October 18, 2021

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

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

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

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

RE: CMS-9907-P, Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement

Dear Secretary Yellen, Secretary Walsh, Secretary Becerra and Director Ahuja:

Thank you for the opportunity to submit comments on the Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement issued by the Office of Personnel Management and the Departments of Health and Human Services ("HHS"), Labor, and the Treasury (collectively, the "Departments").

Our organizations represent millions of patients and consumers facing serious, acute and chronic health conditions across the country. Our organizations have a unique perspective on what patients need to prevent disease, cure illness, and manage chronic health conditions. Our diversity enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource in this discussion.

In March of 2017, our organizations agreed upon three overarching principles[1] to guide any work to reform and improve the nation's healthcare system. These principles state that: (1) healthcare should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare must be adequate, meaning healthcare coverage should cover treatments patients need, including all the services in the essential health benefit (EHB) package.

Many of the individuals we represent are among the one in six Americans who have received a surprise medical bill.[2] Numerous studies and media accounts have documented the financial implications of surprise bills resulting in devastating out-of-pocket costs for those consumers directly affected and in higher premiums for all privately insured consumers. Our organizations worked alongside Congress to develop the bi-partisan No Surprises Act (NSA) to provide protections for patients from receiving unexpected medical bills, and we have provided comprehensive comments on implementation of the new law in advance of rulemaking and more specifically on the interim final rule released in July.

Our organizations offer the following comments on this proposed rule:

Reporting Requirements for Plans and Insurers 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)

Air ambulance services have a history of high and fast-growing prices, particularly where companies are backed by private equity.[3] One recent study, analyzing costs between 2017 and 2020, found air ambulance charges continue to grow substantially.[4] For many of the patients we represent, air ambulance services are an essential service, but a U.S. Government Accountability Office (GAO) report found that the majority of air ambulance rides for patients with private insurance in 2017 were out-of-network, putting patients at risk of exorbitant balance bills.[5]

We therefore applaud the Departments taking a comprehensive approach to collecting data on air ambulance services from health plans and insurers and from the providers of these services.

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[1] Healthcare Reform Principles. Available at: https://www.lung.org/getmedia/24309f63-74e9-4670-8014-d59f21104cfd/092021-ppc-healthcare-principles-42-logos-final.pdf.

[2] L. Lopes, A. Kearney, L. Hamel, and M. Brodie, "Data Note: Public Worries About And Experience With Surprise Medical Bills," Kaiser Family Foundation, February 28, 2020.

[3] L. Adler, K. Hannick, and S. Lee, "High Air Ambulance Charges Concentrated in Private-Equity Owned Carriers," Brookings, October 13, 2020.

[4] FAIR Health White Paper, *Air Ambulance Services in the United States: A Study of Private and Medicare Claims,"* September 28, 2021.

[5] Government Accountability Office, "Air Ambulance: Available Data Show Privately-Insured Patients Are At Financial Risk," March 20, 2019 (GAO-19-292).

As the preamble to the NPRM states, doing so will help inform a more comprehensive report and allow for verifying data across stakeholders.

To that end, we recommend you consider requiring reporting of two additional data points: the provider types staffing air ambulances (for example, a physician, registered nurse, or emergency medical technician) and data on the specific aircraft used (and not just the type). These data will help the Departments get a clearer picture of whether air ambulance providers are regularly using just some of the fleet of aircraft they maintain and how the provider type may affect cost. We also recommend the Departments require claims data specifically identifying balance bills. We understand that even with charges, allowed amounts, and out-of-pocket costs, it can be difficult to identify the frequency and amounts of balance bills without that information being explicitly reported.

With these additional data and the comprehensive approach proposed by the Departments, we are hopeful the data collected will help illuminate an industry that has left the patients we represent with staggering out-of-network bills and inform future policymaking. We urge the Departments to disaggregate data by race, ethnicity, primary language, geographic location, socioeconomic status, gender identity, sexual orientation, age and disability status.

We also support the proposal to require air ambulance companies to report data for each base site that the company owns. We believe the final rule must make clear that this includes subsidiaries of the parent company, in order to provide a complete picture of the air ambulance market. Doing so can help shed light on areas where market concentration and private equity are skewing costs higher for consumers.

