hfma
healthcare financial management association

September 11, 2023

ATTN: Comment Intake
Medical Payment Products

Consumer Financial Protection Bureau
1700 G Street, NW,
Washington, DC 20552.

CFPB-2023-0038

Re: Request for Information Regarding Medical Payment Products

Dear Comment Intake Team:

The Healthcare Financial Management Association (HFMA) would like to thank CMS for the opportunity to comment on *Request for Information Regarding Medical Payment Products.* HFMA is a professional organization of more than 100,000 individuals involved in various aspects of healthcare financial management. HFMA is committed to helping its members improve the management of and compliance with the numerous rules and regulations that govern the industry.

Introduction

Hospitals are committed to fostering the health and well-being of their communities by delivering quality healthcare services. Their mission hinges on the accessibility of these services to patients, and as such, hospitals strive to eliminate any obstacles to care, especially financial ones. This commitment underpins their unwavering support for ensuring that every individual is enrolled in a comprehensive coverage plan. Moreover, when such coverage falls short, hospitals step in and contribute significantly by providing tens of billions in uncompensated care annually. In fact, in 2020, the most recent data available, hospitals extended over $42 billion in uncompensated care, according The AHA's 2020 Uncompensated Care Fact Sheet.

Hospitals embrace and bear the profound responsibility of caring for anyone who seeks their assistance, irrespective of their ability to pay. In essence, they stand as the sole pillar of the healthcare system burdened with this remarkable duty.

Simultaneously, ensuring the provision of top-notch healthcare necessitates the allocation of resources, much like any other commodity or service. These resources encompass the remuneration for the dedicated healthcare professionals, including nurses, doctors, technicians, and support staff, who tirelessly tend to patients. They also encompass the maintenance of physical infrastructure, procurement of medical equipment, pharmaceuticals, implementation of cutting-edge technology systems, and the acquisition of various essential supplies vital for the delivery of healthcare.

Hospitals predominantly derive their financial sustenance from compensations for the healthcare services they render. Given the capricious nature of healthcare demands and the potential exorbitant expenses associated with medical services, the United States healthcare system relies heavily on an insurance-based model to fund most healthcare services.

Regrettably, our healthcare coverage system contains significant gaps, leaving patients vulnerable. These gaps result from the sizable portion of the population lacking comprehensive health insurance, excessive cost-sharing requirements, and reduced coverage due to restrictions on benefits. Consequently, it's all too often that patients must explore alternative methods of covering their healthcare expenses, such as seeking assistance from a hospital's financial aid program.

However, it's crucial to acknowledge that these financial aid programs cannot bridge the widening gap caused by high-deductible coverages, and not all patients who incur medical bills may qualify for assistance. Consequently, patients explore other options to help bridge the gaps, including interest-free payment plans, loans, or credit cards.

The spectrum of medical payment options is extensive and varied, encompassing everything from zero-interest payment plans offered by healthcare providers to credit cards and loans from independent lenders. Hospitals and health systems vehemently oppose any medical payment products that could expose patients to exploitative terms. Nevertheless, it's essential to recognize that not all medical payment products are exploitative. Thus, we advise prudence when contemplating policies or practices to limit predatory products, as doing so should not inadvertently hinder patients' access to financing solutions that can assist them in covering their necessary healthcare expenses.

Patient Healthcare Costs

Patients may turn to medical payment options when faced with situations where their healthcare expenses surpass their financial capacity. These scenarios include being uninsured, facing exorbitant cost-sharing demands, effectively being "underinsured," and encountering unexpected medical bills due to insurer coverage changes or denials.

Individuals without health insurance are typically responsible for covering their entire medical expenses, although some may eventually find coverage or qualify for hospital financial assistance programs. Federal law mandates that hospitals must assess and stabilize any individual who arrives at the emergency department, but the government does not reimburse hospitals for this care.

While the current rate of uninsurance is relatively low, there are still over 25 million individuals in the United States who lack comprehensive health insurance. In certain states that have chosen not to expand Medicaid, as much as 18% of the population remains uninsured. These numbers are expected to increase as states continue to reevaluate Medicaid eligibility during the process of unwinding COVID-related public health emergency measures.

