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Consumer Financial Protection Bureau
Department of Health and Human Services, Centers for Medicare & Medicaid Services
Department of the Treasury

Re: Request for Information Regarding Medical Payment Products
Docket Numbers CFPB–2023–0038; CMS–2023–0106; TREAS–DO–2023–0008

The undersigned organizations submit these comments in response to the above-referenced Request for Information Regarding Medical Payment Products (RFI). We represent a diverse coalition of advocacy organizations that share a commitment to improving health care.

We thank the Consumer Financial Protection Bureau (CFPB), Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), and Department of the Treasury (Treasury) (collectively, the "Agencies") for their attention to medical payment products. As you know, these products can increase medical debt for the most financially vulnerable patients and contribute to deep health inequities in our current health system. We applaud the Agencies' thoughtful questions and coordinated approach to this issue and request that the Agencies continue to collaborate to also address the underlying causes that leave many patients with medical debt.

In this response, we ask that the CFPB: (1) prohibit the offering and promotion of deferred interest credit cards in health care settings; and (2) ban the inclusion of all medical debt on credit reports. We ask that HHS: (1) enact Conditions of Participation to reduce hospital debt and prohibit the most harmful collection actions by hospitals; and (2) address high rates of denials by private insurance companies and by Medicaid managed care organizations (Medicaid MCOs). Finally, we ask that Treasury: (1) strengthen and enforce current regulations for nonprofit hospitals relating to financial assistance policies and collection actions; and (2) reinstate previous guidance requiring nonprofit hospitals to provide charity care.

General Questions

1. **What are the benefits, costs, and risks of medical payment products for consumers, health care providers, and companies offering these products?**

    a. **Overview**

Medical payment products carry financial risks for many patients. These products can increase the amount of medical debt that patients hold through high interest rates. Further, medical payment products may be used in place of financial assistance or traditional interest-free payment plans with the provider. Ultimately, these products may exacerbate existing inequalities in medical debt.

Undoubtedly, medical payment products also provide benefits. For instance, these products reduce administrative hassles for providers, such as handling insurance denials or administering payment plans. Medical payment products also help some patients to access care that they could not otherwise afford. Overall, however, we believe that the underlying issues making health care unaffordable should be addressed by federal action, not financing products.

b. Deferred Interest Medical Credit Cards

For deferred interest medical credit cards, the harms outweigh the benefits. Deferred interest medical credit cards pose financial risks to patients, particularly those who are already financially vulnerable. Deferred interest credit cards offer significant benefits to providers, however, which incentivizes providers to promote these products instead of offering financial assistance to patients. We urge the CFPB to prohibit the offering and promotion of deferred interest credit cards in health care settings.

Deferred interest credit cards pose the following risks to patients:

1. Deferred interest charges. If patients do not pay the full balance by the end of the promotional period, they incur interest dating back to the purchase date, including interest on amounts that have already been paid off.

2. High interest rates. The average deferred interest credit card carries a higher interest rate than the average general purpose credit card.[1]

3. Harm to credit scores. Even a single late or missed payment on a credit card may adversely impact the patient's credit score within 30 days.[2] Nonprofit hospitals may not make adverse credit reports until at least 120 days after the initial billing statement,[3] and the three largest consumer credit reporting agencies have voluntarily agreed to wait one year before reporting, as well as removed medical debt under $500 from credit reports.[4] However, patients lose these protections when they put medical bills on credit cards as it is then treated as any other form of debt and not medical debt.

4. Loss of opportunities for payment plans or financial assistance. Traditionally, providers have offered interest-free payment plans or financial assistance to patients who could not

[1] CFPB, Prepared Remarks of Director Rohit Chopra for the CFPB Hearing on Medical Billing and Collections, July 11, 2023 ("The typical medical credit card has an interest rate of 27 percent — substantially higher than the 16 percent average for general purpose credit cards."), https://www.consumerfinance.gov/about-us/newsroom/prepared-remarks-of-director-rohit-chopra-for-the-cfpb-hearing-on-medical-billing-and-collections/.
[2] Equifax, "When Does a Late Credit Card Payment Show Up on Credit Reports?" https://www.equifax.com/personal/education/credit-cards/when-late-credit-card-payments-post/ (accessed Aug. 10, 2023).
[3] 26 C.F.R. § 1.501(r)-6(c)(3)(i).
[4] CFPB, "Have medical debt? Anything already paid or under $500 should no longer be on your credit report," May 8, 2023 (noting that the voluntary removal of medical debt under $500 does not include medical expenses on credit cards), https://www.consumerfinance.gov/about-us/blog/medical-debt-anything-already-paid-or-under-500-should-no-longer-be-on-your-credit-report/.

afford the full payment at once. However, patients lose these options when they put the entire payment on a medical credit card.

5. Less opportunity to correct billing errors. Medical billing errors are common. For instance, some estimate that 80 percent of medical bills contain an error.[5] When patients put medical bills on a credit card, however, they can no longer resolve billing errors by calling their provider directly.[6] Instead, patients must initiate a dispute with a credit card company in order to correct the bill.[7] Indeed, Synchrony Bank appears to have disclaimed any responsibility for assisting patients with improper charges or amounts that should have been billed to an insurer, noting: "[I]t is up to the hospital to determine how best to bill for care, and how much to bill for care."[8]

6. Less likelihood of using retroactive Medicaid to pay for care. Patients who qualify for Medicaid are generally eligible for up to three months of retroactive coverage.[9] When patients have already signed up for a medical credit card, however, they may be less likely to use their retroactive Medicaid coverage because the cost of care has already been financed.

Providers have an incentive to offer medical credit cards rather than payment arrangements that would be more beneficial to the patient. Specifically, medical credit cards provide the following benefits for providers:

1. Prompt payment and no risk from patient default. For instance, CareCredit offers an attractive financing solution for health and dental providers because it reimburses the provider within two days.[10] CareCredit assumes the full risk of the patient's delay or default in payment.[11] In contrast, health care providers have traditionally offered long-term payment plans when patients cannot afford the cost of their treatment.[12] These payment plans generally do not include interest, and the provider's office assumes the risk of the patient not paying the full cost for treatment already rendered.[13]

2. Payment of full charges. Providers have an incentive to steer patients to medical credit cards rather than offering financial assistance. For instance, three Senators recently raised concerns that: (1) patients who use medical credit cards may be paying the

[5] Modern Healthcare, "Identifying & Addressing Common Medical Billing Errors Pre- & Post-Payment," Aug. 29, 2019, https://www.modernhealthcare.com/finance/identifying-addressing-common-medical-billing-errors-pre-post-payment.
[6] CFPB, "What should I know about medical credit cards and payment plans for medical bills?" May 28, 2023, https://www.consumerfinance.gov/ask-cfpb/what-should-i-know-about-medical-credit-cards-and-payment-plans-for-medical-bills-en-1827/.
[7] *Id.*
[8] Synchrony Bank letter to Senators, at 2, Jan. 26, 2023, https://www.warren.senate.gov/imo/media/doc/Medical%20Credit%20Card%20Companies%20Responses.pdf.
[9] 42 CFR § 435.915.
[10] https://www.carecredit.com/providers/how-it-works/.
[11] *Id.*
[12] Allison J. Zimmon, "Rx for Costly Credit: Deferred Interest Medical Credit Cards Do More Harm Than Good," 35 B.C. J.L. & Soc. Just. 319, 326 (2015).
[13] *Id.*

"chargemaster" rates for services (list prices that virtually no payor reimburses); and (2) patients might be offered financing even if they would otherwise qualify for financial assistance.[14] The response of Synchrony Bank, which owns CareCredit, indicates that its provider agreements do not offer any specific protections against these risks.[15]

3. Avoid insurance hassles. Medical credit cards like CareCredit appear to reimburse providers without requiring prior authorization, documentation of medical necessity, or evidence of the appropriateness of charges.[16] This makes these products more convenient than insurance coverage.

    a. In particular, providers may prefer CareCredit or other medical credit card financing to Medicaid reimbursement rates, which are "notably low."[17] Indeed, news articles have documented cases of dentists in California steering Medicaid patients to CareCredit cards instead of submitting claims to Medicaid.[18] California responded by prohibiting health and dental providers from submitting applications for deferred interest credit cards on behalf of their patients.[19] To protect patients in all states, the CFPB should do the same.

    b. Further, some insurers frequently deny claims. In 2021, one marketplace insurer denied 49 percent of in-network claims.[20] Notably, the Office of Inspector General (OIG) for HHS recently raised concerns about high rates of prior authorization denials by Medicaid MCOs, some of which denied more than 25 percent of prior authorization requests.[21]