Disclosure and Reporting of Agent and Broker Compensation to Individuals in Individual Health Insurance Coverage and Short-Term, Limited Duration Insurance (45 CFR Part 148)

Our organizations have long voiced our deep concern about short-term, limited duration plans and other insurance-like products.[6] We strongly support the requirement that insurers of individual health insurance and short-term, limited duration insurance report to HHS and disclose to consumers the compensation provided to brokers and agents selling these products. We believe this data will begin to provide greater insight into the financial incentives that in many cases help to drive aggressive and often deceptive marketing of short-term plans.[7] However, we believe much more needs to be done to rein in short-term plans and other limited benefit products that leave consumers at risk of uncovered health care needs and high out-of-

[6] See "Under-covered: How "Insurance-Like" Products are Leaving Patient Exposed." March 2021. Available at: https://www.lung.org/getmedia/5b240c9a-72ec-4217-bc75-d416e6f69f51/undercovered_report.pdf.

[7] See S. Corlette, K. Lucia, D. Palanker, O.Hoppe, "The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses," Urban Institute, January 31, 2019; C. Linke Young and K. Hannick, "Misleading marketing of short-term health plans amid COVID-19," Brookings, (2020, April 15).

pocket costs.[8] We therefore urge the Administration to take additional steps to apply these standards to plans that are currently regulated by the Department of Labor (such as excepted benefits) and to limit the availability and sale of insurance products that are not subject to the comprehensive consumer protections of the Affordable Care Act.

Regarding the proposed rule, we have concerns that the scope of the provision may exclude too many contracts in effect prior to December 27, 2021, thereby limiting the data to be reported to HHS and the incidence of disclosures owed to consumers. We recommend the Departments broadly define the types of changes to the material terms of preexisting contracts that would trigger a report to HHS and a disclosure to consumers. We believe these should include any revision to a preexisting contract, including changes in compensation (direct or indirect), and the addition of agents or brokers to an agency already under contract with an insurer.

We also recommend the Departments require insurers to report compensation data in a way that distinguishes between individual health insurance and short-term plans. Without making that distinction clear, data will be of limited use in evaluating differences in the financial incentives for brokers and agents selling short-term plans and individual market insurance. We also recommend the Departments require insurers to report compensation paid on a percent-of-premium basis in terms of the dollar value associated with that percent, in order to allow for an apples-to-apples comparison of actual compensation. One way to do this may be to require reports of percentage-based compensation to include all premium dollars collected and the total number of covered lives, in order to allow for calculating per person dollar compensation.

We strongly support requiring insurers to report on compensation agreements made directly with agents or brokers as well as agreements made through intermediary organizations. To capture the multiple entities that may be engaged in marketing short-term plans, we recommend the Departments require insurers to report any compensation, direct or indirect, paid along the line from insurer to broker or agent. For example, it is common for short-term plans to be sold through web brokers and associations, which may also receive compensation from insurers for the sale of these products.[9] We also recommend that the disclosure to enrollees include compensation paid to intermediaries, to give those shopping for or renewing coverage a full picture of the financial incentives paid to promote the product before them.

The Department also seeks comment on when consumers should receive this information from brokers during the enrollment process. Consumers should have access to this information when

[8] D. Palanker, E. Curran, and A. Salyards, "Limitations of Short-Term Health Plans Persist Despite Predictions That They'd Evolve," The Commonwealth Fund, July 22, 2020; and K.Pollitz, M. Long, A. Semanskee, and R. Kamal, "Understanding Short-Term Limited Duration Health Insurance," Kaiser Family Foundation, April 23, 2018; "Under-Covered: How "Insurance-Like" Products Are Leaving Patients Exposed," March 2021; and C. Linke Young, "Taking a Broader View of 'Junk Insurance,'" Brookings, July 6, 2020.

[9] E. Curran, D. Palanker, and S. Corlette, "Short-Term Health Plans Sold Through Out-of-State Associations Threaten Consumer Protections," The Commonwealth Fund, January 31, 2019.

a broker suggests or offers a coverage option, prior to enrollment, and after enrollment is complete. The disclosure of this information too late in the process would unfairly withhold important decision-critical information from consumers, creating situations where brokers or agents could use high-pressure sales tactics to coerce enrollment. We also applaud the Department's continued recognition of the importance of accessibility standards, including requirements that allow individuals with limited English proficiency, those with disabilities, and others to meaningfully access and understand information.

Finally, we encourage the Departments to develop for public comment and require use of a plain language model disclosure. A model notice for compensation paid to brokers and agents selling short-term plans could, for example, incorporate the disclosure already required under federal rules for short-term plans noting some of the product's limits, with the opportunity for states to tailor the notice to any additional protections or disclosures required under state law. This standard disclosure, developed with input from patient advocates and other stakeholders, will be important to help patients and consumers put the information provided in context and understand how financial incentives may impact the healthcare coverage recommendations being made to them.

