



September 7, 2021

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

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

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

Re: **CMS-9909-IFC, Interim final rules with request for comments, No Surprises Act**

Dear Secretary Becerra, Secretary Yellen, and Secretary Walsh,

The Cancer Support Community (CSC), an international nonprofit organization that provides support, education, and hope to cancer patients, survivors, and their loved ones, applauds the Department of Health and Human Services (HHS), the Department of the Treasury, and the Department of Labor (DOL) (collectively the “Departments”) efforts to protect patients and their families from surprise medical bills and the practice of balance billing. As the largest provider of social and emotional support services for people impacted by cancer, CSC has a unique understanding of the cancer patient experience. In addition to our direct services, our Research and Training Institute and Cancer Policy Institute are industry leaders in advancing the evidence base and promoting patient-centered public policies. We appreciate the opportunity to comment on these interim final rules with requests for comments (IFCs) on the No Surprises Act (NSA).

The need for the NSA is illustrated by the data included in the interim final rules. Between 2010 and 2016, 39 percent of emergency department (ED) visits to **in-network hospitals** resulted in an **out-of-network bill** with the average bill beginning at \$220 in 2010 and increasing to \$628 in 2016. Similarly, during that same time period, 37 percent of inpatient admissions to in-network hospitals resulted in at least one out-of-network bill, with the average of those bills increasing from \$804 in 2010 to \$2040 in 2016 (Requirements related to surprise billing; part i 2021). With recently diagnosed cancer patients and cancer survivors reporting higher out-of-pocket medical costs than those without a history of cancer (*Financial Toxicity and Cancer Treatment (PDQ®)–Health Professional Version, 2021*), the added burden of surprise medical bills has a particularly deleterious impact on cancer patients, survivors, and their caregivers.

We applaud the Departments for addressing the harm caused by surprise medical bills resulting from emergency services, air ambulance services by nonparticipating providers, and non-emergency services by nonparticipating providers at participating facilities. We offer our overall support for these interim final rules, as well as suggestions for improvement on these rules.

We are pleased to see that the NSA prioritizes patients' receipt of timely, seamless care by offering protection from high, unanticipated, burdensome, and previously unavoidable surprise medical bills that resulted from a disjointed and increasingly difficult to navigate health care system. The NSA encourages people to seek the care they need at the time they need it, leading to improved health outcomes which in turn reduces health care costs.

Insurance Coverage Applicability

CSC appreciates the scope of the IFCs' application to group health plans and group and individual health insurance coverage. With approximately 67 percent of workers in the United States receiving their health insurance from **self-funded plans** (Elflein, 2021), which are not subject to state surprise billing legislation, it is especially important that the IFCs protect people with this form of employer coverage. CSC also recognizes the applicability of these IFCs to federal employees' health benefits plans.

Prior Authorization

The costs of cancer care are rising more quickly than the costs of health care in other medical sectors and account for five percent of total U.S. health care spending (Schnipper & Basian, 2016). To help offset the high costs of cancer care and health care generally, insurance plans are turning to increased use of utilization management (UM) tools. Prior authorization (PA) is one UM practice that can delay cancer patients' timely access to treatment and interfere with the patient-provider shared decision-making process (Oncology, 2019). Understanding PA's potential to delay appropriate care at the expense of patients' well-being, and the added urgency of receiving timely care in an emergency, the IFCs' requirement that emergency services be covered without any PA is a necessary and significant victory for all patients.

Telehealth

Telehealth has long been an important care delivery method for improving access in underserved communities, particularly rural areas, areas with physician shortages, and areas with limited access to primary care services. However, the COVID-19 pandemic has highlighted the role of telehealth in helping patients continue to receive timely and safe health care services and treatments from their providers. Telehealth -- including **telemedicine and tele-mental health** -- helps reduce gaps in access to services and care, including access to primary care and specialized providers when in-person visits are not a safe or feasible option. Telehealth and tele-mental health have played a particularly invaluable role for cancer patients and survivors during the public health emergency (PHE). The Departments' recognition that telemedicine constitutes a "visit" when furnished by a health care provider outside a participating health care facility to someone during their visit to a participating health care facility confirms telemedicine's essential role within our health care system.

