related to Surprise Billing; Part I," September 8, 2021
http://nosurprisescampaign.org/wp-content/uploads/2021/09/Sign-On-No-Surprises-Act-Part-I-Comments-Final-9.7.21.pdf

which complaints may be referred. Further, HHS, DOL and states should assure that a consumer calling the wrong entity receives a warm handoff to the appropriate entity.

We support the oversight of plans' and issuers' nonquantitative treatment limits, described in the preamble, to better enforce parity, but 45 CFR 150.303 does not yet explain that this is an area for investigation. The rules broadly provide for investigation of Public Health Service Act requirements, which would include parity. **We recommend that HHS develop procedures or specific references in the regulations to ensure that nonquantitative treatment limits will be an area for review.**

Notice to responsible entities, request for extension [with respect to issuer/plan], market conduct examination, and request for extension [with respect to provider/facility] (45 CFR 150.307, 150.309, 150.313 and 150.507)

These sections provide notice to a plan, issuer, provider, facility or other responsible entity about potential violations of the Public Health Service Act, and provide time periods for the entities to respond and/or request extensions. In each of these instances, the matter in dispute could affect a consumer's liability for health care costs. The second interim final rule requires a provider to suspend billing and collections for self-pay and uninsured patients until a dispute resolution process concludes. **We recommend that HHS clarify how consumers' bills are affected by investigation periods and require that the same suspension standard apply whenever a consumer complains about a surprise bill or whenever a suspected violation of law is being investigated**. Rules should clarify that billing ceases during an investigation that involves billing practices, and that consumers are not liable for interest regarding a disputed bill accumulated during investigation periods. Further, if an investigation showed that a health plan, issuer or provider/facility inappropriately billed consumers or denied their claims, the consumer be given appropriate relief for the claim and any interest.

Filing of request for a hearing [by an aggrieved provider/facility], issues to be heard, and hearing (45 CFR 150.405, 150.445, and 150.517)

These sections lay out a process whereby providers, facilities, health plans, and issuers can seek hearings regarding pending enforcement actions against them. While most consumers will not want to be part of that process (and will more promptly get relief through the consumer complaint process), **we recommend the rules provide that patients or their representatives, including consumer assistance programs, can submit evidence or participate should they wish to do so.**

Basis for Initiating an Investigation (45 CFR 150.503)

We support the broad list of information sources that may trigger an investigation of provider and facility practices. We recommend that HHS also provide a system for targeted and random investigations of provider and facility practices.

We support that entities and representatives acting on an individual's behalf can trigger an investigation. Patients who are ill may not be in a position to seek an investigation directly, particularly if they are contesting post-stabilization responsibilities, so we appreciate broad inclusion of an entity or personal representative acting on an individual's behalf.

We also support the use of both random and targeted investigations, and urge CMS to establish a schedule and staffing plan sufficient to carry out investigations. **For example, at a minimum, CMS**

should ensure that each hospital and other facility subject to the law is regularly inspected either by state government or by CMS to determine if patient notices and procedures are in place to protect patients in accordance with the law.

Additional Recommendation: Empower and Fund Consumer Assistance Programs (CAPs) to Help with Enforcement

HHS should dedicate a portion of No Surprises Act implementation funds to Consumer Assistance Programs as a key part of enforcing the protections described in these rules. Under the Public Health Service Act (42 USC 300 gg-93), the following are among the duties of an office of health insurance consumer assistance or health care ombudsman program:

> "(1)assist with the filing of complaints and appeals, including filing appeals with the internal appeal or grievance process of the group health plan or health insurance issuer involved and providing information about the external appeal process;
>
> (2)collect, track, and quantify problems and inquiries encountered by consumers;
>
> (3)educate consumers on their rights and responsibilities with respect to group health plans and health insurance coverage …
>
> (d)Data collection
>
> As a condition of receiving a grant under subsection (a), an office of health insurance consumer assistance or ombudsman program shall be required to collect and report data to the Secretary on the types of problems and inquiries encountered by consumers. The Secretary shall utilize such data to identify areas where more enforcement action is necessary and shall share such information with State insurance regulators, the Secretary of Labor, and the Secretary of the Treasury for use in the enforcement activities of such agencies."

The outreach, assistance, tracking and data collection that CAPs provide would be extremely helpful to the federal government for enforcement, and to consumers who need to avail themselves of the new protections. **Separately we are urging Congress to adequately fund CAPs in 2022 and ensure that there is stable funding going forward.[16] In the short term, we urge HHS to dedicate a portion of implementation funding appropriated by the NSA to CAPs for enforcement and the specific purpose of building capacity to help consumers with surprise billing problems and reporting to HHS on consumer experiences and outcomes.**

Conclusion

On behalf of the undersigned organizations we appreciate the opportunity to provide the above recommendations. We offer our support in providing 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.

[16] Families USA. Letter to Rep. Rosa DeLauro, Rep. Tom Cole, Senator Patty Murray, and Senator Roy Blunt. Re: "Consumer Assistance Program Funding - FY22 Appropriations." https://familiesusa.app.box.com/file/804492878736?s=fibwicnzcj7pn626men7aol5yhqop77x, April 26, 2021.

Sincerely,

Families USA Action
American Federation of State, County & Municipal Employees
Arthritis Foundation
Center for Independence of the Disabled, NY
Colorado Consumer Health Initiative
Community Catalyst
Community Service Society of New York
Georgia Watch
Georgians for a Healthy Future
Health Access California
Health Care For All New York
Healthcare Rising Arizona
Kentucky Voices for Health
NAACP Nashville Chapter
National Consumer Law Center, on behalf of our low-income clients
New Jersey Appleseed Public Interest Law Center
Northwest Health Law Advocates
Pennsylvania Health Access Network
Tennessee Health Care Campaign