2. What are the terms of medical payment products, including interest rates and fees?

Many deferred interest medical credit cards carry significant annual percentage rates (APRs). For instance, after the promotional period, the CareCredit deferred interest credit card has an annual percentage rate (APR) of about 27 percent.[22] As the CFPB has noted, patients who

[14] Letter from Sen. Elizabeth Warren, Edward Markey, and Sanders to Synchrony Financial and Wells Fargo, at p. 2, Dec. 29, 2022, https://www.warren.senate.gov/imo/media/doc/2023.06.29%20Letter%20to%20CFPB%20re%20medical%20credit%20cards1.pdf.
[15] Synchrony Bank letter to Senators, Appendix: responses to questions 2 and 16, Jan. 26, 2023, https://www.warren.senate.gov/imo/media/doc/Medical%20Credit%20Card%20Companies%20Responses.pdf.
[16] https://www.carecredit.com/providers/how-it-works/.
[17] Commonwealth Fund, "Medicaid Reimbursement Rates Are A Racial Justice Issue," June 16, 2022.
[18] The Sacramento Bee, "Dental Patients Face Years of Debt, Inflated Bills with 'Out-of-Pocket' Credit Cards," Dec. 9, 2019; *see also* Cal Matters, "Californians fall prey to high interest credit card loans while in exam chairs. Here's a fix," July 8, 2019.
[19] *Id.*
[20] KFF, "Claims Denials and Appeals in ACA Marketplace Plans in 2021," https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/.
[21] HHS OIG, "High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care," OEI-09-19-00350, July 2023, https://oig.hhs.gov/oei/reports/OEI-09-19-00350.pdf.
[22] https://www.carecredit.com/howcarecreditworks/prospective/.

are assessed interest on purchases with a deferred interest financing product pay, on average, an additional 23 percent of the purchase price.[23]

As discussed above, providers have traditionally offered zero-interest payment plans to patients who cannot afford the entire cost at once. This is significantly more beneficial to patients who are struggling to afford care. If patients must use a credit card, they are better off using a general-purpose credit card, which usually carries a lower APR[24] and does not result in unexpected deferred interest charges.

Finally, while we appreciate the Agencies' thorough and collaborative approach to gathering information on these products, we respectfully submit that the CFPB already has sufficient information to take action on deferred interest medical credit cards. In May 2023, the CFPB released a comprehensive report on medical financing products, which included an appendix that lists the terms for many medical credit cards.[25] The CFPB has ample authority and evidence to enact a prohibition on the promotion and offering of deferred interest medical credit cards in health care settings.[26]

3. What are the health equity impacts of medical payment products and related billing and collection policies and practices?

Medical debt disproportionately impacts women and historically marginalized communities, which exacerbates existing inequalities. For instance, Black and Latino individuals are more likely to carry medical debt.[27] Black individuals are more likely to be contacted by debt collectors.[28] Further, Black individuals are more likely to be sued for medical debt.[29] Significantly, 60 percent of women face financial hardship in the peripartum period.[30] It is important to note that medical debt also limits important life options, such as the ability to purchase a home, pursue higher education, or even to access food and needed medical care.

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[23] CFPB, "Medical Credit Cards and Financing Plans," at 16, May 2023, https://files.consumerfinance.gov/f/documents/cfpb_medical-credit-cards-and-financing-plans_2023-05.pdf.

[24] CFPB, Prepared Remarks of Director Rohit Chopra for the CFPB Hearing on Medical Billing and Collections, July 11, 2023 ("The typical medical credit card has an interest rate of 27 percent — substantially higher than the 16 percent average for general purpose credit cards."), https://www.consumerfinance.gov/about-us/newsroom/prepared-remarks-of-director-rohit-chopra-for-the-cfpb-hearing-on-medical-billing-and-collections/.

[25] CFPB, "Medical Credit Cards and Financing Plans," at 18-20, May 2023, https://files.consumerfinance.gov/f/documents/cfpb_medical-credit-cards-and-financing-plans_2023-05.pdf.

[26] 15 U.S.C. § 1637(j) (prohibiting double-cycle billing); 15 U.S. Code § 1666i–1 (prohibiting retroactive rate increases); *see generally* National Consumer Law Center, "Deceptive Bargain: The Hidden Time Bomb of Deferred Interest Credit Cards," 18-20, https://www.nclc.org/wp-content/uploads/2022/09/report-deferred-interest.pdf.

[27] CFPB, "Medical Debt Burden in the United States," at 3, February 2022, https://s3.amazonaws.com/files.consumerfinance.gov/f/documents/cfpb_medical-debt-burden-in-the-united-states_report_2022-03.pdf.

[28] Financial Industry Regulator Authority (FINRA), National Financial Capability Study, at 27, https://gflec.org/wp-content/uploads/2016/07/NFCS_2015_Report_Natl_Findings.pdf.

[29] Health Affairs, "Hospital Lawsuits Over Unpaid Bills Increased By 37 Percent In Wisconsin From 2001 To 2018," https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01130.

[30] Jordan Cahn et al., "The Association of Childbirth with Medical Debt in the USA, 2019 - 2020," J Gen Intern Med. 2023 Aug; 38(10): 2340–2346, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10192781/#CR7.

Historically marginalized communities probably incur a higher rate of deferred interest charges. Only 62 percent of individuals with subprime or deep subprime credit scores paid off deferred interest credit cards in 2019, as compared with 89 percent of those with superprime balances.[31] Black and Latino individuals are more likely to have lower credit scores, due disparities in wealth caused by centuries of discrimination.[32] For instance, the median white household has a net worth 10 times that of the median Black household.[33] Wealth allows households to weather financial setbacks, such as a job loss or unexpected medical expenses. When patients experience these financial obstacles and cannot pay off the balance on a deferred interest credit card by the end of the promotional period, they incur significant interest charges on top of the remaining balance – worsening their financial difficulties. Further, patients are more likely to be sued by credit card companies than by medical providers.[34]

Some immigrant communities may also be disproportionately impacted by medical payment products. Noncitizens are significantly more likely than citizens to be uninsured due to restrictions on federal benefits and reduced access to employer-sponsored coverage.[35] Notably, we have heard concerning reports from our partner organizations of medical credit cards being promoted to populations with limited English proficiency (LEP), who are heavily dependent on translators to understand complex financial terms.

4. Patients can pay for care in many different ways, such as by medical credit card or loan, general purpose credit card, insurance, or through a zero-interest payment plan. What are the costs and benefits for health care providers of offering each of these methods? Are there situations where one method of payment is more advantageous than another?

Please see our response above to General Question 1: "What are the benefits, costs, and risks of medical payment products for consumers, health care providers, and companies offering these products?"

5. Where medical payment products are causing harm, what are some specific levers for regulatory oversight and enforcement by Federal agencies that regulate financial products or health care providers? Are there specific areas for Federal enforcement actions? Are there examples of regulation or enforcement at the State or local level to which the Federal government should look?

[31] CFPB, "Consumer Credit Market," p. 97, https://files.consumerfinance.gov/f/documents/cfpb_consumer-credit-card-market-report_2021.pdf.
[32] National Consumer Law Center, "Past Imperfect: How Credit Scores and Other Analytics Bake In and Perpetuate Past Discrimination," May 2016, https://www.nclc.org/wp-content/uploads/2022/09/Past_Imperfect.pdf.
[33] Brookings Institution, "Closing the Racial Wealth Gap Requires Heavy, Progressive Taxation of Wealth," https://www.brookings.edu/articles/closing-the-racial-wealth-gap-requires-heavy-progressive-taxation-of-wealth/.
[34] National Consumer Law Center, "Dealing with Medical Debt: Advice from NCLC," https://library.nclc.org/article/dealing-medical-debt-consumer-advice-nclc.
[35] KFF, "Health Coverage and Care of Immigrants," https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-and-care-of-immigrants/.

As we have previously requested, the CFPB should ban the offering and promotion of these products in health care settings.[36] In 2009, Congress passed the Credit Card, Accountability, Responsibility and Disclosures (CARD) Act in order to "establish fair and transparent practices relating to the extension of credit."[37] As the CFPB has acknowledged, "Deferred interest products...remain the most glaring exception to the general post-CARD Act trend toward upfront credit pricing."[38]

The CFPB has the legal authority to prohibit deferred interest credit products.[39] Further, the CFPB has significant evidence of the harm that these products cause in health care settings.[40] Indeed, CFPB Director Rohit Chopra recently noted: "While medical payment products can offer an enticing promise of cost savings, convenient payment plans and administrative ease for medical providers, **our research indicates that in many cases, patients who use these products end up worse off.**"[41] The CFPB has enough information to take action now.

