November 21, 2023

VIA ELECTRONIC DELIVERY

Consumer Financial Protection Bureau
1700 G Street, N.W.
Washington, DC 20552
CFPB_consumerreporting_rulemaking@cfpb.gov

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

To Whom It May Concern:

The Emergency Department Practice Management Association (EDPMA) and the Healthcare Business Managment Association (HBMA) respectfully submit the following comment on the Small Business Advisory Review Panel for Consumer Reporting Rulemaking Outline of Proposals and Alternatives Under Consideration ("Outline of Proposals"). In particular, we write with respect to aspects of the Outline of Proposals that would prohibit creditors from considering information on medical debt collections and consumer reporting agencies from reporting such information. (the "Medical Debt Proposals"). *See* Outline of Proposals, § III.D, at 18.

In better understanding the practice of emergency medicine and how the Medical Debt Proposals affect emergency medicine physicians and groups specifically, it is essential that the reader take into the account the federal unfunded mandate and the associated obligations imposed on our practices by the Emergency Medicine Treatment and Labor Act. ("EMTALA")[1]

As your office likely knows well, since 1986, EMTALA requires of emergency physicians that … "if any individual … comes to the hospital and a request is made by or on the individual's behalf for examination or treatment of a medical condition, the [emergency physician] must provide an appropriate medical screening examination to rule out the presence of an emergency medical condition." It goes not to further state, that should an emergency medical condition exist, the emergency physician must provide that individual with sufficient care and stabilizing treatment without regard for that individual's ability to pay for such services. While emergency physicians openly embrace its EMTALA obligation, we believe that barriers to payment after the EMTALA obligation has been satisfied place undue hardships on our

[1] 42 U.S. Code § 1395dd - Examination and treatment for emergency medical conditions and women in labor

practices, and the Medical Debt Proposals reflected add undue financial hardship to our practices and impair our ability to deliver high-quality, cost-effective emergency care in accordance with EMTALA.

For the reasons stated below, we respectfully submit that the changes under consideration by the CFPB would not only mark a significant departure from longstanding law and public policy, but would also be contrary to the purposes of the Fair Credit Reporting Act ("FCRA"), harm patients and their emergency medicine physicians, most particularly small-sized physician groups who represent a significant proportion of our membership: emergency medical groups and their small, mainly sole-proprietor, revenue-cycle business partners who take on the responsibility to bill insurance carriers and patients.

The Emergency Department Practice Management Association

EDPMA is the nation's only professional physician trade association focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA membership includes emergency medicine physician groups of all sizes and ownership models, as well as billing, coding, and other professional support organizations that assist healthcare providers in our nation's emergency departments. EDPMA members see or support 60% of all annual emergency department ("ED") visits in the country.

The Healthcare Business Management Association

HBMA is a national non-profit professional trade association for the healthcare revenue cycle management industry. HBMA is a recognized revenue cycle management (RCM) authority by both the commercial insurance industry and the governmental agencies that regulate or otherwise affect the U.S. healthcare system.

HBMA members have an essential role in the operational and financial aspects of the healthcare system. Our work on behalf of medical practices allows physicians to focus their attention and resources on patient care - where it should be directed - instead of on the many administrative burdens they currently face. The RCM process involves everything from the lifecycle of a claim to credentialing, compliance, coding and managing participation in value-based payment programs.

The Medical Debt Proposals and Questions

Through the Medical Debt Proposals, the Bureau is considering whether to: (i) revise Regulation V to prohibit creditors from obtaining or using medical debt collection information to make determinations about consumers' credit eligibility (or continued credit eligibility) and (ii) prohibit consumer reporting agencies from including medical debt collection tradelines on consumer reports furnished to creditors for purposes of making credit eligibility determinations. *See* Outline of Proposals, § III.D, at 18.

The CFPB has solicited comments on a number of questions that apply to all the proposals as well as some questions specific to certain proposals. Among the questions applicable to all proposals, including those relating to Medical Debt, are those relating to the costs of complying with the proposals (Q2), aspects of complying with the proposal that would be most troubling (Q3), alternative approaches that the CFPB may wish to consider (Q4), costs, burdens, and unintended consequences of the proposals (Q5), and statutory obligations that may conflict with the proposals (Q6). With this correspondence we are addressing these questions.

Accuracy of Furnished Information
The fundamental purpose of the Fair Credit Regulation Act ("FCRA") is to promote accuracy, fairness, and the privacy of consumer information. 15 U.S.C. § 1681(a). As Congress noted in enacting the FCRA, "[t]he banking system is dependent upon fair and accurate credit reporting." 15 U.S.C. § 1681(a)(1). These goals, however, would be hindered rather than advanced by the Medical Debt Proposals, which would likely result in substantially less consumer bureau reporting and increased costs to those who rely on robust and complete information in consumer reports, with little to no corresponding benefit to consumer privacy or other public policy objectives.

