From: Denise Coppens
To: CFPB_consumerreporting_rulemaking
Subject: CONCERN
Date: Monday, October 23, 2023 2:12:26 PM

Dear CFPB – Small Business Advisory Review Panel,

We write to you with deep concern and frustration regarding the recent statements made by the Consumer Financial Protection Bureau (CFPB) in their assessment of medical billing practices. We vehemently reject the assertion that there are widespread "inaccuracies" in medical billing or that patients are consistently billed "erroneously." These claims are not only unsubstantiated but also damaging to the medical community and the patients we serve. We demand concrete evidence from the CFPB to support these allegations, or we insist that such statements cease immediately.

First and foremost, the CFPB's reliance on a limited and biased complaint database is deeply flawed. These complaints represent only a fraction of patient interactions and often lack the perspective of medical providers. To label these isolated incidents as representative of the entire healthcare system is not only misleading but also divisive. It creates unnecessary hostility between patients and the medical professionals dedicated to saving lives.

Secondly, the CFPB's dismissal of the predictive nature of medical debt is a grave oversight. Contrary to their assertions, numerous studies, including the 2014 CFPB study "Data point: Medical debt and credit scores," have demonstrated the predictive value of medical debt in assessing creditworthiness. The CFPB's outdated data and misrepresentation of this fact undermine their credibility. We urge the CFPB to update their research, considering the recent industry changes post-March 31st, to provide an accurate picture of the situation.

Furthermore, the proposed changes disregard the financial realities faced by small physician offices. Delays in payments significantly impact our ability to deliver quality healthcare. Forcing providers to absorb these costs could lead to higher prices, upfront billing, or even denial of care. Such consequences would affect all consumers and exacerbate the challenges faced by the healthcare industry.

The removal of accountability through credit bureau reporting may seem advantageous to a select few consumers but is detrimental to the majority. Reporting ensures fairness by distinguishing between those facing genuine financial hardships and those neglecting their responsibilities. Without this mechanism, responsible payers bear the burden of higher healthcare costs due to increased bad debt.

Moreover, the proposed changes have far-reaching consequences beyond the immediate scope. The removal of accountability could lead to a decrease in health insurance coverage among healthy individuals, jeopardizing the entire healthcare system. Additionally, it hampers communication between medical providers and insurance companies, hindering critical processes like coordinating benefits and providing financial assistance.

Lastly, we emphasize the need for transparency and clarity in the regulatory process. The current submission lacks the necessary details of the proposed regulation, falling short of the requirements outlined in SBREFA. We demand a comprehensive outline of the regulation before any further steps are taken in this process.

In conclusion, we urge the panel to halt any consideration of the proposed rulemaking until a new, comprehensive study is conducted using updated data reflecting the recent industry changes. It is imperative to recognize the impact on medical providers, patients, and the credit ecosystem. Failing to do so risks compromising the accuracy of information, increasing lending costs, and imposing undue hardships on both providers and patients.

Sincerely,

INSPIRIT THERAPY ASSOCIATES

Feedback for 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 bureau will cause significant operational changes. We will implement that following -

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

- Ask increase 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 that credit bureau's 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 Classification" 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 twelve 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 – We expect our revenue will decrease by 11% or $299.96. We have already experienced decreases in revenue from March 31st removal of balances $500.00 and less from the credit bureaus and removing the remaining portion of accounts will be more significant.

As for unintended consequences, CFPB removal of medical debt from the credit bureau eliminates the incentive to carry health insurance, which will raise the costs for those that do. Removing accountability would risk young healthy American's need for health insurance. Individuals will choose to be uninsured, saving thousands of dollars a year.

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 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 31st credit bureau changes could support the CFPB's position as such this is a pro to at least attempt to access the current self regulated/free market credit bureau changes first before as CFPB states it "mandating" a change.

2. If the timing of this delay was coordinated with ACA'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 fillings" for insurance eligibility.

2. Mandating versus 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. Thereby creating "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 Insurance Company -** The dispute process should require insurance companies to answer the dispute first and not the data furnisher or the medical provider. This would bring full circle all stakeholders 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 then ensures all dispules are accurate, moving towards the second step of answering from the data furnishers who would then work with their medical providers.

2. The recognition of the CFPB that if medical debt is eliminated altogether from the credit bureau process and thereby the dispute process itself will cease to exist is a positive or pro. 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 worse unknown process.

Q43. For each of the proposals under consideration above, do you expect that your firm 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.
- Refusing service for patient populations with the lowest ability to pay.
- Refusing all non-emergent services if consumer has a past due account.
- Increase our prices to offset the reduction in revenue.
- Ask increase 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 by299.96.

We calculated this by:

1. Actual revenues returned during the collection process.
2. Revenue decreases as medical debt priority for patient is decreased overall

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 a much greater credit risk especially as we look to transfer our business

to future ownership generations.

Thank you for your time,
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