As a model, the CFPB should look at California law.[42] California prohibits providers and their employees from arranging for or establishing an open-end credit or loan with a deferred interest provision.[43] Further, before offering *any* credit or loan through a third party, the provider must provide a treatment plan that indicates: (1) if the provider accepts Medi-Cal,[44] whether Medi-Cal would cover an alternative, medically necessary service; and (2) that the patient has the right to ask for only services covered by Medi-Cal.[45] Providers should make such disclosures about *any* insurance coverage or available financial assistance before signing patients up for financing products.

Finally, the CFPB can take enforcement action against deceptive and abusive practices in health care financing, as the agency did in 2013 against CareCredit.[46] We emphasize, however, that enforcement actions do not solve the underlying problems with health care providers offering deferred interest credit cards in the first place. This is demonstrated by the numerous

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[36] *See* Community Catalyst, Petition to the CFPB for a Rulemaking Pursuant to the Credit Card Accountability and Disclosure Act of 2009, Apr. 13, 2023, https://www.regulations.gov/document/CFPB-2023-0028-0001.
[37] Pub. L. 111-24.
[38] CFPB, "Consumer Credit Card Market Report," at 10, December 2015, https://files.consumerfinance.gov/f/201512_cfpb_report-the-consumer-credit-card-market.pdf.
[39] 15 U.S.C. § 1637(j) (prohibiting double-cycle billing); 15 U.S. Code § 1666i–1 (prohibiting retroactive rate increases); *see generally* National Consumer Law Center, "Deceptive Bargain: The Hidden Time Bomb of Deferred Interest Credit Cards," 18-20, https://www.nclc.org/wp-content/uploads/2022/09/report-deferred-interest.pdf.
[40] CFPB, "Medical Credit Cards and Financing Plans," May 2023, https://files.consumerfinance.gov/f/documents/cfpb_medical-credit-cards-and-financing-plans_2023-05.pdf.
[41] CFPB, "Prepared Remarks of Director Rohit Chopra for the CFPB Hearing on Medical Billing and Collections," June 11, 2023 (emphasis added), https://www.consumerfinance.gov/about-us/newsroom/prepared-remarks-of-director-rohit-chopra-for-the-cfpb-hearing-on-medical-billing-and-collections/.
[42] California Business and Professions Code 654.3.
[43] California Business and Professions Code 654.3(b).
[44] Medi-Cal is the California Medicaid program.
[45] California Business and Professions Code 654.3(h)(3). Additionally, Medi-Cal providers who are notified of a patient's Medi-Cal eligibility may not seek payment, such as through the offer of a credit or loan product, for the cost of covered services. Cal. Welfare and Institutions Code Sec. 14019.4(a).
[46] CFPB, "CFPB Orders GE CareCredit to Refund $34.1 Million for Deceptive Health-Care Credit Card Enrollment," Dec. 10, 2013, https://www.consumerfinance.gov/about-us/newsroom/cfpb-orders-ge-carecredit-to-refund-34-1-million-for-deceptive-health-care-credit-card-enrollment/.

complaints in the CFPB database about unexpected charges after patients signed up for deferred interest credit cards in health care settings.[47] Indeed, the CFPB has acknowledged these underlying problems with deferred interest credit products:

> **The costs of deferred-interest financing are typically less transparent** ...Those who fail to pay off the balance in full, for example those with even a very small balance carried past the promotional expiration date, can end up owing much more in interest than the remaining balance due. **We have received many consumer complaints from people who have found that they have incurred this unexpected charge.[48]**

CFPB questions

1. What actions should the CFPB consider taking to address problematic practices related to medical credit cards or loans, including debt collection and credit reporting practices?

As noted above, the CFPB should ban the offering and promotion of deferred interest credit cards in health care settings. In addition, the CFPB should ban the reporting of medical debt on consumer credit reports.[49] To ensure that medical debt on credit cards is identifiable, the CFPB should ensure that credit card lenders are requiring health care providers to identify themselves using the Merchant Category Codes for the appropriate medical services and supplies.[50]

Additionally, the CFPB should require companies to allow patients to cancel medical financing if they are later determined eligible for financial assistance or public coverage. Providers should also screen for financial assistance eligibility prior to offering medical financing products.

2. Do consumers understand the risks of paying medical bills via a medical credit card, installment loan, or other commercial payment product, including lowered ability to negotiate their bill with their provider?

As noted above in the response to General Question 5, consumers frequently do not understand the risks of deferred interest credit cards. There is ample evidence in the CFPB's consumer complaint database that consumers are often surprised by unexpected and significant interest charges. Patients who are persuaded to sign up for medical credit cards often do not even understand that these financing products are offered by third parties, not directly through their

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[47] *E.g.,* CFPB Complaint 6401464, received Jan. 5, 2023; CFPB Complaint 6098379, received Oct. 18, 2022; CFPB Complaint 3949387, received Nov. 12, 2020.

[48] CFPB, Letter to Credit Card Companies, June 8, 2017 (emphasis added), files.consumerfinance.gov/f/documents/Deferred_Interest__Letter.pdf.

[49] *See* Community Catalyst Petition to the CFPB, Apr. 13, 2023, https://www.regulations.gov/document/CFPB-2023-0027-0001.

[50] *See, e.g.*, Visa Merchant Data Standards Manual - Visa Supplemental Requirements, Apr. 2023, 102 (MCC 8011 - Doctors and Physicians (Not Elsewhere Classified)), available at https://usa.visa.com/content/dam/VCOM/download/merchants/visa-merchant-data-standards-manual.pdf.

health care provider. They are also offered these products in health care settings at a time when they are vulnerable, seeking essential care that they need.

Additionally, consumers often do not understand what they are giving up when they use credit cards. As noted above in the response to General Question 1, patients are giving up the opportunity to negotiate a payment plan directly with the provider, to seek financial assistance from the provider, or to correct billing errors directly through the provider.

4. When hospitals write off a patient's debt as uncollectible or "bad debt" and cease attempts to collect, do they notify patients that collection attempts will cease? Would patients benefit from such notifications, and would such notifications reduce hospital revenue?

Hospitals generally do not notify patients when medical debts have been written off as uncollectible. Such notifications would make a huge difference for patients, however. About two-thirds of individuals with medical debt reported delaying or skipping care that they or a family member needed.[51] Significantly, medical debt itself is associated with higher cancer mortality rates.[52]

We believe these notifications would not impact hospital revenue because it is unlikely patients would otherwise start paying in the future. Indeed, that is precisely what a hospital concludes when it classifies the debt as uncollectible. While the additional notification would entail some additional administrative responsibilities on hospitals, we note that hospitals already have systems in place to regularly send out statements on outstanding bills. The burden of adding an additional notification once the debt has been written off as uncollectible would be minimal.

Further, hospitals already receive reimbursement for a large portion of uncollectible patient debt. Specifically, federal and state governments reimburse hospitals for approximately 80 percent of uncompensated care costs for uninsured patients.[53] It is patently unfair for hospitals to collect reimbursement for the majority of their costs but not inform the affected patients, who may be avoiding or delaying important care because of outstanding bills.

Additionally, many patients whose debt is deemed uncollectible should have qualified for free or discounted care under the hospital's financial assistance policy. For instance, in 2020, up to 48 percent of uncollectible debt for patients at North Carolina nonprofit hospitals should have been provided as charity care.[54] In other words, a large portion of uncollectible debt is for

[51] KFF Health News, "100 Million Americans Are Saddled with Health Care Debt," June 16, 2022, https://kffhealthnews.org/news/article/diagnosis-debt-investigation-100-million-americans-hidden-medical-debt/.
[52] Xin Hu, Zhiyuan Zheng, Kewei Sylvia Shi, Robin Yabroff, and Xuesong Han, "Association of medical debt and cancer mortality in the US," Journal of Clinical Oncology 2023 41:16_suppl, 6505-6505 (medical debt is associated with higher cancer mortality at the county level).
[53] KFF, "Sources of Payment for Uncompensated Care for the Uninsured," April 6, 2021, https://www.kff.org/uninsured/issue-brief/sources-of-payment-for-uncompensated-care-for-the-uninsured/.
[54] North Carolina State Health Plan for Teachers and State Employees, Rice University's Baker Institute for Public Policy, "North Carolina Nonprofit Hospitals Bill the Poor," North Carolina Department of State Treasurer, Jan. 26, 2022, https://www.nctreasurer.com/news/press-releases/2022/01/26/some-north-carolina-nonprofit-hospitals-billing-poor-patients-amid-failures-charity-care.

patients who never should have been billed in the first place. At the very least, hospitals should inform these patients that they are no longer at risk for collection actions.

