Dear CFPB,

Located in Danville, Arkansas, Chambers Memorial Hospital, Inc. is a general hospital licensed with 30 private single-unit patient rooms to help patients feel more at home, as well as a 12 bed Behavioral Health Unit. Since 1956, Chambers Memorial Hospital has served the health care needs of Danville and surrounding communities by providing a range of medical services.

Chambers Memorial Hospital is a not-for-profit hospital that offers vital care while working to keep health care costs down. We are a motivated hospital where family values, teamwork and technology come together. We work closely with local schools and businesses to make a positive difference in the health and safety of our community.

Thank you for the opportunity to submit our response for the Small Business Advisory Review Panel for Consumer Reporting Rulemaking.

- **First**: As a small practice office, we want to express our concern over the rhetoric that is being used by the CFPB. We dispute that there are "inaccuracies" and that patients are billed "erroneously." The CFPB has provided no evidence regarding "inaccuracies." It is purposely conflating several issues related to insurance coverage and, with harmful results, making Americans think medical providers and their agents are purposely seeking to provide erroneous information. For example, the complaint database often includes mere questions, not actual disputes, and has a host of other issues that have been documented over the past decade. These so called "complaints" do not mean that most medical bills have "inaccuracies" and patients are billed "erroneously." Medical providers should not be treated differently than those in other professions, particularly as they are providing lifesaving care.
- **Second**: Medical debt is in fact predictive in nature and beneficial for the entire credit ecosystem, which is even shown in the 2014 CFPB study called "Data point: Medical Debt and Credit Scores." The CFPB has misstated that medical debt credit reporting provides no predictive value in several press releases and statements by the director and others in the CFPB using the language "no to little predictiveness." In addition, the data used in this statement is from 2011-2013, making it more than a decade old. The CFPB should halt any policymaking until it provides a recent, peer-reviewed study about this topic.
- **Third:** Small practice offices often operate on tight budgets, and any delay in receiving payments can have a significant impact on our ability to provide quality health care services. Most medical providers can't absorb this cost and will be forced to increase prices, require upfront billing, or deny care affecting all consumers. This causes larger issues for rural and poverty-stricken areas.
- **Fourth:** This change could be good for a small number of consumers (although taking on new debt they cannot afford due to missing information on their credit report has many risks), but bad for the majority of consumers. Reporting to the credit bureaus ensures fairness to consumers who consistently fulfill their financial obligations. It helps in distinguishing between those who are genuinely facing financial hardships and need assistance, and those who are neglecting their responsibilities. Without this reporting

mechanism, responsible payers will bear the burden of higher health care costs due to the increased likelihood of bad debt.

- **Fifth**: The perceived and/or real accountability created by credit bureaus' reporting has secondary impacts that aren't obvious, including a decrease in the rate in which healthy Americans have health insurance if no accountability is required (the Affordable Care Act requirement of health insurance is gone so why would a healthy, young American have health insurance if there are no repercussions for not having insurance?). The accountability to respond to medical providers' communications in a timely manner is already a difficulty they face. Removing any accountability will prevent medical providers from receiving needed insurance conversations about coordination of benefits (primary and secondary insurance), accident survey requests and financial assistance paperwork responses.
- **Sixth**: Health care policy is complex. Congress and the regulatory agencies that have jurisdiction over medical providers should be shaping, or at the very least be involved in creating, any new policies in this area. These stakeholders include government regulators, payers—whether commercial or governmental—medical providers, employers and their plans that provide unaffordable coverage, and patients, among others.
- **Seventh**: The SBREFA requires that small entities should have the opportunity to talk about the impact of potential changes. This is not what the CFPB has provided. The CFPB has left out key definitions and other information that would be needed to accurately determine the impact on small entities. Thus, the CFPB should conduct a SBREFA process where stakeholders have a meaningful opportunity to provide informed comments.

In conclusion, we urge you to go back to the drawing board and further study this issue in coordination with all stakeholders.

Thank you for your attention to this matter.

Sincerely,

Alexis Keeling
Chambers Memorial Hospital
Collections/Program Specialist

Feedback for SBREFA Questions

Q1. How, if at all, will the proposal under consideration require your firm to change its operations, products, or services?
Answer: Removing all medical debt from the credit bureaus will cause significant operational changes. We will have to consider implementing that following:

- Require up-front payments based on estimated costs.

- Require credit cards with authorization forms completed before services are provided.
- Refuse service for patient populations with the lowest ability to pay. A large percentage of our patient population.
- Refuse all non-emergent services if the consumer has a past due account.
- Increase our prices to offset the reduction in revenue.
- Ask for increases in small claims/legal actions to maintain collections.

Q4. What alternative approaches, if any, should the CFPB consider in lieu of the proposal under consideration?

Answer:

1. Require credit bureaus to statistically edit medical debt or other debt classifications' predictiveness to be similar in nature. In this alternative approach, it would require credit bureaus to submit a third-party audited study of all types of debt in the 15 different "Creditor Classifications" from the Metro2 data file received by the credit bureau from data furnishers. The study would determine that debts of similar profile of "like" balances and "creditor classifications" predictiveness be plus or minus 2% accuracy for future repayments and future delinquencies. This report would be required to be provided to the CFPB once every 12 months to ensure "fairness" of all debts predictiveness.
2. Wait to determine the impacts of the March 31, 2023, credit bureau changes before proposing regulations.
3. Do nothing. Penalizing one industry/one type of debt is unfair to medical providers.

