American Hospital Association™
Advancing Health in America

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October 30, 2023

The Honorable Rohit Chopra
Director
Consumer Financial Protection Bureau

Submitted Electronically

RE: Small Business Advisory Review Panel for Consumer Reporting Rulemaking: Outline of Proposals and Alternatives Under Consideration

Dear Director Chopra:

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, we thank you for the opportunity to provide comments on the Consumer Financial Protection Bureau's (CFPB) proposals related to medical debt reporting.

In the first quarter of 2023, household debt in America rose to $17.05 trillion, representing a precipitous increase over the last decade.[1] In part, rising debt can be attributed to cost growth outpacing income growth which requires many Americans to borrow more to pay for housing, higher education and consumer goods. For example, one study found that college costs have increased by almost 170% since 1980, while the average earnings for young adults (aged 22-27) have only increased by 19%.[2] Middle class Americans are shouldering much of this debt, and many are living paycheck to paycheck.

Medical debt, a consequence of patients not paying some or all their health care bills, is one type of debt held by many Americans. While health insurance is intended to be the primary mechanism to protect patients from unexpected and unaffordable health care costs, for too many that coverage is either unavailable or falling short.

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[1] https://www.newyorkfed.org/microeconomics/hhdc
[2] https://www.cnbc.com/2021/11/02/the-gap-in-college-costs-and-earnings-for-young-workers-since-1980

Trends in health insurance coverage are driving an increase in medical debt: these include inadequate enrollment in comprehensive health care coverage, growth in high-deductible and skinny health plans that intentionally push more costs onto patients, and misleading health plan practices that confuse patients' understanding of their coverage. These gaps in coverage leave individuals financially vulnerable when seeking medical care. We wrote to you at length about these issues in our recent comments for the medical payment products request for information. Therefore, we will only briefly summarize the root causes of medical debt here.

- **There are still too many uninsured Americans.** Affordable, comprehensive health care coverage is the most important protection against medical debt. While the U.S. health care system has achieved higher rates of coverage over the past decade, gaps remain, and big new threats are on the horizon. One of the persistent gaps is the decision by some states to not expand Medicaid. And the most imminent threat is the potential loss of Medicaid coverage for millions of people across the country as a result of the end of the COVID-19 public health emergency.

- **High-deductibles subject many Americans to cost-sharing they cannot afford.** High-deductible plans are designed to specifically increase patients' financial exposure through high cost-sharing in exchange for lower monthly premiums. Yet many individuals enrolled in high-deductible plans find they cannot manage what their health plan requires they pay. A recent Federal Reserve report found that 37% of adults would not be able to afford a $400 emergency,[3] an amount $1,000 less than the average general annual deductible for single, employer-sponsored coverage.

- **Skinny health plans provide inadequate benefits and frequently lead to surprise gaps in coverage.** Short-term, limited-duration health plans and health sharing ministries cover fewer benefits and include few to no consumer protections, such as required coverage of pre-existing conditions and limits on out-of-pocket costs. Patients with these types of plans often find themselves responsible for their entire medical bill without any help from their health plan, including for critical services such as emergency medical and oncology care. These denials can lead to accumulating significant medical debt.[4,5,6]

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[3] https://www.federalreserve.gov/publications/2023-economic-well-being-of-us-households-in-2022-expenses.htm
[4] https://kffhealthnews.org/news/sham-sharing-ministries-test-faith-of-patients-and-insurance-regulators/
[5] https://ctmirror.org/2020/03/02/im-relying-on-prayer-complaints-pile-up-against-health-care-sharing-ministries-as-state-mounts-a-defense/
[6] https://www.nytimes.com/2020/01/02/health/christian-health-care-insurance.html

- **Complex health plan benefit design and misleading marketing can expose patients to unexpected costs.** Many health plans have complex benefit designs that are not transparent to patients, such as what is covered pre-deductible, the interaction between point-of-service copays, coinsurance and deductibles, and poor communication and education about what the insurer actually covers. For example, a recent National Association of Insurance Commissioners (NAIC) report found significant gaps and inconsistencies with the way that insurers share information about pre-deductible, no cost-sharing preventive services with their members, resulting in a "meaningful barrier to effective understanding and use of preventive service benefits."[7] In addition, both Congress and the Administration have honed in on the issue of misleading health plan marketing, which can complicate patients' understanding of their benefits. Indeed, the Senate Finance Committee held a hearing on "deceptive" marketing practices in the Medicare Advantage program earlier this month.[8]

Hospitals and health systems are very concerned about patients' medical debt. Hospitals are the only part of the health care sector that provide services to patients regardless of their ability to pay. In addition, they backstop that commitment by providing financial and other assistance for those who cannot pay — including helping patients qualify for federal and state health care programs, such as Medicaid and the Health Insurance Marketplaces. In doing so, patients can receive regular preventive care, not just episodic care for serious injuries or illness. In addition, hospitals absorb billions of dollars of losses for patients who are unable to pay their bills, mainly due to inadequate commercial insurance coverage; in 2020, the latest figure available, hospitals provided more than $42 billion in uncompensated care.[9]

This is why hospitals are staunch supporters of ensuring everyone is enrolled in some form of comprehensive coverage. They deeply value and take seriously their duty to care for anyone who comes through their doors regardless of ability to pay and, indeed, are the only part of the health care system with such awesome responsibility.