HHS Questions

1. Are there particular health care provider types that are most associated with being offered or offering medical payment products?

The use of medical payment products is widespread, and it appears to be increasing. For instance, Synchrony Bank announced that the CareCredit network included over 266,000 locations in 2022.[55] Dental providers accounted for 53 percent of the fees and interest on loans in Synchrony Bank's Health and Wellness line.[56]

Deferred interest credit cards are particularly prevalent in dental care due to the widespread lack of insurance coverage in this area. Medicare does not cover most dental care, including cleanings, fillings, tooth extractions, or dentures.[57] Dental coverage for adults is not currently an Essential Health Benefit (EHB), so insurers do not have to offer adult dental coverage.[58] We urge HHS to include adult dental coverage as an EHB, which will improve health outcomes and decrease health care debt**.** [59]

Medical payment products are also increasing in the hospital sector. Hospitals offering medical payment products include Atrium Health in North Carolina, Allina Health in Minnesota, Chino Valley Medical Center in California, and UNC Health in North Carolina.[60] These medical payment products can increase medical debt significantly.

For instance, UNC Health, which had long offered payment plans with no interest, began contracting with AccessOne in 2019.[61] By 2022, around 100,000 UNC Health patients had an AccessOne loan, about half of whom had an interest rate of 13 percent on their loans.[62] As NPR noted, a patient with a $7,000 hospital bill who enrolls in a five-year financing plan at 13 percent interest will pay at least $2,500 in interest on top of the original debt.[63]

2. How might HHS improve patient understanding of options for covering the cost of medical treatments? At what points in the care process could patients be

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[55] Synchrony Bank 10-K for the fiscal year ending Dec. 31, 2022. Note that CareCredit cards include both deferred interest credit cards and other credit cards that do not include deferred interest terms. Further, CareCredit cards can be used for "health and wellness" purchases other than medical or dental care, such as veterinary care.
[56] *Id.*
[57] Dental services, https://www.medicare.gov/coverage/dental-services.
[58] Essential health benefits, https://www.healthcare.gov/glossary/essential-health-benefits/.
[59] Letter to HHS and CMS in Response to December 2022 Request for Information on EHBs, July 19, 2023, https://communitycatalyst.org/wp-content/uploads/2023/07/EHB-Sign-on-Letter-7.19.pdf.
[60] NPR, "How Banks and Hospitals Are Cashing In When Patients Can't Pay for Health Care," Nov. 17, 2022, https://www.npr.org/sections/health-shots/2022/11/17/1136201685/medical-debt-high-interest-credit-cards-hospitals-profit.
[61] *Id.*
[62] *Id.*
[63] *Id.*

provided with information about their financial obligations and payment options?

HHS could improve patient understanding of options for covering the cost of medical treatments by: (1) increasing the accessibility of financial assistance; (2) providing guidance to assure hospitals that they may advertise the availability of financial assistance; and (3) addressing the high rates of insurance denials.

To increase the accessibility of financial assistance, HHS should publish a model streamlined financial assistance application and encourage hospitals to use this application. The model application should not require excessive documentation or burdensome requirements, such as notarization. Further, the model application should not require information on immigration status or residency. The model application should be translated into Spanish, at a minimum, which could also reduce translation costs for hospitals that use the recommended application.

Further, HHS should require hospitals to screen patients for eligibility for the hospital's financial assistance policy, unless the patient declines screening. This could be accomplished through Conditions of Participation for hospitals that participate in Medicare and Medicaid. Please see the section titled Recommendations for Medical Debt for further discussion.

To assure hospitals, HHS should publish guidance on the permissibility of advertising financial assistance policies. Many hospitals do not inform patients about presumptive eligibility for financial assistance or proactively notify patients about financial assistance because of fear of liability. Specifically, we have heard that many hospitals believe such notifications could be considered improper inducement of Medicare or Medicaid beneficiaries[64] or could result in liability under the Anti-Kickback Statute.[65] To be clear, we do not believe these concerns have any merit.[66] However, we request that HHS provide updated guidance[67] to assure hospitals that they may notify patients about presumptive eligibility determinations and generally advertise the availability of financial assistance without risking such liability.

Finally, HHS should also address the high rates of insurance denials. Such denials complicate predictions about the cost of treatment. Please see Recommendations for Medical Debt further discussion on insurance denials.

Treasury Questions

1. What policy actions should Treasury consider taking to address problematic practices related to medical credit cards or loans, including debt collection and

[64] 42 U.S.C. §1320a–7a(5) (civil monetary penalties may be imposed for offering remuneration to any individual eligible for Medicare or Medicaid in order to influence their choice of provider).
[65] 42 U.S. Code § 1320a–7b(b).
[66] *E.g.*, CMS, "Questions on Charges for the Uninsured," Feb. 17, 2004, https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/downloads/faq_uninsured.pdf ("Nothing...prohibits a hospital from waiving collection of charges to any patients, Medicare or non-Medicare, including low-income, uninsured, or medically indigent individuals, if it is done as part of the hospital's indigency policy.").
[67] Such guidance could be in the form of a Special Advisory Bulletin or a shorter policy statement.

credit reporting practices, to conform with the existing tax laws and regulations pertaining to tax-exempt hospitals?

First, Treasury should enforce existing requirements for nonprofit hospitals, including both specific rules relating to financial assistance and general expectations for tax-exempt, charitable institutions. When nonprofit hospitals offer medical payment products, Treasury should analyze whether the hospitals are offering such products in place of financial assistance. Finally, Treasury should require screening for financial assistance eligibility prior to offering medical payment products.

Many nonprofit hospitals are not complying with existing requirements for financial assistance or, more generally, with expectations for tax-exempt, charitable institutions. For instance, instead of complying with the statutory requirement to "widely publicize" their financial assistance policies,[68] 45 percent of nonprofit hospitals routinely bill patients whose incomes are low enough to qualify for financial assistance.[69] In North Carolina, nonprofit hospitals brought over 90 percent of lawsuits against patients.[70]

When nonprofit hospitals push medical payment products, there may be underlying problems with the hospital's financial assistance policies and practices. For instance, nonprofit Atrium Health in North Carolina advertises AccessOne financing on its website, high above the notification about financial assistance.[71] Atrium Health also filed the most lawsuits against patients of any hospital in North Carolina.[72] While Treasury should scrutinize Atrium's promotion of AccessOne, Treasury should also ask why Atrium Health, a purportedly charitable institution that generates over $27 billion in revenue,[73] is not providing more financial assistance to patients who cannot pay their hospital bills.

Finally, Treasury should require nonprofit hospitals to offer to screen patients for financial assistance eligibility prior to offering medical payment products. Treasury should also consider requiring hospitals to use the tools they have for screening for financial products to screen for financial assistance or Medicaid eligibility.

2. Should a tax-exempt hospital's signing patients up for medical payment products be considered similar to a tax-exempt hospital's selling medical debt, such that the special rules that only exclude debt sales from being extraordinary

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[68] *See* 26 U.S.C. 501(r)(4)(A)(v) (requiring nonprofit hospitals to have measures to widely publicize their financial assistance policy).
[69] KFF Health News, "Patients Eligible for Charity Care Instead Getting Big Bills," Oct. 14, 2019, available at: https://kffhealthnews.org/news/patients-eligible-for-charity-care-instead-get-big-bills/.
[70] Barak Richman et al., Hospitals Suing Patients, at 2, August 2023, https://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=6961&context=faculty_scholarship.
[71] https://atriumhealth.org/for-patients-visitors ("AccessOne helps patients to manage their medical bills by offering easy ways to make monthly payments.").
[72] Barak Richman et al., "Hospitals Suing Patients," at 12, August 2023, https://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=6961&context=faculty_scholarship.
[73] Advocate Health Care, "Advocate Aurora Health and Atrium Health to combine," (noting that the new organization will have combined revenues of $27 billion), https://www.advocatehealth.com/news/advocate-aurora-health-and-atrium-health-to-combine.

collection actions if certain requirements are met would be applied to these payment products?

