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October 14, 2021

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

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

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

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

Re: Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement (RIN 0938-AU61) CMS-9907-P

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

The Association of American Medical Colleges (AAMC or the Association) welcomes the opportunity to comment on the proposed rule entitled "Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement," (86 *Fed. Reg.* 51730) September 16, 2021, issued by the Department of Health and Human Services, the Department of the Treasury, the Department of Labor and the Office of Personnel Management (the Departments). Our comments address enforcement of consumer protections against surprise billing, telehealth, and agent/broker compensation disclosures.

The AAMC is a nonprofit association dedicated to transforming health through medical education, health care, medical research, and community collaborations. Its members are all 155 accredited U.S. and 17 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and the millions of individuals employed across academic medicine, including more than 186,000 full-time faculty members, 94,000 medical students, 145,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

The AAMC supports the Departments' decision to delay enforcement of some aspects of the No Surprises Act[1] for which rulemaking cannot be completed before the requirements become effective. We request that the Department of Health and Human Services (HHS) delay enforcement of additional requirements until after the public health emergency (PHE) ends to allow providers and hospitals to focus scarce resources on caring for patients.

The AAMC supports efforts to increase affordable health insurance options for consumers. More needs to be done, however, to educate consumers about plan options to help them choose coverage that best fits their needs. Consumers should be given all agent/broker compensation information for plans the agents/brokers market and sell so consumers can evaluate whether they are being steered toward plans with high commissions and bonuses.

CMS ENFORCEMENT WITH RESPECT TO PROVIDERS AND FACILITIES

In this rule, the HHS proposes to add subpart E to 45 CFR 150 to implement the requirements of section 2799B-4 of the Public Health Services (PHS) Act. The new subpart specifies the enforcement processes with respect to the No Surprises Act (NSA) that would apply to providers and facilities subject to Centers for Medicare & Medicaid Services' (CMS) enforcement authority. Specifically, HHS is proposing that this new subpart would apply to current CMS enforcement authority to providers and facilities that do not comply with patient protections under the No Surprises Act in states that are unable to perform oversight and enforcement. According to the proposed rule, this enforcement authority would align with CMS's current process as it relates to investigations of possible violations by health plans and issuers. Under the proposal, CMS could conduct investigations based on any information it receives that indicates a provider or facility is not complying with the No Surprises Act requirements. HHS believes that the proposal would allow CMS to "effectively enforce new requirements and ensure providers and facilities are sufficiently informed of the steps in and how to comply with the investigative process." (p. 51751).

Delay Enforcement Until the COVID-19 Public Health Emergency Ends

The COVID-19 public health emergency (PHE) has stretched hospitals, physicians and other providers to the breaking point. Hospitals are battling multiple waves of COVID infections, increases in hospitalizations from patients who delayed care during the PHE and significant staffing shortages and burnout. Many hospitals have had to divert scarce resources to secure additional staffing, expand capacity, and procure supplies needed to care for patients and keep staff safe. Despite all this, hospitals and providers are working to comply with the requirements of the No Surprises Act. Given the current challenges faced by providers and facilities, we urge CMS to delay enforcement for providers that are making a good faith effort to comply with the No Surprises Act (NSA) requirements. At a minimum, we recommend CMS delay application of

[1] Consolidated Appropriations Act, 2021. Pub.L. 116-260. Division BB – Private Health Insurance and Public Health Provisions.

the civil monetary penalties for at least six months after the end of the PHE. This delay would align with other CMS waivers that delay enforcement of other requirements during the PHE.

Clearly Identify Whether the State or CMS Will Assume Enforcement Authority

States have primary enforcement authority when determining whether a provider or facility is compliant with the requirements under the No Surprises Act. CMS would assume enforcement authority, however, if it is determined that a state does not have authority or has failed to enforce the PHS Act requirements. In such instances, the proposed rule would allow CMS to investigate complaints and enforce requirements under the PHS Act that a provider or facility is failing to comply with the requirements. CMS should make clear to providers and facilities which entity – CMS or the state – has enforcement authority to decrease confusion about enforcement authority and publish a list of states for which CMS has assumed enforcement authority. For example, Missouri, Oklahoma, Texas, and Wyoming have not enacted legislation to enforce other PHS requirements. If those states do not enact legislation to begin enforcing the PHS more generally or the requirements under the No Surprises Act, we recommend that CMS notify providers in these states that the agency has enforcement authority.