Subsequently, insured patients typically cover only a portion of their healthcare expenses out of pocket. This cost-sharing typically involves copays, deductibles, and coinsurance as determined by their health insurance plan. While cost-sharing was originally designed to discourage unnecessary healthcare utilization, some insurers have raised these expenses to levels that surpass what is necessary to address this concern, potentially imposing excessive financial burdens onto patients.

Patients now encounter significantly higher cost-sharing requirements compared to just 5 to 10 years ago. According to the Kaiser Family Foundation's 2022 Employer Health Benefits Survey, 88% of workers had a plan with a deductible in 2022, marking a significant increase from 72% in 2012. The average annual deductible for single coverage reached $1,562, representing a 95% increase from 2012. Additionally, the survey revealed that most patients with employer-sponsored coverage are subject to copayments for office visits, with average amounts of $27 for primary care and $44 for specialty care. Furthermore, most plans require coinsurance for healthcare services, which poses challenges for patients as it's now determined only after the completion of care when the final costs are known.

As mentioned earlier, with any individuals undergoing Medicaid coverage reassessment this year, it's crucial to highlight the substantial cost-sharing structure inherent in bronze plan offerings within the exchange. Enrolled individuals may confront a substantial annual deductible, which can reach as high as $9,100 for individuals and $18,200 for families in 2023. It's worth noting that these figures are set to increase to $9,450 and $18,900, respectively, in 2024.

The cost-sharing requirements passed on from health insurance plans are often beyond the means of many patients. A recent Federal Reserve report on U.S. household economic well-being showed that 37% of adults wouldn't be able to afford a $400 emergency, which is significantly less than the average annual deductible for single, employer-sponsored coverage, which is over $1,000. Consequently, it's not surprising that the same report revealed that 25% of adults reported forgoing medical care due to financial constraints, including 43% of those in poor health.

Apart from cost-sharing, healthcare insurance policies are also shifting more of the healthcare cost onto patients in other ways. They are increasingly reducing the scope of their coverage, in some scenarios, even for essential medical care. This is accomplished through coverage rules that limit which services are covered and where they can be received. Often, these changes in coverage are implemented during the year when patients and employers have limited options to switch plans. Recent instances of this include mid-year restrictions on coverage for specialty drugs, outpatient surgeries, and diagnostics. Patients who encounter denials due to these coverage modifications may face unexpected medical bills covering the full cost of their care.

Patients face significant challenges in planning and affording their healthcare due to a combination of factors such as high rates of uninsurance, rising patient cost-sharing demands, unjustified coverage denials, and patient uncertainty about their coverage. In this environment characterized by gaps in coverage caused by both uninsurance and underinsurance, patients may request alternative financing options, including various medical payment products, to assist in covering their healthcare expenses.

Medical Payment Products

Patients have various options to cover their portion of healthcare costs, including seeking financial assistance, immediate payment through their preferred method (cash, personal credit card, etc.), or exploring medical-specific financing options like payment plans, medical loans, or medical credit cards. In many scenarios, hospitals and providers may only be involved in or aware of certain payment arrangements. For instance, if a patient chooses to use a regular credit card for payment, the hospital typically isn't informed or involved in the terms of the agreement between the patient and the lender. This can also apply to medical-specific payment products that are available.

When a patient discusses their bill-related concerns to a hospital during their care path, they are assessed for eligibility for healthcare coverage and for financial assistance, regardless of whether they are uninsured or underinsured. All full-service hospitals, regardless of their tax status, are required to offer financial assistance policies. These policies can be customized to align with the specific needs of their communities while ensuring the hospital's financial sustainability and continued community access to care.

Moreover, HFMA and our membership of 100,000 plus members have been steadfast supporters and champions of HFMA's *Best Practices for Resolution of Medical Accounts*. These best practices establish industry-wide, uniform patient education and engagement strategies, focusing on the proper resolution of patient bills for medical goods and services. Within these guidelines, the existing 501(r) regulations set forth by the IRS are not only delineated but also endorsed as the best practices to ensure that hospitals fulfill their mandated community benefit obligations as per the tax code. Consequently, any proposed amendments or modifications to the existing regulations would essentially undermine the integrity of the IRS's 501(r) regulations.