We agree that medical financing products can have significant collection implications for patients. However, we are concerned that this proposal would offer limited protection to patients because many nonprofit hospitals do not comply with current restrictions on extraordinary collection actions (ECAs). We urge Treasury to strengthen and enforce current rules related to ECAs. We also urge Treasury to strengthen and enforce current rules related to financial assistance so that fewer patients require financing to afford care.

First, Treasury should note that many hospitals do *not* comply with the statutory requirement to make reasonable efforts to determine whether a patient is eligible for financial assistance prior to engaging in ECAs.[74] Indeed, nonprofit hospitals are more likely than for-profit hospitals to sue patients for debt[75] and more likely than for-profit hospitals to garnish patient wages.[76] Over a two-year period, New York nonprofit hospitals placed 4,880 liens on patient homes, although many of these patients likely qualified for financial assistance.[77]

Second, Treasury should strengthen current rules regarding ECAs. For instance, Treasury should prohibit nonprofit hospitals from engaging in the following ECAs: (1) garnishing patient wages; (2) foreclosing on primary residences; (3) placing liens on primary residences; and (4) bringing civil actions against patients or their family members to collect hospital debt. Treasury should also require nonprofit hospitals to offer to screen patients for financial assistance prior to engaging in ECAs.

Third, as detailed in Question 5 below, Treasury should strengthen and enforce requirements to make financial assistance policies more accessible so that patients can afford the care they need.

4. How do tax-exempt hospitals' promotion of medical payment products compare to their operationalization of the requirement that their financial assistance policies be widely publicized?

Nonprofit hospitals are not complying with the statutory requirement to widely publicize their financial assistance policies. We are deeply concerned by the increasing number of patients

[74] 26 U.S.C. 501(r)(6).
[75] Barak Richman et al., "Hospitals Suing Patients," at 2, August 2023, https://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=6961&context=faculty_scholarship (nonprofit hospitals brought over 90% of the lawsuits against patients in North Carolina over a five-year period); Zack Cooper, James Han, Neale Mahoney, "Hospital Lawsuits Increased by 37 Percent in Wisconsin from 2001 to 2018," 40 Health Affairs, 1830– 1835 (Dec. 2021), https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01130# (nonprofit hospitals in Wisconsin were more likely to sue patients than for-profit hospitals).
[76] Bruhn WE, Rutkow L, Wang P, et al. Prevalence and Characteristics of Virginia Hospitals Suing Patients and Garnishing Wages for Unpaid Medical Bills. JAMA. 2019;322(7):691–692. doi:10.1001/jama.2019.9144, https://jamanetwork.com/journals/jama/fullarticle/2737183.
[77] Community Service Society of New York, "Discharged Into Debt: Nonprofit Hospitals File Liens on Patients' Homes," at 2 and 9, November 2021, https://cssny.org/publications/entry/discharged-into-debt-nonprofit-hospitals-file-liens-on-patients-homes (many of the counties where liens were frequently placed on patient homes have median incomes below the threshold for financial assistance in New York).

using medical financing products to afford care. It is likely that many patients who use medical financing products would have qualified for financial assistance. Further, the effective promotion by nonprofit hospitals of medical financing products shows that nonprofit hospitals could be doing more to inform patients about financial assistance.

Significantly, nonprofit hospitals are not effectively notifying eligible patients about financial assistance. As previously noted, about 45 percent of nonprofit hospitals routinely bill patients whose incomes should qualify them for charity care,[78] and large portions of uncollectible debt are from patients who should have qualified for charity care.[79] Some hospitals even deliberately obscure the availability of financial assistance. For instance, the Providence health system, one of the country's largest nonprofits, provided employees "with a detailed playbook for wringing money out of patients – even those who were supposed to receive free care because of their low incomes."[80]

In contrast, some nonprofit hospitals do prominently advertise medical financing on their websites. For instance, nonprofit Atrium Health advertises AccessOne financing at the top of its Patients and Visitors page, including a list of benefits such as "Flexible payment plans and no hidden fees" and "Bilingual staff."[81] Patients must scroll much farther down to find a section on Financial Assistance, which does not list any benefits of the program or the fact that translations are available.[82]

Similarly, nonprofit St. Luke's University Health Network lists benefits of CareCredit on its Payment Options webpage, highlighting that the "promotional financing options to help you get the care you need, when you need it."[83] The same page provides only a link to "Self-Pay/Uninsured." Unlike the CareCredit announcement, the Self Pay/Uninsured section does not provide any information about the program or even explain that it refers to financial assistance or "charity care."[84]

Instead of promoting medical payment products, nonprofit hospitals should promote financial assistance and train their office and billing staff to assist patients with financial assistance applications. Treasury should strengthen the regulations on widely publicizing financial assistance policies, looking to what nonprofit hospital are doing to advertise medical payment products as examples of what could be done to promote financial assistance. Treasury should also bring enforcement actions against nonprofit hospitals that deliberately obscure the availability of financial assistance.

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[78] KFF Health News, "Patients Eligible for Charity Care Instead Getting Big Bills," Oct. 14, 2019, https://kffhealthnews.org/news/patients-eligible-for-charity-care-instead-get-big-bills/.
[79] North Carolina State Health Plan for Teachers and State Employees, Rice University's Baker Institute for Public Policy, "North Carolina Nonprofit Hospitals Bill the Poor," North Carolina Department of State Treasurer, Jan. 26, 2022, https://www.nctreasurer.com/news/press-releases/2022/01/26/some-north-carolina-nonprofit-hospitals-billing-poor-patients-amid-failures-charity-care.
[80] New York Times, "They Were Entitled to Free Care. Hospitals Hounded Them to Pay," Dec. 15, 2022, https://www.nytimes.com/2022/09/24/business/nonprofit-hospitals-poor-patients.html.
[81] https://atriumhealth.org/for-patients-visitors.
[82] *Id.*
[83] https://www.slhn.org/billpay/payment-options.
[84] *Id.*

5. What are best practices for hospitals publishing and making patients aware of financial assistance programs (beyond compliance with the widely publicized requirements found in the section 501(r) regulations)?

We recommend the following practices for hospitals:

a. Screen all patients for eligibility for financial assistance, unless the patient declines screening;
b. Use presumptive eligibility for certain groups of likely qualified patients;
c. Include a prominent link to the financial assistance application (not just the Financial Assistance Policy (FAP) summary) on the hospital's homepage;
d. Include a prominent link to the financial assistance application on all payment portals;
e. Use a simplified application that does not require excessive documentation, notarization, or request information on citizenship status or assets;
f. Include paper copies of the financial assistance application (not just the FAP summary) in waiting areas, intake and discharge paperwork, and with all billing statements;
g. Assist patients with the financial assistance application;
h. Ensure that translated versions of the FAP application are accessible to those who do not speak English, for example by requiring that translated copies of the FAP application are provided to patients who the hospital has reason to know speak a language other than English;
i. When applicable, use marketplace determinations of income rather than requiring patients to provide additional documentation of income;
j. Use pay stubs to determine income (rather than requiring tax returns or non-filing letters); and
k. Verbally inform patients about financial assistance in all calls about billing and collection matters.

We also emphasize that many nonprofit hospitals' financial assistance policies do not cover key hospital providers and services, such as anesthesia services, laboratory/pathology services, and independent providers. However, patients do not choose their providers at the hospital, and patients often have little insight into whether particular providers are directly employed by the hospital or independent contractors. To ensure that essential hospital care is covered by financial assistance policies, we urge Treasury to require nonprofit hospitals to include *all* hospital providers and services in their financial assistance policies.

6. Does the availability of medical payment products generally benefit the community or assist patients financially?

Please see our response to General Question 1.

Recommendations to Address Medical Debt

We appreciate that the Agencies have also requested "comment on policy options to address practices by health care providers...that result in consumers paying excess costs."[85] While we applaud the Agencies' attention to medical payment products, we urge them to also address the systemic issues that leave patients in need of financing for medical care. Each of the Agencies should use its existing authority to significantly reduce medical debt in this country. We provide specific recommendations for Treasury and HHS below.

I. Treasury

Treasury should strengthen requirements for nonprofit hospitals under Section 501(r) of the Internal Revenue Code. Treasury should also issue guidance to nonprofit hospitals on expectations for charity care. Finally, Treasury should increase transparency and enforce existing requirements for nonprofit hospitals.

A. Strengthen Regulations Implementing Section 501(r)

Treasury should strengthen the current regulations that implement Section 501(r) of the Internal Revenue Code. The regulations should: (1) ensure that financial assistance policies are widely accessible to patients; (2) prohibit billing any patients inflated charges; and (3) require nonprofit hospitals to determine patient eligibility for financial assistance prior to engaging in ECAs, and ban the most harmful ECAs altogether.