Broadly Defined Terms

CSC supports the broad definition of 'emergency services' included in the IFCs. We appreciate **pre-stabilization** services provided to a patient after they are moved out of the emergency department and admitted to a hospital being categorized as emergency services. Limiting the definition of 'emergency services' solely to the immediate initial response in the emergency department (ED) without including

services necessary to facilitate the improvement of a patient once moved from the ED could inhibit the benefits conferred on the patient through the initial emergency service.

We similarly support including services provided at an **independent freestanding ED** to be within the definition of ‘emergency services.’ People confronting a medical emergency should not be tasked with understanding the distinction between a hospital and an independent freestanding ED. In keeping with this reasoning, we strongly urge the Departments to reconsider their decision not to include **urgent care centers** as an independent freestanding ED within the definition of ‘**health care facilities**’ in these IFCs. Regardless of how a state chooses to license the urgent care centers within its borders, the very use of the word “urgent” in the title or description of these facilities and its use in common vernacular when referencing these facilities not only supports but demands these IFCs include urgent care centers in the definition of ‘health care facilities.’ Inasmuch as the perspective of a **prudent layperson** who possesses an average knowledge of health and medicine is used to determine whether a situation arises to an “emergency medical condition,” so, too, should the perspective of such a prudent layperson be looked to in deciding whether an urgent care center is a health care facility that people reasonably turn to for emergency care services. In the midst of seeking emergency care, people should not be expected to know a state’s licensing regulations or understand the serious financial implications such regulations could have on them. Prompted by the word “urgent,” a prudent layperson may well turn to an urgent care to seek services in an emergency and these individuals deserve to be equally protected against surprise and balance billing under the NSA.

We agree with the Departments’ conclusion that **post-stabilization services** are emergency services when received as part of outpatient observation or an inpatient or outpatient stay following receipt of the emergency services unless multiple conditions are met. We emphasize the importance of the attending physician or treating provider taking the person’s medical condition, *including mental health*, into consideration when determining whether the patient is able to travel to an available participating provider or facility located within a reasonable travel distance using nonmedical transportation or nonemergency medical transportation *and* that the patient should be involved in the decision-making process, if possible.

CSC strongly agrees with the Departments’ recognition that varying patient circumstances and perspectives, including those of people from **geographically isolated and/or underserved communities**, must be considered when determining if nonmedical or nonemergency transportation is an appropriate or viable option. In addition to the location, social risk, and income considerations referenced, the potential for increased risk of exposure to COVID-19 and/or the mental stress associated with that risk is a very real concern for cancer patients, survivors, and their loved ones who care for them. CSC urges that the burden to overcome the **presumption that post-stabilization services are emergency services** should necessarily be high and difficult to overcome. Patients should receive written notice clearly explaining that post-stabilization services are presumed to be emergency services and such notices should be easily understandable, culturally appropriate, and delivered in a language the patient understands.

With regard to the Departments’ **request for comments on the definition of “reasonable travel distance”** and whether specific standards or examples should be provided regarding what constitutes an unreasonable travel burden, CSC strongly urges that the term “reasonable travel distance” be changed to “reasonable travel” and that the totality of each patient’s circumstance, encompassing cultural and contextual factors specific to underserved and other communities, be considered in determining “reasonable travel,” foregoing reliance on generic standards such as travel distance. Factors to consider in determining “reasonable travel” should be similar to, but not limited to, those used to determine whether notice and consent requirements are met. 1) Is the patient in a condition to travel? 2) Is the patient capable of understanding that they will be leaving the current facility and going elsewhere for care? 3) Is the patient’s state of mind after receiving the emergency services and their emotional state conducive to changing facilities and traveling to a new facility? As referenced above, considerations such as increased

risk of exposure to COVID-19 and/or the mental stress associated with that risk as well as the availability of specialized care or services at the current facility as compared to the alternate facility should be included in the determination. If the answer to any of these questions or other questions relevant to a particular patient is no, then the **default must remain that post-stabilization services are emergency services.**

