American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

September 11, 2023

The Honorable Rohit Chopra
Director
Consumer Financial Protection Bureau

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

The Honorable Thomas C. West Jr.
Deputy Assistant Secretary for Domestic Business Tax, Office of Tax Policy
U.S. Department of the Treasury

Submitted Electronically

RE: Request for Information Regarding Medical Payment Products

Dear Director Chopra, Administrator Brooks-LaSure, and Deputy Assistant Secretary West:

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, we thank you for the opportunity to provide our perspective on certain financial products patients may use to pay for medical care (medical payment products).

Hospitals and health systems are very concerned about patients' medical debt. Hospitals are the only part of the health care sector that provide services to patients regardless of their ability to pay. In addition, they backstop that commitment by providing financial and other assistance for those who cannot pay — including helping patients qualify for federal and state health care programs, such as Medicaid and Medicaid. In doing so, patients can receive regular preventive care not just episodic care for serious injuries or illness. In addition, hospitals absorb billions of dollars of losses for patients who are unable to pay their bills, mainly due to inadequate

commercial insurance coverage; in 2020, the latest figure available, hospitals provided more than $42 billion in uncompensated care.[1]

This is why hospitals are staunch supporters of ensuring everyone is enrolled in some form of comprehensive coverage and, when that coverage is inadequate, hospitals also provide tens of billions of dollars in uncompensated care annually. They deeply value and take seriously their duty to care for anyone who comes through their doors regardless of ability to pay and, indeed, are the only part of the health care system with such awesome responsibility.

Unfortunately, major gaps in our health care coverage system leave patients exposed to costs they often cannot afford. The administration recently acknowledged this by allowing certain Medicare patients to pay for their prescription drugs over time.[2] These gaps are caused by inadequate health insurance coverage, excessive cost-sharing requirements and an erosion of coverage caused by restrictions on covered benefits. These problems often require that patients, who do not qualify for financial assistance from the hospital at which they received care, look for alternate approaches to pay for their care. No commercial insurance company offers any program of which AHA is aware to help patients pay when the gaps in their coverage threaten to create medical debt. And the fact is that no matter how generous, hospital financial assistance programs cannot close the gap inadequate commercial insurance coverage creates. That is why patients must look for other options, including payment plans, loans and credit cards.

The AHA is not an expert in the universe of financial products used to pay for medical care; however, our research and outreach suggests they are diverse, ranging from zero interest payment plans operated by a hospital or other provider to credit cards and loans sold by community-based lenders with no affiliation to a provider. We recognize that there is and should be a role for this agency to ensure that the commercial entities offering these financial products to patients are fair and transparent about the terms and conditions and abide by the hospital's financial assistance commitment and obligations. However, until there is more done to address the gaps created by commercial health insurance, it would be unwise for this agency to impede access to financing products that meet reasonable consumer protection requirements and can help patients pay for the care they need.

In the following comments, we aim to:

- provide additional context on patients' exposure to medical costs;

---

[1] https://www.aha.org/system/files/media/file/2020/01/2020-Uncompensated-Care-Fact-Sheet.pdf

[2] Seniors will be able to spread their out-of-pocket drug costs over 12 months under a new program recently announced by CMS, the latest effort by the Biden administration to address prescription drug costs. https://www.cms.gov/newsroom/press-releases/cms-issues-draft-guidance-new-program-allow-people-medicare-pay-out-pocket-prescription-drug-costs#:~:text=By%20enabling%20seniors%20and%20people,of%2Dpocket%20prescription%20drug%20costs.

- provide insights into the universe of medical payment products as we understand it; and
- provide considerations for policymakers and regulators interested in additional consumer protections in health care financing.

Patients' Exposure to Health Care Costs

Every single instance in which a patient seeks a medical payment product is triggered by a need to pay out-of-pocket for some or all the cost of a health care service. Nearly all patients are responsible for paying some portion of their care out-of-pocket. In many instances, patients pay their medical bills without issue. However, there are three specific scenarios in which patients' cost exposure may exceed their ability to pay, which may lead them to consider a medical payment product.