First, Treasury should increase the accessibility of financial assistance policies by enacting regulations to require the steps outlined in response to Treasury Question 5. Nonprofit hospitals are not effectively informing eligible patients about the availability of financial assistance. At the same time, many nonprofit hospitals *are* effectively advertising and promoting medical financing products, showing that the such hospitals could be doing more to connect eligible patients with financial assistance. Treasury should strengthen these regulations to ensure that patients learn about and access the financial assistance to which they are entitled.

Second, Treasury should prohibit nonprofit hospitals from billing any patient gross charges. These charges, often known as "chargemaster" rates, are inflated prices that no payor actually reimburses.[86] The statute prohibits nonprofits from using gross charges generally, but current regulations only apply this protection to patients who are eligible for financial assistance.[87] This leaves other patients at risk for inflated charges, as a recent investigation found: "Hospitals routinely bill uninsured patients their highest rates."[88] Treasury should protect

[85] 88 Fed. Reg. 132 at 44282.
[86] NPR, "Hospitals Have Started Posting Their Prices Online. Here's What They Reveal," July 2, 2021, https://www.npr.org/sections/health-shots/2021/07/02/1012317032/hospitals-have-started-posting-their-prices-online-heres- what-they-reveal.
[87] *Compare* 26 U.S.C. 501(r)(5)(B) (a nonprofit hospital must "prohibit[] the use of gross charges") with 26 C.F.R. 1.501(r)-5(A) (prohibiting nonprofit hospitals from using gross charges for care that is covered under their financial assistance policies).
[88] Wall Street Journal, "Hospitals Often Charge Uninsured People Their Highest Prices, New Data Show," July 6, 2021.

all patients from paying inflated charges by amending the regulation to be consistent with the broad statutory prohibition on gross charges.

Third, Treasury should require nonprofit hospitals to determine patient eligibility for financial assistance prior to engaging in ECAs. The statute requires nonprofit hospitals to make "reasonable efforts" to determine financial assistance eligibility prior to initiating ECAs.[89] Given the prevalence of property liens against patients in low-income communities[90] and the sheer number of lawsuits filed by some nonprofit hospitals,[91] it is clear that the regulations on "reasonable efforts" should be strengthened. Treasury should: (1) prohibit ECAs until after patients have been screened for eligibility for federal or state programs or hospital financial assistance, unless the patient declines screening; and (2) require nonprofit hospitals to process financial assistance applications at any time during the collection process.

Further, Treasury should prohibit the most harmful ECAs. These include: (1) the denial of medical care due to outstanding bills; (2) wage garnishment; (3) bank account seizures; (4) home foreclosures; and (5) property liens. Such actions have devastating and long-lasting effects on the health and well-being of patients, and they are inconsistent with longstanding requirements for tax-exempt, charitable institutions.[92]

B. Clarify Expectations for Charity Care

Treasury should clarify expectations for nonprofit hospitals concerning charity care. Specifically, Treasury should reinstate the previous requirement that nonprofit hospitals provide charity care to the extent of their financial abilities and provide guidance on the patients who should qualify for charity care. Treasury, through the Internal Revenue Service (IRS), should issue a new Revenue Ruling with such guidance.

In 1956, the IRS issued a Revenue Ruling on nonprofit hospitals.[93] The IRS noted that hospitals are typically granted federal tax exemptions because they are organized and operated for *charitable* purposes.[94] Ultimately, the IRS held that, in order for a hospital to qualify for federal tax exemption as a charitable organization, the hospital must provide charity care "to the extent of its financial ability."[95]

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[89] 26 U.S.C. § 501(r)(6).
[90] Community Service Society of New York, "Discharged Into Debt: Nonprofit Hospitals File Liens on Patients' Homes," at 2 and 9, November 2021, https://cssny.org/publications/entry/discharged-into-debt-nonprofit-hospitals-file-liens-on-patients-homes (in many of the counties where hospitals frequently placed property liens on patient homes, the median incomes are below the threshold for financial assistance in New York).
[91] KFF Health News, UVA Has Ruined Us: Health System Sues Thousands Of Patients, Seizing Paychecks And Claiming Homes, https://kffhealthnews.org/news/uva-health-system-sues-patients-virginia-courts-garnishment-liens-bankruptcy/ (noting that the University of Virginia Health System sued 36,000 patients over a six-year period and frequently garnished wages from patients with low-wage jobs).
[92] *Better Bus. Bureau v. United States*, 326 U.S. 279, 283 (1945) (holding that a single non-exempt purpose, such as the pursuit of profits, will destroy a tax-exemption regardless of the number of truly exempt purposes)
[93] Rev. Rul. 56-185, 1956-1 C.B. 202.
[94] *Id.* at 1 (emphasis added).
[95] *Id.* at 2.

Subsequently, the IRS issued a new Revenue Ruling ("1969 Revenue Ruling") that replaced the previous charity care requirement with a "community benefits" standard.[96] The IRS explicitly removed the previous requirement that nonprofit hospitals provide free or discounted care.[97] Under the new community benefits standard, hospitals could qualify for tax exemption through practices such as accepting Medicare and Medicaid patients, maintaining an open medical staff policy, operating an emergency room open to all, and having a Board of Trustees comprised of independent civic leaders.[98] Today, as the IRS has acknowledged, most of these factors have lost relevance due to legislative and industry developments.[99]

Significantly, the 1969 Revenue Ruling removed the charity requirements for nonprofit hospitals based primarily on lobbying by the hospital industry. Hospitals argued that, after the enactment of Medicare and Medicaid in 1965, the demand for charity care would not be sufficient to satisfy the previous IRS standard and thus a more flexible standard for nonprofit hospitals was necessary.[100] The epidemic of medical debt in this country – most of which originates from hospitals – demonstrates that the assumptions underlying the 1969 Revenue Ruling were tragically incorrect.

To address these issues, the IRS should issue a revised Revenue Ruling on nonprofit hospitals. Specifically, the IRS should reinstate the previous requirement that nonprofit hospitals be "operated to the extent of [their] financial ability for those unable to pay."[101] The IRS should also provide guidance on the term "unable to pay," such as a rebuttable presumption that uninsured patients under 200 percent of the Federal Poverty Line and insured patients with out-of-pocket medical costs over 10 percent of their household income are "unable to pay" and should qualify for charity care.

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[96] Rev. Rul. 69-545, 1969-2 C.B. 117.
[97] *Id.* at 4.
[98] *Id.* at 3.
[99] *See, e.g.,* The Tax-Exempt Hospitals Sector, Hearing before the House Ways and Means Committee, 109th Cong. at 13, (2005) (statement of Mark W. Everson, Commissioner of Internal Revenue) ("Having an open medical staff, participating in Medicare and Medicaid, and treating all emergency patients without regard to ability to pay are now common features of tax-exempt and for-profit hospitals rather than distinguishing factors").
[100] Congressional Research Service, "501(c)(3) Hospitals and the Community Benefits Standard," at 2, May 12, 2010, https://crsreports.congress.gov/product/pdf/RL/RL34605 ("It appears the community benefit standard was adopted partly in response to the enactment in 1965 of Medicare and Medicaid, which some thought would reduce the need for hospitals to provide charity care."); Senate Finance Committee Minority Staff, "Tax Exempt Hospitals: Discussion Draft," at 5 July 19, 2007, https://www.finance.senate.gov/imo/media/doc/prg071907a.pdf ("It is important for policymakers (including those in the executive branch) to recognize that Rev. Rul. 69-545 was not put forward by the IRS in response to any changes in the tax laws [but instead it was] based on what turned out to be an inaccurate expectation of other legislation (namely that Medicaid and Medicare would eliminate or greatly reduce the need for charity care)"; House Ways and Means Committee Hearing on the Tax Exempt Hospital Sector, Statement of John Colombo at 87 (May 26, 2005), https://www.govinfo.gov/content/pkg/CHRG-109hhrg26414/pdf/CHRG-109hhrg26414.pdf (explaining that nonprofit hospitals began lobbying the IRS for new exemption standards in the mid-1960s, arguing that there would no longer be a sufficient demand for charity care after the passage of Medicare and Medicaid).
[101] Rev. Rul. 56-185, 1956-1 C.B. 202 at 2.

