August 9, 2024

The Honorable Rohit Chopra, MBA
Director
Consumer Financial Protection Bureau
1700 G Street NW
Washington, DC 20552

Re: Docket No. CFPB-2024-0023; RIN 3170-AA54

Dear Director Chopra:

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

The American Medical Association's 2022 Benchmark Survey reports that more than 70% of emergency physicians in the U.S. are independent contractors. Thus, they are not employed by hospitals where they practice. The nature of independence, consequently, is that they do not have access to the financial support that hospital-employed emergency physicians would otherwise ordinarily have.

EDPMA thanks the Consumer Financial Protection Bureau (CFPB) for the opportunity to provide feedback in response to its proposed rule entitled "Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information (Regulation V)." As the proposed rule states, in 2022, 41% of adults stated they had some kind of medical debt, which makes this an issue of urgent importance.

Emergency medicine physicians are dedicated to protecting patients, including from unexpected medical bills due to limits on care and payment created by insurance products. Concurrently, EDPMA and its members are committed to protecting the emergency care system.

Most importantly, emergency medicine is unique because it is subject to the longstanding federal law EMTALA (Emergency Medical Treatment and Labor Act). Since 1987, EMTALA has provided a statutory guarantee that every patient who presents to an emergency department must be evaluated and medically stabilized regardless of the patient's insurance status or ability to pay for their care. Said another way, 100% of all patients who come to the emergency department for timely care benefit from EMTALA's protections and care.

Unlike office-based practices, which can identify insurance status and collect patient deductible and cost-sharing payments, emergency physicians cannot collect this same information at the time of service due to EMTALA. Instead, emergency physicians must first diagnose the emergency medical condition and provide stabilizing treatment before even identifying the source of payment. This creates a vastly different dynamic, which we believe necessitates certain exemptions with respect to the delivery of emergency care. Regardless of the obligations and responsibilities it imposes on emergency physicians, EMTALA is a critical feature of our nation's safety net and emergency care system. EDPMA members are proud to be a pivotal part of that safety net.

As a direct result of EMTALA, emergency physicians see patients with a broad representation of insurance statuses and products, including the uninsured Medicaid, Medicare, and commercially insured patients. Even for patients with insurance, high deductible and cost-sharing requirements result in patients being underinsured relative to what they are able to pay.

Compared to private insurance rates, relatively low Medicaid and Medicare payment rates, combined with lack of coverage for uninsured patients, can contribute to a funding gap for emergency services. With 11% of emergency visit costs attributed to self-pay or no-charge patients, 25% attributed to Medicaid beneficiaries, and 30 percent attributed to Medicare beneficiaries (see data here), more than 65% of aggregate emergency visit costs are at risk of underpayment. Coupled with significant workforce challenges in recent years, this results in a substantial strain on emergency care practices.

As stated above, office-based practices and other specialties not subject to EMTALA have more flexibility to adjust processes for patient financial screening or patient scheduling to ensure the economic stability of their practices. Physician practices that are not subject to EMTALA can first inquire about patients' ability to pay or require insurance information or payments before care is delivered. Emergency physician practices have the unique opportunity, but also the affirmative challenge of providing clinical care first, and only afterwards attempt to collect appropriate reimbursement in order to sustain their practices and provide timely patient access to care.

Across the healthcare system, the national trends towards cost-shifting are evident in health insurance coverage and have exacerbated the issue of medical debt. Because of the EMTALA impacts described above, these cost-shifting trends have a uniquely detrimental impact on patients in need of timely emergency care and the clinicians who treat them.

Insurers are increasingly shifting costs to patients through plans with high deductibles and high levels of post-deductible cost-sharing. According to the Kaiser Family Foundation, just 3% of covered workers were enrolled in Health Savings Account-qualified High Deductible Health Plans in 2007. By 2023, that percentage had increased to 24%, and the general annual deductible for family coverage was $4,674. In other words, almost a quarter of covered workers owe over $4,600 out-of-pocket before their insurer begins to pick up a share of the cost.

Not only are more families subject to deductibles, the size of the deductibles themselves has increased exponentially. According to KFF's 2023 Employer Health Benefits Survey, "Among workers with single coverage and any deductible, the average deductible amount has increased 10% over the last five years and 53% over the last ten years." (Emphasis added.) For the 28% of Americans with less than $1,000 in savings, this kind of coverage amounts to having no coverage at all. The average patient cannot afford a deductible of thousands of dollars. Increased cost-shifting onto patients is a significant driver of medical debt, which must be addressed as a matter of policy. Simply omitting credit reporting will not address this issue for patients, nor does it make the debt disappear. Furthermore, it does not provide the resources required to sustain emergency care, which is the nation's only health care safety net.

Additionally, the proposal has an unintended consequence that could inadvertently encourage even more cost-shifting onto consumers by payers, thereby further destabilizing an already fragile acute care system. Currently, there is no consequence for insurers shifting costs onto patients. This proposal tells insurers (who are flush with premium revenues) that even greater cost-shifting to patients (who already have trouble meeting their payment obligations) will be met with fewer consequences, leaving the providers of medical care – largely emergency providers – as the only party bearing the consequences of insurers' increasing underfunding of coverage.

As the proposal states, there are unique attributes to medical debt that reduce its usefulness for purposes of credit scoring and underwriting. However, preserving medical debt credit bureau reporting for a select subset of commercially insured patients who possess the financial means to remit payment for their emergency care is a necessary tool to facilitate payment and help offset the pressures emergency physicians are facing with regards to escalating uncompensated care. Experience has shown that financially viable medical debtors are faced with the need to remove blemishes from their credit report when seeking mortgages and loans remit long overdue payments.

Notably, in the case of overdue payments to emergency medicine practices, the problem expressed by the CFPB – that is, information about medical debt being prone to error – is alleviated when considering emergency care. Indeed, emergency medicine providers have long recognized that for the insured population, it is impractical and imprudent to bill prior

to insurance payer claims adjudication, which in turn validates the accuracy of the debt and patient obligation as specified in payer-issued explanations of benefit (EOBs).

Due to ever-increasing cost-shifting to patients, these outstanding balances serve as a critical source of revenue needed to sustain the emergency medical safety net. At the same time, creating a medical debt floor and ceiling not to fall below $100 nor above $1,000 as a safe harbor for credit bureau reporting ensures that small balances do not unfairly encumber medical debtors' credit history and that excessively large balances do not bankrupt individuals that can hound debtors for the rest of their lives.

In closing, EDPMA thanks the CFPB for this opportunity to respond to the proposed rule. We remain hopeful that the CFPB recognizes the unique challenges imposed by EMTALA on the delivery of emergency care by independent practicing emergency department physicians.

We trust the CFPB recognizes the challenges faced by the emergency medical safety net and the unintended financial consequences well-meaning proposed rulemaking could have on the fragile system that currently exists. Therefore, we hope you will consider our feedback and impose a safe-harbor exception by allowing credit bureau reporting of medical debt incurred by commercially insured health plan beneficiaries for cost-sharing obligations on insurer/health plan adjudicated amounts of not less than $100 and no more than $1,000.

Contact Cathey Wise, EDPMA's Executive Director, at cathey.wise@edpma.org with questions or clarifications.

Sincerely,

Andrea Brault

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Chair
Emergency Department Practice Management Association