- The first is if they are uninsured.
- The second is if their health insurer subjects them to unaffordable cost-sharing requirements, making them effectively "underinsured."
- The third is when their insurer changes the rules of their coverage or denies medically-necessary care resulting in unexpected medical bills.

We explore each of these further below.

When individuals are uninsured, they are generally responsible for the entirety of their medical bills, though those with few resources are connected to coverage and/or may qualify for hospital financial assistance policies. While federal law requires hospitals to triage and stabilize any individual that presents to the emergency department, the government does not compensate hospitals for that care and does not prohibit hospitals from billing patients for the care they receive. While the rate of uninsurance is currently close to record low levels, there are still more than 25 million individuals who are not enrolled in comprehensive health insurance. In some states that have opted not to expand Medicaid, upwards of 18% of the population is uninsured.[3] These numbers are expected to grow as states complete the eligibility redetermination process for Medicaid as part of the COVID-19 public health emergency unwinding.

Insured individuals, in contrast, are generally responsible for paying a portion of their care out-of-pocket. Their cost-sharing is usually the result of some combination of copayments, deductibles and coinsurance established by their health insurer. While cost-sharing traditionally was seen as a way to reduce the risk of unnecessary utilization, insurers have increased the amounts of patient cost sharing to levels that far exceed what may be necessary to address that moral hazard.[4] The increasing share of the costs being shouldered by patients has also had the unintended effect of

---

[3] https://aspe.hhs.gov/sites/default/files/documents/e06a66dfc6f62afc8bb809038dfaebe4/Uninsured-Record-Low-Q12023.pdf

[4] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2783878#:~:text=The%20primary%20aim%20of%20cost,health%20care%20use%20to%20patients.

disincentivizing patients from seeking high-value care, such as preventive services, vaccines, or asthma medication, that are cost-effective and can be critical to maintaining health or preventing more severe and costly illness.[5] Recent consumer polling found that 68% of patients feel they are paying too much for health care and believe insurance costs are the driver behind why those costs are too high.[6] In addition, a majority of patients report their health insurance premiums being too expensive as part of their family budget, difficulty affording insurance or both. These results are confirmed by data on actual changes in health insurance benefit design.

Patients face significantly higher cost-sharing today than they did just 5 to 10 years ago. According to the Kaiser Family Foundation's 2022 Employer Health Benefits Survey, 88% of workers had a plan with a deductible in 2022, up from 72% in 2012; the average general annual deductible for single coverage was $1,562, which is 95% higher than in 2012.[7] The same survey found that most patients with employer-sponsored coverage face a copayment for office visits (on average, $27 for primary care and $44 for specialty care), and the majority of plans require coinsurance for hospital admissions. Coinsurance is particularly challenging for patients to plan for as the amount, which is a percentage of the cost of services rendered, can only be determined after the course of care is complete and the final costs are known.

The amount of cost-sharing required by health insurers is unaffordable for many patients. A recent Federal Reserve report on the economic well-being of U.S. households revealed that 37% of adults would not be able to afford a $400 emergency, an amount over which is $1,000 less than the average general annual deductible for single, employer-sponsored coverage.[8] And yet, health insurers continue to foist more of the cost of coverage onto patients, and the federal government permits it by setting the annual limit on out-of-pocket costs for most individuals at $9,100 (for 2023). It should therefore be no surprise that the same Federal Reserve report found that 25% of adults reported skipping medical care due to an inability to pay, including 43% of adults who reported being in poor health.