However, we appreciate that closing the remaining coverage gaps may be a longer-term solution and that more immediate steps can be taken to help prevent medical debt, as well as protect patients from the consequences of medical debt. To that end, the AHA has routinely developed patient billing guidelines to help mitigate patient's risk of medical debt. Our Board of Trustees adopted the most recent set of guidelines in 2020, which reaffirm the hospital field's commitment to:

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[7] https://healthyfuturega.org/ghf_resource/preventive-services-coverage-and-cost-sharing-protections-are-inconsistently-and-inequitably-implemented/
[8] https://www.finance.senate.gov/chairmans-news/wyden-announces-hearing-on-medicare-advantage-marketing-and-enrollment
[9] https://www.aha.org/system/files/media/file/2020/01/2020-Uncompensated-Care-Fact-Sheet.pdf

- Treating all people equitably, with dignity, respect and compassion;
- Serving the emergency health care needs of all, regardless of a patient's ability to pay; and
- Assisting patients who cannot pay for part or all the care they receive.

Notably, several of the guidelines directly address medical debt, including encouraging hospitals to forego adverse credit reporting of medical debt. So far, nearly 2,800 hospitals and health systems have affirmed their commitment to the guidelines, and the AHA revisits them frequently for updating.

The AHA patient billing guidelines, therefore, largely align with the CFPB's proposals to:

1. Revise Regulation V § 1022.30(d), to modify the exemption such that creditors are prohibited from obtaining or using medical debt collection information to make determinations about consumers' credit eligibility (or continued credit eligibility), and
2. Prohibit consumer reporting agencies from including medical debt collection tradelines on consumer reports furnished to creditors for purposes of making credit eligibility determinations.

Below, we specifically address the questions posed by the agency as requested. We are replying to the Medical Debt Collection Information section, which requires responses to 1-7 (general questions) and 35-38 (medical debt specific questions).

<u>**General Questions on All Proposals and Alternatives Under Consideration**</u>

Q1. How, if at all, will the proposal under consideration require your firm to change its operations, products, or services? As the AHA is not involved in the provision of credit, the proposals will have no impact on the AHA directly. We are uncertain how these proposals may impact hospitals as we are unaware of the extent to which hospitals directly offer medical payment products that would require a credit eligibility determination and assume there is variation across hospitals.

Q2. What do you anticipate will be the initial and ongoing costs to your firm, if any, of complying with the proposal under consideration? If applicable, how do those costs compare to your firm's current costs to comply with the provision(s) of the FCRA or Regulation V related to the proposal under consideration? Please quantify all such costs by type and amount to the extent possible. These proposals would not generate any costs to the AHA. We do not have information on the extent to which these proposals may create new costs for certain hospitals and health systems; however, we expect costs would vary based on hospitals' role in extending credit to patients to help finance their care.

Q3. What aspect or aspects of complying with the proposal under consideration would be the most challenging? We do not have a perspective on this question.

Q4. What alternative approaches, if any, should the CFPB consider in lieu of the proposal under consideration? We do not have any recommendations on alternative approaches to consider.

Q5. Other than compliance costs, what costs, burdens, or unintended consequences should the CFPB consider with respect to the proposal under consideration? Please quantify if possible. What alternatives, if any, would mitigate such costs, burdens, or unintended consequences? It is possible that this proposal could remove an incentive for individuals to get insurance if they believe they can rely on not paying their bills. While hospitals offer financial assistance, such assistance is not a substitute for comprehensive health insurance and, as a result, patients who choose to forego coverage may face a barrier to routine preventative and restorative care. It is also possible that this proposal may incentivize patients to forego paying bills for care that they received and for which they have been determined liable. However, it is not possible to quantify the cost of either of these potential consequences.

Q6. Are there any statutes or regulations with which your firm must comply that may duplicate, overlap, or conflict with the proposal under consideration? What challenges or costs would your firm anticipate in complying with any such statutes or regulations and the CFPB's proposal under consideration? We are not aware of any duplicative or overlapping statutes or regulations.

Q7. What factors disproportionately affecting small entities should the CFPB be aware of when evaluating the proposal under consideration? Would the proposal under consideration provide unique benefits to small entities? N/A

<u>Specific Questions on Medical Debt Collection Information</u>
Q35. Under the proposals under consideration, would you anticipate that medical debt collectors would stop furnishing medical debt collection information to consumer reporting agencies and use alternative debt collection methods? If so, which ones? If the CFPB prohibits the sharing of medical debt information with consumer reporting agencies, we would expect debt collectors to comply.

Q36. To what extent do creditors currently use medical debt collection information when making credit eligibility determinations, including to comply with other laws or requirements? Do creditors use medical debt collection information for other purposes in connection with a credit transaction? N/A

Q37. From what sources do creditors obtain consumers' medical debt collection information, other than consumer reports? N/A

Q38. What are the pros and cons of an alternative approach of mandating a delay in the furnishing and reporting of medical debt for a particular period of time, and not reporting or furnishing medical debt below a particular dollar amount? Both

alternatives have merit. Only permitting reporting after a certain period has passed could preserve any disincentive for an individual to choose not to pay a medical bill for which they are both liable and able to pay while giving sufficient time to educate the patient on their obligations and provide the opportunity for repayment. Setting a minimum dollar value threshold to unpaid balances that may be subject to collections could prevent small dollar claims from disproportionately impacting an individual's credit score.

Q39. What are the pros and cons of an alternative approach of requiring consumer reporting agencies and furnishers, upon receiving a dispute, to conduct an independent investigation to certify that a disputed medical debt is accurate and not subject to pending insurance disputes? Requiring that consumer reporting agencies verify that any disputed medical debt is valid could help both preserve the disincentive to forego paying valid medical bills while preventing individuals from errors that could inappropriately damage their credit.

We appreciate your consideration of our comments. Please contact me if you have questions or feel free to have a member of your team contact Molly Smith, AHA's group vice president for public policy, at mollysmith@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development