EDPMA and HBMA strongly support accurate credit bureau reporting. However, there is little evidence that medical debt collection information is less accurate than information relating to other types of debt collection. In the Outline of Proposals, the CFPB relies largely upon its 2014 study related to medical debt collection. *See* Consumer Fin. Prot. Bureau, *Consumer credit reports: A study of medical and non-medical collections* (Dec. 2014) (herein "2014 Study"). That report, however, is nearly ten years old, during which time there have been significant developments to enhance the accuracy of collection information. Most recently, the Bureau's Regulation F, which took effect on November 30, 2021, requires debt collectors (including medical debt collectors) to communicate with consumers and offer them an opportunity to dispute the debt prior to the debt collector furnishing information to a consumer reporting agency. 12 C.F.R. § 1006.30(a). Accordingly, whatever the validity of the findings from the 2014 Study, there is little reason to believe they bear on the accuracy of data being currently furnished.

It is also important to note that *predictive value* of data is not the same as *accuracy*. Congress has expressly allowed information relating to medical debt to be reported and used in assessing a consumer's creditworthiness, leaving it to users of the information to evaluate whether it is sufficiently predictive and whether they wish to make use of such information. Creditors and others who use consumer reports have every incentive to use only information that is predictive of risk. Moreover, creditors must notify consumers of the reasons taken for adverse action, and consumers have the legal right to dispute the validity of furnished information and require furnishers to investigate the accuracy of that information—thus providing substantial protection to consumers with respect to potentially inaccurate information. *See* 12 C.F.R. § 1002.9; 15 U.S.C. §§ 1681m(a), 1681s-2(b). And while Congress is currently considering legislation to restrict the use of medical information,[2] given the statutory purposes of the FCRA, this decision clearly must be left to Congress, not to rulemaking.

We also are concerned that the CFPB appears to be drawing misleading conclusions about the accuracy of medical debt information based on *dispute volume*. The CFPB's 2014 Study cites a 2012 Federal Trade Commission ("FTC") report about consumer reporting accuracy that largely relied on consumer disputes and the responses to those disputes to assess accuracy of furnished information. *See* FTC, Report to Congress under Section 319 of the Fair and Accurate Credit Transactions Act of 2003 (Dec. 2012). However, the fact that a consumer has disputed a

[2] Bill to amend the Fair Credit Reporting Act to prohibit the inclusion of medical debt on a consumer report, and for other purposes, H.R. 6003, 118th Cong. (2023); Consumer Protection for Medical Debt Collections Act, H.R. 1773, 118th Cong. (2023); Medical Debt Relief Act of 2023, S. 3103, 118th Cong. (2023).

debt does not mean that such information is inaccurate. Indeed, as the FTC noted in its report, "not every alleged error is in fact an error." *Id.* at 36. For instance, disputes may arise from consumer unawareness of the debt or misunderstanding of the portion of medical expenses covered by insurance, particularly, and most notably, the prolific trend by commercial insurers to shift a greater share of the patient's health benefit to the consumer in the form of greater out-of-pocket cost reflected in increased co-payments, deductibles, and non-covered benefits. Moreover, as noted above, since the time of the FTC's report, there have been significant legislative and regulatory developments to improve billing transparency and consumer notice of debts, including the promulgation of Regulation F and the enactment of the *No Surprises Act*, 26 U.S.C. § 9816, which effectively protects patients from surprise medical billing, which historically was a basis for inaccurate credit bureau reporting, which is no longer the case today. In sum, there is no reason to believe that more than 10-year-old information relied upon by the Bureau, which was itself based on inferences from dispute volume, is relevant to the accuracy of furnished data today.

The Outline of Proposal also solicits comments on whether, rather than barring the reporting of medical debt collections altogether, the Bureau should establish a minimum dollar threshold or a time delay before such information would be reported. And while EDPMA and HBMA do not support the premise in the aforementioned Outline of Proposal with respect to an outright prohibition on credit bureau reporting, should the Bureau choose to take a firm position on this question, we believe a narrow exception must be established as well, on the basis of the need for the protection of small business, namely, small sized emergency medicine physician groups and their small-sized revenue cycle partners.

To this extent, EDPMA and HBMA strongly support and encourage the Bureau to adopt a narrow exception to its Outline of Proposal, one that would allow for a waiver specific for consumers who are: (i) beneficiaries of commercially insured health benefit plans, (ii) for which the undisputed debt in question is under $500, *adjusted for inflation*, and (iii) reflects patient co-payments, deductibles and non-covered services.

The basis for this exception is based on the important understanding that uninsured and indigent consumers of medical debt would *not* fall under this exception and thus remain within the protections described in the Outline of Proposal. Our members remain committed to ensuring access to the indigent and uninsured as it is those specific consumers who are most likely affected by access barriers to health care services; further, credit bureau reporting of indigent consumers does not serve our members and only exacerbates the barriers to accessing care for this vulnerable population that we're trying to protect.