Challenges with cost-sharing are exacerbated for individuals and families enrolled in coverage products that do not need to meet the consumer protections that apply to most forms of comprehensive coverage. Specifically, short-term limited duration health plans and health sharing ministries can subject patients to even greater amounts of out-of-pocket costs than individuals enrolled in comprehensive coverage. In a recent proposed rule, the departments of Treasury, Labor and Health and Human Services

---

[5] Gibson TB, Maclean RJ, Chernew ME, Fendrick AM, Baigel C. Value-based insurance design: Benefits beyond cost and utilization. Am J Manag Care. 2015;21(1):32-35.
[6] https://www.aha.org/infographics/2023-07-11-new-consumer-poll-finds-patients-are-concerned-about-commercial-insurer-barriers-care-infographic
[7] https://files.kff.org/attachment/Report-Employer-Health-Benefits-2022-Annual-Survey.pdf
[8] https://www.federalreserve.gov/publications/2020-economic-well-being-of-us-households-in-2019-dealing-with-unexpected-expenses.htm

specifically called out the role of short-term limited duration health plans increasing the "risk of high out-of-pocket health expenses and medical debt."[9]

Cost sharing, however, is not the only way in which insurers offload more of the cost of care onto patients. Insurers increasing are scaling back the scope of their coverage even for medically-necessary care. They do this through coverage rules that restrict which services will be covered and where, and they often implement these coverage changes midyear when the patient does not have the option of switching plans. Recent examples of this include midyear restrictions on coverage for specialty drugs,[10] outpatient surgeries[11] and diagnostics,[12] as well as excessive use of prior authorization and inappropriate coverage denials. In other cases, insurers inappropriately deny covered services that meet coverage and billing rules, as was observed by the Office of the Inspector General for the Department of Health and Human Services (OIG-HHS) in their April 2022 report on Medicare Advantage denials. Patients who experience denials because of these coverage changes or inappropriate denials can be subject to unexpected medical bills. These unexpected bills, in turn, can disincentivize patients to seek care when they need it. Unexpected denials also make it difficult for patients to plan for medical expenses when medically necessary covered services are adjudicated and denied by their insurer sometimes months or years after the care was received. The same consumer polling referenced above found that 62% of patients report their household has experienced at least one insurance coverage-related barrier in the past two years; 43% of those patients report their health has gotten worse as a result.[13]

Below are several recent findings of how some health insurers inappropriately deny patient care, which can significantly impact patients' costs, including when frustrated patients eschew their coverage and solicit care on a self-pay basis.

- An analysis of government-reported data by the Kaiser Family Foundation found that "across HealthCare.gov insurers with complete data, nearly 17% of in-network claims were denied in 2021. Insurer denial rates varied widely around this average, ranging from 2% to 49%."[14]
- The aforementioned April 2022 HHS-OIG report found that 13% of Medicare Advantage Organization (MAO) prior authorization denials and 18% of claims denials were inappropriate, raising "concerns about beneficiary access to medically necessary care."[15]

---

[9] https://www.govinfo.gov/content/pkg/FR-2023-07-12/pdf/2023-14238.pdf
[10] https://static.cigna.com/assets/chcp/resourceLibrary/medicalResourcesList/medicalPlansAndProduct/cigna-specialty-pathwell-network.html
[11] https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medicaid-comm-plan/outpatient-surg-procedures-site-service-cs.pdf
[12] https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-medical-drug/screening-colonoscopy-procedures-site-service.pdf
[13] https://www.aha.org/infographics/2023-07-11-new-consumer-poll-finds-patients-are-concerned-about-commercial-insurer-barriers-care-infographic
[14] https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/
[15] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

- The OIG HHS found that many MAO prior authorization and payment denials were inappropriate, as evidenced by MAOs overturning 75% of their own denials raising "concerns that some Medicare Advantage beneficiaries and providers were initially denied services and payments that should have been provided. This is especially concerning because beneficiaries and providers rarely used the appeals process, which is designed to ensure access to care and payment."[16]
- The OIG HHS recently found that Medicaid managed care plans deny a high rate — one out of every eight — of prior authorization requests, and some plans had "prior authorization denial rates greater than 25 percent—twice the overall rate."[17]