Lengthen Timeframe to Respond to a Claim of Violation

Under the proposed rule, if CMS receives information that indicates a possible violation of the No Surprises Act requirements or selects a provider or facility for investigation, CMS would provide written notice to the provider or facility. The notice would give the provider or facility the information that prompted the investigation; state whether a civil monetary penalty may be assessed; and provide a date by which the provider or facility must respond with additional information, including documentation of compliance. CMS proposes to revise the regulations to remove the 30-day timeline for a response, and give CMS the discretion to provide the date by which the provider or facility must respond to the notice. In the rule, CMS states that it anticipates generally providing 14 days for response. CMS does not clarify whether it is referring to 14 calendar days or 14 business days.

CMS believes that 14 days is sufficient time for a response as the requested information should be readily available to the provider or facility to formulate a response. CMS would be permitted to further shorten that timeframe if the complaint involves urgent medical issues or allegations of fraud and abuse. (p. 51752). The proposal would allow providers and facilities to request an extension to respond to CMS's request for additional information. CMS would consider examples of "good cause" to grant an extension, such as limited staffing resources to prepare a response. (p. 51752).

The 14-day window for providers or facilities to respond is too short as it is not unusual for complaints that are sent to a provider or facility to take several days to reach the correct office. This is particularly true for large teaching hospitals. Furthermore, providers and facilities need time to understand the allegation of noncompliance and to compile sufficient supporting

documentation. CMS presumes that the information would be readily available to providers in computerized patient billing records; however, that is not always the case. **We urge CMS to allow a minimum of 30 business days for a provider or facility to respond to the notice and allow for providers to seek an extension if necessary.**

Consider Providers' Good Faith Efforts to Comply Before Imposing Penalties or Corrective Action Plans

The proposed rule would codify statutory language that permits HHS to impose a civil money penalty (CMP) if a provider or facility is found to be in violation of a No Surprises Act requirement. (p. 51753). CMS would also have authority to require corrective action plans to correct any violations. (p. 51752). HHS proposes that CMS would consider all relevant documentation and any mitigating and aggravating circumstances related to the violation when determining whether to impose a CMP. HHS is also proposing that if certain criteria are met, CMS would waive a penalty. (p. 51753).

We urge HHS to delay implementation of CMPs and corrective action plans for noncompliance until a minimum of six months after the end of the PHE. Imposing CMPs during the COVID-19 PHE would further negatively impact hospitals, physicians, and other providers that are already challenged financially. The AAMC believes it would be appropriate to delay applying any CMPs until a period of time after the PHE ends to allow providers additional time as they return to regular business. Further, CMS should take into account providers' and facilities' good faith efforts to comply with the myriad surprise billing act requirements. Providers and facilities are working to comply with all requirements and these efforts should be taken into consideration when evaluating whether a provider or facility is, in fact, in violation.

TELEHEALTH

In the rule, CMS proposes that a state would be the primary enforcer of the PHS Act requirements on 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. HHS is aware that many states have relaxed licensure requirements during the pandemic to allow out-of-state providers to furnish telehealth services. HHS seeks comment on whether this policy would present challenges with respect to providers or facilities furnishing telehealth services.

While we recognize the importance of having enforcement authority over out-of-state providers, we believe that this could be confusing for providers and difficult to operationalize. The out of state provider may furnish telehealth services to patients in multiple states and therefore may need to be familiar with different processes for investigations, enforcement and appeals, depending on the state. It will be important for the state to have a mechanism for communicating with the out of state provider. As an example, the out of state provider may need to designate and provide the address of a "registered agent" within the state that would be notified of any violations.

AGENT AND BROKER FEES

When looking for affordable health insurance options, plans that offer lower premiums are attractive to many consumers. Unfortunately, some lower cost plans do not provide adequate minimal coverage to meet consumers' needs. Consumers searching for affordable insurance options may not be aware of slim benefits packages or recognize cost-sharing liabilities and network limitations that often come with lower premium plans. Certain plans, such as short-term, limited-duration (STLDs) plans, tend to provide inadequate coverage, leaving many consumers without coverage for essential health benefits, exposed to significant out-of-pocket cost sharing, and subjected to narrow provider networks that may impede access to needed care.