These IFCs require that a **notice and consent** document must be made available in any of the 15 most common languages in the geographic region where the facility is located. While 15 languages are certainly a generous number of languages, they serve no purpose if the patient and their authorized representative do not understand any of the 15 languages. CSC advocates for the IFCs to require that a notice and consent document be made available in the 15 most common languages in the facility's geographic region and any additional language as required to ensure the patient and authorized representative fully understand the terms of the notice and consent document. In addition to the importance of appropriate languages, CSC also supports the Departments' conclusion that consent obtained through a threat of restraint or immediacy of the need for treatment is not voluntary. CSC agrees with the Departments' position that post-stabilization notice and consent procedures should generally be applied in limited circumstances, where the individual knowingly and purposefully seeks care from a nonparticipating provider or facility, but with one caveat – notice and consent procedures should **only** be applied where the individual knowingly and purposefully seeks care from a nonparticipating provider or facility. Reporting requirements and enforcement procedures for notice and consent requirements should be designed and implemented to ensure patients are protected and the objectives and intent of the NSA are achieved.

Air Ambulances

Requiring the assistance of a fixed wing or rotary wing **air ambulance**, whether due to the severity of an injury or illness or a patient's location, necessarily means that a medical emergency has occurred. No one confronting such a challenge cannot reasonably be expected to research their insurance plan to determine the in-network or out-of-network status of the air ambulance prior to requesting transport. Limiting cost-sharing for out-of-network air ambulance services to in-network levels and requiring that cost-sharing count toward any in-network deductibles and out-of-pocket maximums promotes timely access to emergency care without imposing insurmountable expenses on a patient. Protecting those in need of an air ambulance from out-of-network cost sharing and balance billing aligns with the goals of the NSA and people requiring **emergency ground ambulance services** are no less deserving of such protections. These IFCs reference emergency ground ambulance services as being one of the services most often associated with surprise bills. Every day, countless people require the use of a ground ambulance to transport them to emergency care, only to later be shocked, not surprised, by the exorbitant and uncovered cost of that service. CSC urges the Departments to include emergency ground ambulance services within these IFCs.

Patient Cost-Sharing

CSC appreciates the IFCs' **patient-centeredness methodologies** used to determine patient cost-sharing. By limiting patient cost-sharing for emergency services, air ambulance services, and non-emergency services by nonparticipating providers at participating facilities to in-network levels that must also count toward any in-network deductible and out-of-pocket maximums, these IFCs lift a heavy burden that subject many patients and families to crushing debt and financial toxicity, especially for people from underserved communities and those of limited financial means.

By calculating a patient's cost-sharing for emergency services by a nonparticipating emergency facility and non-emergency services by nonparticipating providers in a participating facility on the "recognized

amount,” a consistent methodology is employed for determining cost-sharing that also ensures patients are not subject to price disputes between plans and facilities/providers. The IFCs’ commitment to patients is further demonstrated by calculating cost sharing on the *lesser* of the QPA or the amount billed when the All-Payer Agreement or a state law does not apply. While a “recognized amount” does not apply to air ambulances by nonparticipating providers, the IFCs established that the cost-sharing requirement for nonparticipating air ambulances must be the same as if the services were provided by a participating provider and any coinsurance or deductible must be based on rates that would apply for such services if furnished by a participating provider.

High Deductible Health Care Plans

Recognizing the unavoidable nature of the services (e.g., emergency) or the unanticipated out-of-network status of a provider(s), CSC acknowledges the Departments purposefulness in drafting IFCs that cover such services in a consistent manner for *all* patients notwithstanding that a patient with a high deductible health plan (HDHP) may not yet have met their deductible at the time the services were delivered. In addition to ensuring these patients are not subject to higher out-of-pocket costs than similarly situated patients that do not have a HDHP, the IFCs preserve the HDHPs eligibility as a qualified HSA plan.

Conclusion

Thank you again for the opportunity to share these comments. We look forward to working with the Departments and other stakeholders to further facilitate patients’ receipt of timely and seamless care under the NSA and protection from the negative consequences of surprise medical bills and balance billing. If you have any questions or would like to discuss these comments in more detail, please reach out to Kim Czubaruk at kczubaruk@cancersupportcommunity.org.

Sincerely,



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