08/12/2024

Ladies and Gentlemen:
My name is Kimberly Scaccia and I am the Vice President of Revenue Cycle at Mercyhealth Systems. In this letter I represent Mercyhealth from the perspective of our accounts receivable team. I am writing to ask you to consider our concerns regarding the Consumer Financial Protection Bureau's ("CFPB") Notice of Proposed Rulemaking on the Fair Credit Reporting Act related to medical debt and credit reporting.

The current proposed rule stands to impact over sixty million dollars in our receivable operations, which directly affects our financial model and would therefore negatively impact the patients we are here to serve. In its proposal, the CFPB requests comments about the potential impacts on health care providers' revenues and costs. It specifically references the possibility of an increased need to litigate to recoup payments. This proposed rule will increase administrative costs and will drive up the cost to provide quality healthcare to the communities we serve.

According to the American Hospital Association's comments on the CFPB's proposal outline, this rule could take away the incentive for patients to purchase insurance if they expect they will not have to pay their medical bills. Patients who choose to forego insurance coverage may have limited access to health care, as the financial assistance hospitals and health care providers, like Mercyhealth, are able to provide is not a match for comprehensive health insurance.

I have personally reviewed multiple comments related to his ruling; most appear personal in nature and lack the understanding of what has occurred in the past decade in healthcare including the rise of High Deductible Health Plans (HDHP), Medicare Advantage growth, and the complete lack of governmental oversight on the payer side of the equation, causing the burden and cost to be borne by the healthcare provider.

For example, in January 2022, the No Surprises Act went into effect with a goal to protect consumers from surprise medical bills. There were numerous requirements on healthcare providers to create and publish complex files and good faith estimates for patients, causing additional cost in labor and technical resources to the healthcare provider. However, one key factor of the No Suprises Act required healthcare payers to provide an Advanced EOB; this document was designed to ensure the patient and the provider were fully aware of the expected total out of pocket costs for the patients we serve, which is governed by the patient's insurance, not the healthcare provider. Now, almost two and a half years later, this Advanced EOB has not gone live and the regulatory agencies have continued to allow that requirement to be repeatedly deferred. All of this while payer profits continue to skyrocket and healthcare organizations suffer compounding financial losses and an increasingly complex payer/patient/provider landscape, driving increased costs of care and reduced access and quality for the patients and communities we serve. (see Becker's 2/7/2024 Article of "Big Payers ranked by 2023 profit").

Additionally, according to the American Medical Association, "…the size of HDHP deductibles has also increased dramatically, leading to financial challenges for patients facing increased out-of-pocket (OOP) health care costs. In studying HDHP dynamics, research has found that reductions in health care spending achieved through HDHPs have been due to patients simply receiving less medical care. Patients declining recommended evidence-based medical services can lead to negative clinical outcomes, increased disparities, and higher aggregate costs." This is yet another example of the payer-driven

healthcare industry within which we live; denials and reductions in payments plague the industry and healthcare insurers provide less than acceptable benefits for their consumers.

In the manuscript published in 2021, "Impact of High Deductible Health Plans on Diabetes Care Quality and Outcomes: Systematic Review", the authors state:

> "Our review of the literature reveals that while HDHPs reduce some healthcare utilization and costs, they do so at the expense of limiting necessary high-value care and medication adherence. HDHP impact on delayed or deferred care is disproportionately felt by lower-income individuals, who also have the highest burden of diabetes and its complications.33 Policymakers, employers, payers, and healthcare providers should be cognizant of the potential detrimental nature of HDHPs when assessing the best course of action for diverse populations."

Even more concerning, is that according to the Kaiser Family Foundation, "Health insurance, however, does not offer ironclad protection as one in five adults with insurance (21%) still report not getting health care they needed due to cost."

Mercyhealth, like many health systems across the nation, works tirelessly to locate community benefits, educate consumers on healthcare payer rules, regulations, and the complex language surrounding deductibles, coinsurances and more. Our uninsured patients are provided with options for financial assistance, copay assistance, and in some cases COBRA assistance. While uninsured patients, in our opinion, could be provided additional benefits, my goal here today is to focus on the larger problem of underinsured patients. As previously mentioned this problem could negatively impact over $60 million in receivables for Mercyhealth 49.9% of that amount is directly related to patients who have primary insurance.

While I understand the desire to assist consumers with surprise medical debt or to ensure that uninsured patients are not negatively impacted by healthcare costs, I truly believe that the CFPB should set some parameters around uninsured vs. insured patients in its ruling. Many patients who purchase insurance are not educated by their employer or the payer to understand exactly what they have purchased. This leaves patients misunderstanding their financial responsibility when healthcare services are needed. By working together in this space, providing education to patients and employers about the healthcare payer landscape and the purchases of healthcare insurance that consumers make, we truly could make a difference for not only health care providers across the country, but most importantly, our patients and the communities we serve.

Unfortunately, by passing this ruling as written, the CFPB will eliminate the only option that healthcare providers have in pursuing amounts owed that otherwise would result in litigation. Litigation is an unpleasant process for all involved, it is expensive and the resulting wage garnishments would further drive-up administrative healthcare costs in this country. I don't believe the CFPB desires any of these outcomes and would strongly encourage further review and potential partnerships for education as well as potential lobbying for payer involvement in this matter.

Respectfully,
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Kimberly Scaccia
Vice President of Revenue Cycle
Mercyhealth Systems, Inc.

References:

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