Coverage has also grown more confusing in ways that can expose patients to greater costs. Much of this confusion is due to increasingly complex insurance designs that are not transparent to patients, such as what is covered pre-deductible, the interaction between point-of-service copays, coinsurance and deductibles, and poor communication and education by a patient's insurer. For example, a recent National Association of Insurance Commissioners (NAIC) report found significant gaps and inconsistencies with the way that insurers share information about pre-deductible, no cost-sharing preventive services with their members, resulting in a "meaningful barrier to effective understanding and use of preventive service benefits."[18]

The combination of high rates of uninsurance, increasing patient cost-sharing requirements, inappropriate coverage denials and patient confusion over their coverage makes it hard for patients to plan and subsequently pay for their care. Gaps in coverage, due to uninsurance and underinsurance, may force patients to turn to other tools to help finance their care, including various medical payment products.

Role of Financial Assistance and Medical Payment Products

Patients have several options for paying for their portion of the cost of their care. They can pay their bills immediately using their preferred approach; they can apply for financial assistance; or they can look to a medical-specific financing option, such as a payment plan, a medical loan or a medical credit card.[19] Hospitals and other providers may only be privy to certain details of these arrangements. For example, if a patient elects to pay for their care with a standard credit card, the hospital is generally not

---

[16] https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf
[17] https://oig.hhs.gov/oei/reports/OEI-09-19-00350.pdf
[18] https://healthyfuturega.org/ghf_resource/preventive-services-coverage-and-cost-sharing-protections-are-inconsistently-and-inequitably-implemented/
[19] It is worth noting that unless a patient alerts the hospital to financial concerns, use of a standard credit card does not necessarily suggest to hospitals that a patient is experiencing financial challenges. Indeed, many patients may elect to pay all types of bills via credit cards for reasons that have nothing to do with a need for financing, such as the ability to track purchases, the security credit cards offer over cash, or the accumulation of points/benefits the card may offer. In addition, like many industries, not all providers accept cash payment.

aware of or involved in the terms of the agreement between the patient and the lender. This also can be the case with medical-specific payment products that are sold in the community. Below, we further discuss hospital financial assistance programs and medical payment products.

Hospital Financial Assistance Programs

If a patient alerts a hospital to the need for assistance with their bill, they will be assessed first for eligibility for both health care coverage and for financial assistance (whether the individuals is uninsured or underinsured). While financial assistance policies are required for tax-exempt hospitals, all full-service hospitals offer financial assistance. Hospitals tailor these policies to both meet the needs of their communities, as well as ensure that the hospital can absorb the expense of these policies without sacrificing access to care in the community. As such, there can be variation in hospital policies. However, the AHA has a long history of promoting voluntary patient billing guidelines that carefully balance those interests.[20] The billing guidelines encourage hospitals to provide care at no cost for individuals below 200% of the poverty level and at a discounted rate for individuals up to a certain amount of income and assets that makes sense for their community. Tax-exempt (as well as most, if not all, for-profit) hospitals inform patients about the availability of financial assistance in a variety of ways, including directly with the patient, conspicuous notices in the admissions area and the emergency room, through the hospital website, upon request, through various community channels that focus on those most likely to be in need, and in the bill.

Indeed, the Internal Revenue Service's (IRS) 501(r) regulations require that tax-exempt hospitals adhere to a number of patient-centered practices. Tax-exempt hospitals must:

- **Limit Extraordinary Collection Actions (ECAs):** 501(r) regulations mandate that tax-exempt hospitals must make reasonable efforts to determine whether a patient is eligible for financial assistance before engaging in ECAs, such as filing liens, wage garnishments, or reporting unpaid debts to credit agencies. This helps protect vulnerable patients from aggressive collection tactics.
- **Notify Patients of Financial Assistance Policies:** Tax-exempt hospitals are required to clearly communicate their financial assistance policies to patients. This includes providing written notice about the availability of financial assistance and the application process. This transparency helps patients understand their options and rights.
- **Adhere to Fair Billing and Collection Practices:** 501(r) regulations stress the importance of billing patients in a clear, concise, and understandable manner. Bills should include essential information about the services provided, the charges incurred, and any financial assistance available. Hospitals must also provide patients with plain-language summaries of their bills.