Consumers and employers often look to agents/brokers to help them navigate the complex maze of purchasing insurance coverage. Insurers utilize agents/brokers to market and sell their insurance products; in return, agents/brokers receive commissions (*i.e.,* direct compensation) and other compensation such as bonuses (*i.e.,* indirect compensation) for the products they sell. Commissions are usually based on a percentage of the premium.[2] This perverse incentive means that the more a consumer or employer pays for insurance, the higher the agent/broker compensation. Insurers may also offer bonuses as an added incentive to promote certain products. Conversely, insurers will lower or stop paying commissions to disincentivize sales.[3]

The proposed rule includes proposals to implement Section 202 of the Consolidated Appropriations Act, 2021[4] that requires disclosure of agent and broker compensation to consumers purchasing individual health insurance or STLDs and the submission of reports to HHS regarding certain direct and indirect compensation paid by insurers to agents or brokers selling these plans. (p. 51740). Under the proposal, health insurance issuers would be required to disclose to potential or existing or renewing policyholders the amount of direct or indirect compensation the issuer gives the agent/broker to enroll consumers in the issuers' individual health insurance plans or STLDs. The disclosure would be required to include the direct compensation information, such as the commission schedule, and indirect compensation, such as bonuses, which may not be captured in the commission schedule but are used to determine the compensation owed to the agent/broker for enrolling an individual in the insurance product. (p. 51741).

We support increased transparency of agent/broker compensation; however, merely providing compensation tables to consumers along with the myriad of other documents without explaining how agent/broker compensation impacts the marketing of insurance products by insurers and agents/brokers is not useful. Further, this disclosure will likely not decrease enrollment in insurance products that do not meet the needs of consumers. Choosing health insurance coverage can be daunting for consumers and simply giving consumers more paperwork could exacerbate current misunderstandings about health insurance coverage.

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[2] https://www.insurancebusinessmag.com/us/opinion/the-trouble-with-commissions-237407.aspx
[3] https://ctmirror.org/2015/12/09/unitedhealthcare-to-stop-paying-commissions-for-obamacare-exchange-plans/
[4] Division BB – Private Health Insurance and Public Health Provisions. Title II – Transparency.

Provide Agent/Broker Compensation Information Before Plans are Chosen

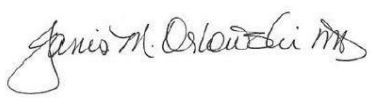
Under the proposal outlined in the proposed rule, direct and indirect agent/broker compensation would be required to be disclosed to consumers. The disclosure would be provided to the consumer prior to finalizing plan selection or with the invoice for the first premium payment, depending on state or Federal law. Minimum disclosure requirements would be met by using commission schedules or other documents that detail the applicable commission levels and indirect compensation such as bonuses. (p. 51941).

We support arming consumers with information to assist them in making health insurance purchasing decisions. However, to truly achieve transparency in agent/broker compensation, the agent/broker compensation information consumers receive should include direct and indirect compensation for ***all*** insurance products sold by the agent/brokers, not just what the agent/broker will be paid for enrolling an individual in a specific insurance product. This would provide greater transparency on whether consumers are being steered toward certain products that provide higher direct and indirect compensation. Additionally, this information should be provided to consumers earlier in the insurance selection process ***before*** insurance options are discussed and more importantly ***before*** choices made. Specifically, this information should be provided to consumers during initial conversations about coverage options so consumers can understand if they are being steered to products with higher commissions and bonuses. Further, written information should be in plain language that describes how agent/broker compensation is calculated should be included with the compensation information to ensure consumers understand how insurers incentivize certain products. This will give consumers the opportunity to ask questions about the compensation structure and to make informed decisions about insurance options presented to them.

CONCLUSION

Thank you for the opportunity to provide input as you develop regulations that protect patients from surprise medical bills and ensure appropriate payment to providers. We would be happy to work with you on any of the issues discussed above or other topics that involve the academic medical center community. If you have questions regarding our comments, please feel free to contact Mary Mullaney at mmullaney@aamc.org and Gayle Lee galee@aamc.org.

Sincerely,



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