The IRS's 501(r) regulations support patient-centered practices through:

- Limiting Extraordinary Collection Actions (ECAs): 501(r) regulations mandate that nonprofit hospitals must make reasonable efforts to determine whether a patient is eligible for financial assistance before engaging in ECAs, such as filing liens, wage garnishments, or reporting unpaid debts to credit agencies. This helps protect vulnerable patients from aggressive collection.
- Notification of Financial Assistance Policies: Nonprofit hospitals are required to clearly communicate their financial assistance policies to patients. This includes providing written notice about the availability of financial assistance and the application process. This transparency helps patients understand their options and rights.
- Fair Billing and Collection Practices: 501(r) regulations stress the importance of billing patients in a clear, concise, and understandable manner. Bills should include essential information about the services provided, the charges incurred, and any financial assistance available. Hospitals must also provide patients with plain-language summaries of their bills.
- Reasonable Billing Amounts: The regulations specify that the amounts charged to patients eligible for financial assistance must be limited to what would be billed to an individual with insurance. This prevents uninsured and underinsured patients from facing exorbitant charges.
- Prohibition of Discrimination: Nonprofit hospitals are prohibited from discriminating against patients based on race, ethnicity, or other protected characteristics. This ensures that all patients are treated fairly and without bias.
- Plain Language Communications: The regulations emphasize using plain language in all communications with patients, including financial assistance policies, billing statements, and collection notices. This helps ensure that patients can understand their rights and responsibilities.
- Community Health Needs Assessment (CHNA): Nonprofit hospitals must conduct a CHNA every three years to identify and address the health needs of their communities. This process involves soliciting input from the community, including patients, to better align services with community needs.

Hospitals often provide patients with alternative options for financing their care if they do not qualify for financial assistance. These options may include hospital-offered payment plans, which are often requested by patients based on feedback from both healthcare providers and consumer research. Additionally, some hospitals may directly offer loans or refer patients to third-party payment products that they have vetted and stand behind. However, patients may also secure independent financing outside of a healthcare provider's purview, such as personal loans or medical credit cards. Hospitals many times have no knowledge of whether a patient has obtained a personal loan or credit card for healthcare financing, and they are not bound by the terms of those arrangements.

Considerations for Policymakers

HFMA appreciates the Departments' attention to potentially concerning medical payment products, especially considering that Americans' high exposure to financial strain and debt is on the rise.

We highly recommend the agency take steps in addressing the underlying factors that prompt patients to turn to medical payment products, primarily by reducing the prevalence of unmanageable healthcare expenses. This can be accomplished by ensuring that all individuals have access to comprehensive healthcare coverage with affordable cost-sharing. Such an approach not only diminishes the necessity for medical payment products, thus mitigating the risks associated with potentially exploitative options, but also yields numerous advantages for patients, employers, communities, and healthcare providers.

The following are five concrete proposals aimed at preventing patients from encountering unaffordable healthcare costs:

1. Sustain efforts to ensure universal enrollment in comprehensive healthcare coverage for all individuals.
2. Consider allevaiating providers from the collection of cost-sharing by encouraging health plans, the entities determining enrollees' financial obligations, to directly collect the required cost-sharing amounts. This would significantly reduce patient bills from providers and other care givers.
3. Restrict the availability of high-deductible health plans to individuals who can demonstrate the capacity to afford the associated cost-sharing.
4. Prohibit the sale of health sharing ministry products and short-term, limited-duration plans that extend coverage beyond 90 days.
5. Lower the maximum allowable out-of-pocket cost limits.

HFMA looks forward to any opportunity to provide assistance or comments to support CMS efforts to address Americans' high exposure to financial strain. We take pride in our long history of providing balanced, objective financial technical expertise to Congress, CMS and advisory groups. We are at your service to help CMS gain a balanced perspective on these complex issues. If you have additional questions, please reach out to me or Shawn Stack, Director of Perspectives and Analysis at sstack@hfma.org or at 708.571.3955 ext. 607.

Sincerely,

Richard L. Gundling, FHFMA, CMA
Senior Vice President, Professional Practice
Healthcare Financial Management Association

About HFMA

HFMA is the nation's leading membership organization for more than 100,000 healthcare financial management professionals. Our members are widely diverse, employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant and consultant.

HFMA is a nonpartisan professional practice organization. As part of its education, information and professional development services, HFMA develops and promotes ethical, high-quality healthcare finance practices. HFMA works with a broad cross-section of stakeholders to improve the healthcare industry by identifying and bridging gaps in knowledge, best practices and standards.