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?

Answer: Consider other answers listed as contributing factors

1. Overall decrease in patient satisfaction and patient population secondary to up front payment required, increase in charges to offset lost revenue and possibility of ability to provide all current services.
2. Possible pay cuts or layoffs, increasing stress and further increase of burn out contributing to the overall shortage of healthcare professionals currently.
3. Avoidance of receiving necessary healthcare as most of the population in rural areas will be unable to afford stimulation that are going to come because of this. Which are listed above in Q1.

Alternatives at this time as simple as revisiting the proposal entirely as well as considering how this will negatively impact small practices such as ourselves.

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?

Answer:
Many times, we are the medical provider of last resort for many of these patients. The bigger providers with thousands of employees may be able to absorb the cost, but not the small companies. There are zero benefits.

Q32. How might the CFPB define "systemic" issues for purposes of the proposals it is considering? What may be the cause(s) for a furnisher or consumer reporting agency to have erroneous reporting for multiple consumers of the same type (e.g., issues with common processes, policies and procedures, infrastructure limitations, training)? How does your firm become aware of systemic issues that cause consumer reporting errors?

Answer:
We dispute the premise of this question and first ask the CFPB to showcase holistically, with all patient populations the problem of inaccuracies and erroneous reports. The complexities of multiple stakeholders create confusion for patients and pit the provider vs. payer, payer vs. employer, and provider vs. patient. The CFPB is not the regulatory body suited to solve this.

Q33. If furnishers or consumer reporting agencies (or both) investigate and address systemic issues that may be causing consumer reporting errors affecting multiple consumers, based upon a single consumer's notice of dispute, what kind of notice should go to other potentially similarly situated consumers affected by the systemic issue? At what point(s) of the process? What should that notice(s) say?

Answer:
We don't believe there are systematic issues and as such no notice should be created as it will only increase the cost with no added benefit.

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?

Answer:
Pros:

1. Accessing the March 31 credit bureau changes could support the CFPB's position, therefore this is a pro to at least attempt to access the current self-regulated/free-market credit bureau changes first before, as the CFPB states, "mandating" a change.
2. If the timing of this delay was coordinated with the Affordable Care Act's's IRS 501r requirement of 240 days from the date of the first statement, additional accountability could be created to ensure financial assistance applications are received in a timely manner. If 240 days was also used by CMS for insurance requirements of "timely filing" requirements, it would take all stakeholders into account.

Cons:

1. Delays could cause less accountability by patients, which will hurt "timely filings" for insurance eligibility.
2. Mandating vs. allowing the "free market" approach to be realized could create future issues as the regulation itself could have unintended consequences in later years that we can't fully comprehend.
3. Balance thresholds penalize doctors' offices whose services are the least expensive per procedure. Examples of this include radiology, chiropractic, dentist, pathology, and dermatology to name a few. This creates an imbalance in priority to which even a medical debt is paid. It also creates "winners" and "losers" in regulation.

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?

Answer:

Pros:

1. **Independent Investigation from the insurance company**. The dispute process should require insurance companies to answer the dispute first—not the data furnisher or the medical provider. This would bring all stakeholders full circle to discuss the dispute. Today insurance companies regularly advise their "clients/patients" to argue medical billing "codes" were inaccurately used and/or the insurance companies deny claims on behalf of patients based upon obtuse requirements put on the providers or patients. Payments are delayed and cause additional administrative costs to the system. Requiring insurance companies to first confirm or reject the dispute of the patient will eliminate the false positives that are occurring in today's dispute process. This ensures all disputes are accurate, moving toward the second step of answering from the data furnishers who would then work with their medical providers.

2. **The CFPB's recognition that if medical debt is eliminated altogether from the credit reporting process, the dispute process itself will cease to exist.** The dispute process allows credit bureaus to monitor the approach that collection agencies themselves are taking to collect on accounts instead of an obscure or, even worse, unknown process.

Q43. For each of the proposals under consideration above, do you expect that your practice would restrict or eliminate any product or service offerings to comply with the rule? If so, how would the proposals impact those products or services?

Answer:

- Require up-front payments based on estimated costs.
- Require credit cards with authorization forms completed before services are provided.
- Refuse service for patient populations with the lowest ability to pay. Which, again, is a large percentage of our patient population.
- Refuse all non-emergent services if the consumer has a past due account.
- Increase our prices to offset the reduction in revenue.

- Ask for increases in small claims/legal actions to maintain collections.

Q44. For each of the proposals under consideration above, please provide information, data, and/or estimates of impacts to your firm's business operations and revenue, including to both current operations and revenues and to future operations and revenues that could potentially be lost.

Answer:
With the proposed removal of medical debt, we expect our revenue to decrease by 5-10% annually. As understanding of the novel regulations spread across our patient population revenue would continue to decrease as there are no consequences for neglecting balances.
We calculated this by:

1. Actual revenues returned during the collection process.
2. Revenue decreases as medical debt priority for patients is decreased overall in comparison to past years (2022, 2023 and current 2024 fiscal year).

Q46. What benefits do you expect small entities may experience from any of the proposals under consideration listed above?

Answer:
None. This will create a larger competitive advantage for the large players, pushing many more of the small players out of the business.

Q47. Would the proposals under consideration affect the cost and availability of credit to small entities?

Answer:
We would assume yes. A reduction in cash flow will make small entities have a much greater credit risk, especially as we look to transfer our business to future ownership generations.