Alternatively, our members believe that the vast majority of the commercially insured consumers that would fall within our recommended exception are financially able to pay these debts without hardship. Additionally, the commercially insured consumers who fall within this exception would be spared from the increased costs that would likely otherwise be incurred as small physician groups, in lieu of previously allowed credit reporting, would now seek resolution of these same debts through the courts. That would result in litigation judgments and increased court costs and fees against these consumer debtors as part of the resolution of that action that would otherwise have been avoided through credit bureau trade line reporting.

Additionally, it is important to know that many of our emergency physician members advise they are currently in certain markets resolving as little as less than 10% of the balance of cost-sharing debts with commercially insured patients and this rate of collections continues to decline. This is an unsustainable rate of collection as more and more of this debt is shifted from the insurer and health benefit plan to the consumer. It is important to also further note that credit bureau reporting by our members of commercially insured consumers allows our members to resolve debts owed to them by this class of debtors but only over time, and only when the debtor consumer seeks financial credit, predominately on large purchase items such as homes, autos and boats and only as a means to satisfy and clear the debtor's credit report to allow for the consumer debtor to consummate the desired purchase. Additionally, we believe that medical costs incurred by consumers overall will increase and not just to this select group of individuals (i.e., commercially insured individual debtors who have failed to remit payment on copayments and deductibles). This would in fact penalize a broader population of consumers and would not be limited to consumer debtors who do, in fact, have the ability to remit payment but choose not to and do so solely because credit reporting enforcement is removed.

EDPMA and HBMA share the Bureau's interest in appropriate safeguards in connection with data furnishing practices and agree that a seasoning requirement or delay in reporting may promote accuracy. In this regard, however, we note that medical debt is *already* reported at the collections phase, not at the time of billing. Moreover, the accuracy of information furnished by debt collectors is promoted by Regulation F, which requires that collectors give consumers notice of debts submitted for collection and the opportunity to dispute them prior to reporting.

Despite these existing safeguards, EDPMA and HBMA would support a reasonable delay in reporting medical debt collections, tied to the date of medical service, in order to ensure that all reasonable efforts could be made to qualify patients for financial assistance, identify third party sources of payment, and bill and collect from such payors. In addition, in those cases where a third-party payor, such as insurance carrier or health benefit plans, pays a collection account, and the consumer has no further liability for commercially insured co-insurance, co-payments, deductibles or non-covered benefits, EDPMA and HBMA would support the deletion of the trade line in furtherance of the goal of accuracy.

In lieu of that, we respectfully submit and request that the Bureau adopt a narrow exception to its proposed Outline that recognizes the ever-increasing trend of the shifting of health care costs from insurers to consumers resulting in reduced health benefits from third party insurers and health benefit plans. Our specific request is to create an exception that would allow for trade line credit bureau reporting of commercially insured consumers on undisputed debts of less than $500, *adjusted for inflation*, representing patient cost-sharing of copayments, deductibles or non-covered health care services and benefits.

Fairness to Consumers, Providers, and Patients

The consumer credit ecosystem operates most efficiently—and promotes fairness—when there is open and robust access to payment history data. EDPMA and HBMA are concerned that the CFPB's proposal would run contrary to those principles.

We believe that creditor access to consumers' payment record for all types of debt, including collections accounts, best serves the overall interest of consumers. In particular, any rule that restricts or prohibits the reporting or consideration of accurate medical debt collection

information means that the quality of information available to creditors will be reduced. As a result, risk scoring systems cannot operate at maximum efficiency, lender costs (and thus consumer prices) will be pushed higher, and consumers with better credit histories, including a record of repaying medical debts, will effectively subsidize those who have not paid such obligations.

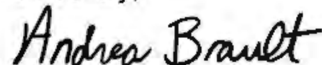
Notwithstanding these significant concerns, EDPMA and HBMA would support a more limited approach of restricting small dollar collections to co-pays and deductibles of less than $500. As noted above, the reporting of a consumer's history of paying debts associated with co-pays and deductibles raises minimal concerns regarding accuracy. Moreover, allowing the reporting of such information would be unlikely to negatively impact indigent individuals and by definition would not impact individuals who lack insurance.

Providing creditors with access to medical payments data also promotes fairness to physicians and their patients. If medical debt is treated differently than other forms of debt and broadly excluded from consumer reports, consumers may prioritize the payment of other debt. This in turn would ultimately harm medical service providers, many of whom operate on thin margins, and struggle to continue providing care to vulnerable consumers. In addition, where medical debts are not paid, collectors will have little recourse but to resort to litigation, a costly and inefficient approach that burdens the system as a whole.

In sum, EDPMA and HBMA submit that fairness to consumers, providers, and patients is best served by allowing the reporting of accurate medical debt payment history.

We appreciate the opportunity to provide feedback on the Medical Debt Proposals. If you have any questions, please contact EDPMA Executive Director, Cathey Wise at cathey.wise@edpma.org and HBMA Executive Director, Brad Lund at brad@hbma.org.

Sincerely,



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