C. Strengthen Transparency Requirements and Enforcement of Existing Requirements for Nonprofit Hospitals

a. Transparency

The IRS should increase transparency regarding nonprofit hospitals' financial assistance practices. Specifically, the IRS should require hospitals to report the total number of financial assistance applications received and the total number approved. The current IRS Form 990 Schedule H only requests the number of persons who received financial assistance, and disclosure is optional.[102] Clear and consistent reporting on financial assistance applications is essential to allow oversight of these practices.

b. Enforcement

The IRS should send a stronger signal to hospitals about the importance of compliance by enforcing existing requirements. For ten years, the IRS did not revoke the tax-exempt status of *any* nonprofit hospitals, even though some reported no spending at all on financial assistance or community benefits.[103] Indeed, despite press accounts of nonprofit hospitals denying necessary medical care[104] and pursuing collections so aggressively that patients could no longer afford groceries, [105] we are not aware of the IRS investigating or revoking the nonprofit status of any of these hospitals.

While we understand that IRS investigations and audits are not public, it does not appear that many nonprofit hospitals face tax repercussions for actions that are inconsistent with Section 501(r) and with their status as charitable institutions. We urge the IRS to increase investigation and enforcement activities in this area.

II. HHS

HHS should enact regulations for all hospitals that participate in Medicare and Medicaid to address the harmful effects of medical debt. HHS should also increase oversight and transparency concerning denials by private insurance plans and Medicaid managed care organizations (Medicaid MCOs).

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[102] IRS, Schedule H (Form 990), 2022, https://www.irs.gov/pub/irs-pdf/f990sh.pdf.
[103] GAO, "IRS Oversight of Hospitals' Tax-Exempt Status," at 8, Apr. 26, 2023, https://www.gao.gov/assets/gao-23-106777.pdf.
[104] The New York Times, "This Nonprofit Health System Cuts Off Patients with Medical Debt," June 1, 2023, https://www.nytimes.com/2023/06/01/business/allina-health-hospital-debt.html (detailing how Allina Health, a nonprofit with revenue of over $4 billion annually, denies services to patients with medical debt, including children and those with chronic illnesses like diabetes and depression).
[105] New York Times, "They Were Entitled to Free Care. Hospitals Hounded Them to Pay," Dec. 15, 2022 https://www.nytimes.com/2022/09/24/business/nonprofit-hospitals-poor-patients.html (noting that some patients "had to cut back on groceries to pay what Providence [health system] claimed they owed");
NPR, "When Hospitals Sue For Unpaid Bills, It Can Be 'Ruinous' For Patients," June 27, 2019 https://www.kcur.org/2019-06-27/when-hospitals-sue-for-unpaid-bills-it-can-be-ruinous-for-patients (quoting one Mary Washington patient as stating: "I literally have no food in my house because they're garnishing my check.").

A. Conditions of Participation to Address Medical Debt

HHS, through the Centers for Medicare and Medicaid Services (CMS), should enact Conditions of Participation related to medical debt. Specifically, CMS should: (1) require screening of all patients for eligibility for financial assistance, unless the patient declines screening; (2) prohibit the most aggressive collections actions; and (3) require hospitals to notify patients when their debt has been determined to be uncollectible.

CMS may establish requirements for Medicare- and Medicaid-participating hospitals that are "necessary in the interest of the health and safety of individuals who are furnished services in the institution."[106] Notably, CMS does not require specific legislation to enact additional requirements for hospitals as Conditions of Participation. For instance, after the 1999 Institute of Medicine report on preventable medical errors that generated significant attention, CMS promulgated a set of Conditions of Participation on the Quality Assessment and Performance Improvement (QAPI) program.[107] Similarly, after a Presidential Memorandum on Hospital Visitation, CMS promulgated a set of Conditions of Participation related to hospital visitation.[108]

Today, it would be appropriate for CMS to open a rulemaking for Conditions of Participation related to medical debt and hospital collections practices. The Biden Administration has directed agencies to consider "policies or practices that help reduce the burden of medical debt on households."[109] The Administration has also emphasized that medical debt directly affects health because many individuals with medical debt avoid seeking medical care.[110] Further, medical debt also exacerbates existing disparities that this Administration has pledged to address,[111] as Black and Latino individuals are significantly more likely to carry medical debt.[112]

Finally, we note that hospital collections practices do not just impact uninsured or underinsured patients with private insurance. Hospital collections practices also directly impact Medicare beneficiaries. This is because, to claim reimbursement for Medicare bad debt, hospitals must engage in similar collections practices for collecting Medicare deductibles and coinsurance amounts as they do for comparable amounts owed by non-Medicare patients.[113] For instance, this

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[106] 42 U.S.C. § 1395x(e)(9) (Medicare); 42 CFR § 440.10(1)(3)(iii) (Medicaid).
[107] 68 Fed. Reg. 16, at 3435 (Jan. 24, 2003).
[108] 75 Fed. Reg. 223 (Nov. 19, 2010).
[109] Executive Order on Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage, Section 2(f), April 5, 2022, https://www.whitehouse.gov/briefing-room/presidential-actions/2022/04/05/executive-order-on-continuing-to-strengthen-americans-access-to-affordable-quality-health-coverage/?msclkid=887ba3d9b67111ec81e80c7ddd11167b.
[110] Fact Sheet: The Biden Administration Announces New Actions to Lessen the Burden of Medical Debt and Increase Consumer Protection, April 22, 2022, https://www.whitehouse.gov/briefing-room/statements-releases/2022/04/11/fact-sheet-the-biden-administration-announces-new-actions-to-lessen-the-burden-of-medical-debt-and-increase-consumer-protection/.
[111] Executive Order 13985, Advancing Racial Equity and Support for Underserved Communities Through the Federal Government, Jan. 20, 2021, https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/.
[112] CFPB, "Medical Debt Burden in the United States," at 3, February 2022, https://s3.amazonaws.com/files.consumerfinance.gov/f/documents/cfpb_medical-debt-burden-in-the-united-states_report_2022-03.pdf.
[113] 42 CFR § 413.89(e)(2)(A)(1) (collections efforts required for non-indigent Medicare beneficiaries).

may require hospitals to send Medicare accounts to collections agencies if they take these actions against comparable non-Medicare patients.[114]

To protect patients from harmful collections practices, CMS should promulgate Conditions of Participation that require hospitals to screen all patients for financial assistance eligibility, unless the patient declines screening. These Conditions of Participation should also prohibit: (1) denying or delaying necessary medical care because of outstanding medical bills; (2) garnishing wages; and (3) placing liens or foreclosing on patients' primary residences. Finally, these Conditions of Participation should require hospitals to notify patients when their debt is written off as uncollectible so that patients do not needlessly avoid care due to a fear of collection actions.

B. Increase Transparency and Oversight of Insurance Denials

Insurance denials are frequent, both in private coverage and in Medicaid managed care. Such denials result in unexpected costs to patients and medical debt, losses for providers, and reduced access to care. HHS should require additional reporting on these practices in private coverage, which the agency has clear authority to do. HHS should also require state oversight and external reviews of denials by Medicaid managed care organizations (MCOs).

Health insurance denials are increasing.[115] Cigna, which covers or administers health plans for 18 million individuals in the United States[116] (including expanding marketplace coverage[117]), implemented an automatic system that allows its doctors to reject claims without even opening the patient file.[118] Over a period of two months, Cigna doctors denied over 300,000 claims using this method, spending an average of 1.2 seconds on each one.[119]

Many Medicaid MCOs appear to be similarly rejecting or delaying claims in bulk. This has significant equity implications because Medicaid MCOs cover nearly three quarters of

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[114] CMS, "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Final Policy Changes and Fiscal Year 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals," 85 Fed. Reg. 182 at 58994 (Sept. 18, 2020) ("If a provider elects to refer its non-Medicare accounts a collection agency, the provider must similarly refer its Medicare accounts of 'like amount.'").

[115] PBS, "Analysis: Health insurance claim denials are on the rise, to the detriment of patients," May 28, 2023, https://www.pbs.org/newshour/health/analysis-health-insurance-claim-denials-are-on-the-rise-to-the-detriment-of-patients.

[116] The Cigna Group, "Cigna Reports Strong Fourth Quarter and Full Year 2022 Results, Establishes 2023 Guidance and Increases Dividend," Feb. 3, 2023, https://newsroom.thecignagroup.com/2023-2-3-Cigna-Reports-Strong-Fourth-Quarter-and-Full-Year-2022-Results-Establishes-2023-Guidance-and-Increases-Dividend.