CMS Enforcement of Group and Individual Insurance Market, and Provide and Facility Requirements (45 CFR Part 150)

With regard to the proposed approach to enforcement, we recommend that HHS set standards for states to meet in asserting primary enforcement of the NSA, particularly with regard to the provisions that apply to providers and facilities. This could include demonstrating the state's authority and ability to enforce, designating the agencies or departments responsible for enforcement and demonstrating they are free of conflict with the regulated entities, and developing a process to publicly report enforcement actions. Ultimately, these criteria as well as the selected entities responsible for enforcing the NSA should be posted publicly both on state-facing resources and websites as well as on a national directory kept and updated by HHS. Patient facing resources, including Consumer Assistance Programs where they are available, should also be displayed alongside enforcement entities such that consumers can easily access information about enforcement responsibilities and where to seek help.

While it may be appropriate to apply the same approach to enforcement of the NSA as has applied to other major reforms to the Public Health Service Act, the NSA applies new requirements to providers and facilities in the majority of states and for those covered under self-funded plans. Further, states have gained authority under the NSA to enforce provider provisions on air ambulances where they were previously barred under the Airline Deregulation Act (ADA). Further, as the Departments note in the preamble to the NPRM, enforcement authority over the provisions that apply to providers and facilities may often fall to state agencies other than the departments of insurance and will vary across states.

We believe it is therefore appropriate to require states to demonstrate their plans for enforcement of all provisions of the NSA and for the Departments to make public the plan for each state – whether enforcement will fall to the state or federal regulators, or be shared under

a collaborative enforcement agreement. This transparency will make it clearer to all stakeholders, including consumers, how enforcement is being conducted and where to go for further information and help.

In addition, we recommend the Departments ensure enforcement of the provider and facility requirements applies to all entities that have a role in billing, including downstream entities and third parties working with facilities and providers to process and pay claims. Multiple entities are involved in processing claims and should bear responsibility for preventing patients from being improperly billed for items and services protected under the NSA. We also believe it would be helpful for the Departments to provide state regulators with examples of the types of enforcement or regulatory actions that states could take over air ambulance providers that would be consistent with their authority under the NSA and would not run afoul of the ADA.

Our organizations urge the Departments to clarify how enforcement will work if the provider and the patient are located in different states. Especially with the growth of the telehealth during the pandemic, for example, a patient may receive a balanced bill from an out-of-state provider for care provided via telehealth. In cases that cross state lines, it may make sense for federal regulators to handle enforcement.

We applaud the proposal to authorize CMS to conduct random and targeted investigations and market conduct exams to verify compliance with NSA provisions applicable to insurers, health plans, providers and facilities. We agree that this approach will allow for a more effective and efficient enforcement program that ensures consumers are getting the benefits and protections to which they are entitled without having to receive a complaint. In order to make certain this authority can be fully utilized, we urge the Departments to adequately fund and staff these functions.

Our organizations recommend that the Departments clearly articulate a role for the HHS-administered complaints process in enforcement of the NSA. The Departments' goal of providing a seamless way for consumers and others to file complaints about potential violations – whether it's a balance bill improperly sent or a waiver of protections improperly obtained – can be a powerful tool for state and federal enforcement efforts. Investigating individual complaints will provide relief for individual consumers, but an enforcement approach that incorporates data from the complaints process can help identify where there are broader problems with compliance that warrant closer scrutiny.

Finally, a robust and effective enforcement program must include a broad, well-funded education campaign to notify consumers of their new rights under the NSA. The vast majority of the privately insured, including the nearly 135 million people in self-insured plans, will newly gain these comprehensive protections when the law takes effect on January 1, 2022. Investing in consumer education will help ensure more patients are aware of their rights under federal law before being presented with a form seeking their consent to waive these protections. We applaud HHS' release of a website for consumers and other stakeholders to find information on

the new law, but much more must be done to make clear the reach of the protections and where consumers can go to get help and file a complaint.

Conclusion

Our organizations thank you for the opportunity to provide comments on this proposed rule. If you have any questions, please contact Hannah Green (hannah.green@lung.org) with the American Lung Association.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Lung Association
American Kidney Fund
Arthritis Foundation
Cancer Support Community
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Muscular Dystrophy Association
National Alliance on Mental Illness
National Hemophilia Foundation
National Organization for Rare Disorders
National Patient Advocate Foundation
Susan G. Komen
The Leukemia & Lymphoma Society