[20] https://www.aha.org/standardsguidelines/2020-10-15-patient-billing-guidelines

- **Charge Reasonable Billing Amounts:** The regulations specify that the amounts charged to patients eligible for financial assistance must be limited to what would be billed to an individual with insurance. This prevents uninsured and underinsured patients from facing exorbitant charges.
- **Not Discriminate:** Tax-exempt hospitals are prohibited from discriminating against patients based on race, ethnicity, or other protected characteristics. This ensures that all patients are treated fairly and without bias.
- **Use Plain Language Communications:** The regulations emphasize using plain language in all communications with patients, including financial assistance policies, billing statements, and collection notices. This helps ensure that patients can understand their rights and responsibilities.
- **Conduct a Community Health Needs Assessment (CHNA):** Tax-exempt hospitals must conduct a CHNA every three years to identify and address the health needs of their communities. This process involves soliciting input from the community, including patients, to better align services with community needs.

In summary, 501(r) regulations provide a regulatory framework that encourages tax-exempt hospitals to adopt patient-centered collection practices by promoting transparency, limiting aggressive collection actions, and ensuring that patients are aware of their rights and available financial assistance options. These regulations aim to strike a balance between hospitals' financial sustainability and fair treatment of patients, especially those who are vulnerable or facing financial hardship. And while these regulations only apply to tax-exempt hospitals, many, if not most, other hospitals also follow similar practices.

Medical Payment Products

Patients may have other options for financing their care if they do not qualify for financial assistance. Many hospitals offer payment plans — something that patients themselves have requested according to input from our members, as well as consumer research.[21] In addition, some hospitals may either directly offer loans or make referrals to different payment products offered by independent third parties. Separately, and not uncommonly, patients may find their own independent financing within the community, such as through a personal loan or medical credit card. Hospitals generally have no way of knowing if a patient has obtained a personal loan or credit card to finance their care and are not subject to the terms of those arrangements.

Notably, hospitals report seeing an increase in community-based financing products. We have heard instances of patients requesting that hospitals allow them to use medical credit cards that were sold to them in veterinary offices or when they were paying for retail medical services, such as cosmetic surgery. Again, hospitals are aware of these products but not privy to the agreements between the vendors selling them and

[21] https://www.flywire.com/resources/survey-patients-prefer-payment-plans-as-payment-option

the patients purchasing them. They also have no knowledge or ability to intervene in any consequences should patients default on them. Therefore, it is entirely possible that a patient may be sent to collections for medical debt they held on one of these community-based loans without any awareness by the provider.

Considerations for Policymakers

We appreciate the agency's attention to potentially concerning medical payment products, especially considering Americans' high exposure to financial strain and debt. In the first quarter of 2023, household debt in America rose to $17.05 trillion, representing a precipitous increase over the last decade.[22] In part, rising debt can be attributed to cost growth outpacing income growth which requires many Americans to borrow more to pay for a wide range of goods and services, including housing, higher education and consumer goods. For example, one study found that college costs have increased by almost 170% since 1980, while the average earnings for young adults aged 22-27 have increased only by 19%.[23] Middle class Americans are shouldering much of this debt, and many are living paycheck to paycheck. Medical debt, a consequence of patients not paying some or all their health care bills, is one type of debt held by many Americans, and some of that debt may be held in the types of medical payment products described in the RFI.

We strongly recommend tackling the root causes that lead patients to seek medical payment products: reducing patient exposure to unaffordable health care costs. This would best be achieved by ensuring all individuals are enrolled in some form of comprehensive health care coverage with affordable cost-sharing. Such an approach would not only minimize the need for medical payment products (therefore limiting the risk of potentially predatory products), but it would provide innumerable other benefits to patients, communities and providers.[24] Specifically, coverage is associated with improved patient access to care, improved health outcomes, appropriate health care utilization, improved ability of individuals to participate in the workforce, and reduced incidence of both violent and property crime, among other individual and community benefits.