[117] Cigna Healthcare, "Cigna Grows ACA Marketplace Presence, Giving More Customers and Communities Access to Quality, Cost-Effective Care," Aug. 29, 2022, https://newsroom.cigna.com/2022-08-29-Cigna-Grows-ACA-Marketplace-Presence,-Giving-More-Customers-and-Communities-Access-to-Quality,-Cost-Effective-Care#assets_all.

[118] ProPublica, "How Cigna Saves Millions by Having Its Doctors Reject Claims Without Reading Them," March 25, 2023, https://www.propublica.org/article/cigna-pxdx-medical-health-insurance-rejection-claims.

[119] *Id.*

Medicaid beneficiaries,[120] and half of Medicaid MCO enrollees are people of color.[121] One Medicaid MCO employed a "denial nurse" who felt pressured to uphold most of the preliminary rejections she reviewed, explaining: "If it was a high-dollar case, they tried to deny it."[122] With another Medicaid MCO, California state officials determined that beneficiaries were "in imminent danger of not receiving medically necessary health services because [the MCO] is not timely processing requests for services."[123]

In practice, many individuals with health insurance do not actually have effective coverage. For instance, in 2021, one marketplace insurer's denial rate was *49 percent* for in-network claims.[124] Similarly, some Medicaid MCOs denied *more than 25 percent of prior authorization requests*.[125] HHS should address these increasing claims denials, both in private coverage and among Medicaid MCOs. We provide suggestions below for actions in both areas.

1. Private Coverage

HHS has statutory authority to require detailed claims data reporting from marketplace plans, non-grandfathered group plans, and health insurers offering group or individual coverage.[126] As of 2018, more than 92 percent of individuals with private health insurance were covered by plans that should be required to comply with these reporting requirements.[127] HHS should fully implement these requirements and increase transparency for consumers.

Under the Affordable Care Act (ACA), the information that must be reported to HHS and made available to the public includes:

- Claims payment policies and practices;
- Data on enrollment and disenrollment;
- Data on the number of claims that are denied;
- Data on rating practices;

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[120] KFF Health News, "Coverage Denied: Medicaid Patients Suffer as Layers of Private Companies Profit," Jan 3, 2019, https://kffhealthnews.org/news/coverage-denied-medicaid-patients-suffer-as-layers-of-private-companies-profit/.

[121] HHS OIG, "High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care," OEI-09-19-00350, at 1, July 2023, https://oig.hhs.gov/oei/reports/OEI-09-19-00350.pdf.

[122] KFF Health News, "Coverage Denied: Medicaid Patients Suffer as Layers of Private Companies Profit," Jan 3, 2019.

[123] California Department of Health Care Services, "SynerMed Corrective Action Plan," Nov. 17, 2017, https://californiahealthline.org/wp-content/uploads/sites/3/2017/11/synermed-corrective-action-plan-nov-17.pdf

[124] KFF, "Claims Denials and Appeals in ACA Marketplace Plans in 2021," https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/.

[125] HHS OIG, High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care," OEI-09-19-00350, at 1, July 2023, https://oig.hhs.gov/oei/reports/OEI-09-19-00350.pdf.

[126] Affordable Care Act § 1311(e)(3) (authority to require reporting from plans seeking certification as Qualified Health Plans) and § 2715A (requiring group health plans and health insurance issuers offering group or individual coverage to comply with the reporting requirements in § 1311(e)(3)); CMS, Transparency in Coverage, https://www.qhpcertification.cms.gov/s/Transparency%20in%20Coverage.

[127] Department of the Treasury, Department of Labor, and Department of Health and Human Services, Transparency in Coverage, 85 Fed. Reg. 219, at 72159 n.1 (Nov. 12, 2020).

- Information on cost-sharing and payments for out-of-network coverage;
- Information on enrollee and participant rights; and
- Other information as determined appropriate by the Secretary.[128]

HHS has not fully implemented these requirements, however. First, reporting is only currently required for Qualified Health Plans (QHPs) offered on HealthCare.gov, which cover less than 10 percent of people with private health insurance.[129] Second, even for these federal marketplace plans, HHS does not collect data on all of the enumerated fields.[130] Third, HHS has not required any other information that would improve oversight, such as data on claims denials for specific services or prior authorization denials.[131]

To address the frequency of claims denials in private health insurance, HHS should: (1) require reporting for all plans covered by the ACA's transparency requirements; (2) require reporting on all fields enumerated by the ACA and specify additional information to be included, such as claims denials for specific services and prior authorization denials; (3) exercise oversight over plans that appear to be improperly denying claims; and (4) develop tools for consumers to compare denial rates among plans.

2. Medicaid MCOs

The Office of Inspector General (OIG) for HHS recently provided recommendations for HHS to increase oversight of Medicaid MCO denials. We urge HHS to use implement these measures: (1) require States to review the appropriateness of a sample of Medicaid MCO prior authorization denials regularly; (2) require States to collect data on Medicaid MCO prior authorization decisions; (3) issue guidance to States on the use of Medicaid MCO prior authorization data for oversight; (4) require States to implement automatic external medical reviews of upheld Medicaid MCO prior authorization denials; and (5) work with States on actions to identify and address Medicaid MCOs that may be issuing inappropriate prior authorization denials.[132]

Conclusion

We thank the Agencies for their attention to medical payment products and their coordinated approach. Respectfully, we also urge the Agencies to collaborate in addressing additional underlying causes of medical debt. Working together, these Agencies can greatly increase access to affordable care and financial stability for families.

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[128] Affordable Care Act § 1311(e)(3) (authority to require reporting from plans seeking certification as Qualified Health Plans) and § 2715A (requiring group health plans and health insurance issuers offering group or individual coverage to comply with the reporting requirements in § 1311(e)(3)); CMS, Transparency in Coverage, https://www.qhpcertification.cms.gov/s/Transparency%20in%20Coverage.

[129] ProPublica, "How Often Do Health Insurers Say No to Patients? No One Knows," June 28, 2023; KFF, Claims Denials and Appeals in ACA Marketplace Plans in 2021, Feb. 9, 2023.

[130] *Id.*

[131] *Id.*

[132] HHS OIG, High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care," OEI-09-19-00350, at 17-19, July 2023.

We appreciate the opportunity to provide these comments, and we welcome further discussion about our recommendations. Please feel free to contact Mona Shah at mshah@communitycatalyst.org, who can connect you to any of the undersigned organizations or facilitate a group conversation.

Respectfully submitted,

ABC for Health, Inc.
ACA Consumer Advocacy
The AIDS Institute
Alliance for a Healthy Kansas
Americans for Financial Reform Education Fund
California Pan-Ethnic Health Network
Casa de Salud
Catalyst Miami
Central Florida Jobs with Justice
Center for Health Progress
Center for Popular Democracy
Children's Action Alliance
Citizen Action of Wisconsin
Civil Justice, Inc.
Community Catalyst
The Children's Partnership
Colorado Center on Law and Policy
Colorado Consumer Health Initiative
Colorado Immigrants Rights Coalition (CIRC)
Community Service Society of NY
Consumers for Affordable Health Care
CT Health Policy Project
Debt Collective
Florida Health Justice Project
Georgia Equality
Georgia Watch
Health Access California
Health Care Voices
Health Equity Solutions, Inc.
Health Law Advocates
Illinois Coalition for Immigrant and Refugee Rights
Innovation for Justice
Justice in Aging
Kairos Center for Religions, Rights and Social Justice
Kentucky Voices for Health
Legal Aid Justice Center
Legal Council for Health Justice
Mano a Mano Family Resource Center

Michigan Disability Rights Coalition
MS Black Women's Roundtable
Mujeres Latinas en Accion
National Consumer Law Center (on behalf of its low-income clients)
National Council of Jewish Women, Pennsylvania
National Disability Rights Network (NDRN)
New Jersey Citizen Action
New Mexico Center on Law & Poverty
New York State Council of Churches
Northwest Harvest
Northwest Health Law Advocates
Pennsylvania Health Access Network
People Power United
Protect Our Healthcare Coalition RI
Public Counsel
Service Employees International Union, Local 49
Special Needs & Parent Support Services of LA, LLC
South Carolina Appleseed Legal Justice Center
Southwest Georgia Project for Community Education, Inc.
Southwest Suburban Immigrant Project
Southern Vermont Area Health Education Center
SOWEGA Rising
Third Way
Tzedek DC
UHCAN Ohio
UnidosUS
La Union del Pueblo Entero
Virginia Coalition of Latino Organizations
Virginia Interfaith Center for Public Policy
Virginia Poverty Law Center
Western Center on Law and Poverty
Young Invincibles