The following are six concrete ideas to prevent patients from experiencing unaffordable costs for their care.

- **Continue efforts to ensure every individual is enrolled in some form of comprehensive health care coverage with a particular focus on connecting**

---

[22] https://www.newyorkfed.org/microeconomics/hhdc
[23] https://www.cnbc.com/2021/11/02/the-gap-in-college-costs-and-earnings-for-young-workers-since-1980
[24] https://www.aha.org/guidesreports/report-importance-health-coverage#:~:text=Studies%20confirm%20that%20coverage%20improves,on%20individuals%2C%20families%20and%20communities.

people to existing coverage options for which they may be eligible, as well as expanding Medicaid in every state.

- **Remove providers from the collection of cost-sharing altogether by requiring health insurers, which are the entity determining how much patients must pay, to directly collect the cost-sharing amounts they impose.** This approach would eliminate most patient bills from providers altogether.
- **Restrict the sale of high-deductible health plans to only those individuals with demonstrated means to afford the associated cost-sharing.**
- **Prohibit the sale of health sharing ministry products and short-term, limited-duration plans that offer coverage for longer than 90 days.**[25] These products frequently leave patients exposed to medical bills they expected would have been covered and generally lack consumer protections.
- **Lower the maximum out-of-pocket cost limits that apply in most forms of health care coverage and establish such limits where they do not exist today.** As previously noted, individuals in many health insurance plans face up to $9,100 in total annual cost sharing. For Medicare beneficiaries without any supplemental coverage, there is no limit on how much they may need to pay in cost-sharing. Capping out-of-pocket costs at more reasonable amounts, especially for lower to middle income individuals and families, would significantly reduce the need for medical payment products.
- **Hold the health insurers accountable to providing a full and robust eligibility information via the 270/271 response for the HIPAA transaction set.** The lack of or limited information provided by the plans electronically makes it difficult for hospitals to provide true patient transparency and the development of sound cost estimates for patients. Electronic health insurer responses often do not provide benefit limitations (what is/is not a covered benefit) or the copays and benefits for certain service codes despite the mechanism for doing so already existing.

With respect to the inquiries related to tax-exempt hospitals and the selling of medical debt, the RFI explains the requirements for tax-exempt hospitals, which are comprehensive. Specifically, in order to sell medical debt, hospitals must enter into a legally binding contract with the buyer that:

1. prohibits extraordinary collection actions;
2. limits interest to that allowed under treasury regulations, currently 7%;
3. assures the debt is recallable if the patient subsequently qualifies for financial assistance; and

[25] The Centers for Medicare & Medicaid Services recently issued a notice of proposed rulemaking to limit short-term limited duration health plans to no more than four months, which we support. See: https://www.cms.gov/newsroom/fact-sheets/short-term-limited-duration-insurance-independent-noncoordinated-excepted-benefits-coverage-level

4. should the debt not be recalled, limits repayment to the amount the patient would have paid under the hospital's financial assistance policy.

These requirements are designed to protect patients who do not qualify for financial assistance at the time care is delivered but do so before the debt is satisfied. Any concerns about applying these consumer protections more broadly for other types of financial products patients may use to pay their debt should be directed to the financial firms that offer those products. Ensuring the financial payment products are adequately disclosed and fairly administered is well within the agency's responsibility and should be the focus of its efforts. Hospitals are at a disadvantage where the agency is not in ensuring these sensible consumer protection measures are required of the financial firms that make these products available. As discussed above, patients may acquire these products in many different venues outside the control of the hospital, e.g., veterinary offices, doctor's offices and clinics. Imposing obligations solely on hospitals, which are concerned about patient debt and already aiding those most in need, and not on the financial industry more generally would be neither prudent nor effective in addressing the issue about which the agency is concerned.

We appreciate your consideration of these issues. Please contact me if you have questions or feel free to have a member of your team contact Molly Smith, AHA's group vice president for public policy, at mollysmith@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development