



August 25, 2023

Octavian Carare
Supervisory Economist
Consumer Financial Protection Bureau
Comment Intake—Request for Information Regarding Medical Payment Products
1700 G Street, NW
Washington, DC 20552

Czarina Biton
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: Docket No. CMS-2023-0106
P.O. Box 8010
Baltimore, MD 21244-8010

Thomas West
Deputy Assistant Secretary
U.S. Department of the Treasury
Attention: Docket No. TREAS-DO-2023-0008
1500 Pennsylvania Avenue, NW
Washington, DC 20220

RE: Request for Information Regarding Medical Payment Products

Dear Ms. Carare, Ms. Biton, and Deputy Assistant Secretary West:

On behalf of the American Speech-Language-Hearing Association (ASHA), I write to offer comments on the request for information regarding medical payment products.

ASHA is the national professional, scientific, and credentialing association for 228,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology assistants; and students. Many ASHA members treat patients who may use medical payment products to pay for health care services; therefore, we have a vested interest in ensuring their patients maintain access to critical health care services without assuming significant and inappropriate financial risk.

II. REQUEST FOR INFORMATION

A. General Questions

- 9. How do medical payment products and health insurance coverage interact? Do group health plan or health insurance issuer practices contribute to uptake of medical payment products by patients and providers?*

It is possible that health insurance vendor practices are leading to an uptick in the use of medical payment products. For example, some plan beneficiaries might not be aware of any restrictions on coverage for services (e.g., audiology and speech-language pathology services) such as prior authorization or the scope of cost sharing. A recent study by the Department of Health and Human Services Office of Inspector General (HHS OIG) found that approximately 18% of prior authorization requests submitted to Medicare Advantage plans were inappropriately denied, leading to appeals and delays in care. The same can be said for prior authorization requests that are submitted to Medicaid managed care plans, where HHS OIG found that 12 of the 115 managed care plans reviewed had a denial rate greater than 25%.¹

A patient in need of critical health care services does not have time to navigate this appeals process and hope the denial will be overturned. Income-restricted beneficiaries cannot pay out of pocket and hope for reimbursement. As a result, patients may enlist the assistance of a medical payment product to ensure timely access to care pending the outcome of the appeals process.

ASHA believes that health insurance companies should be required to ensure all coverage and payment requirements are transparent and those with high appeal overturn rates should face consequences (e.g., civil monetary penalty). Patients should not be subjected to medical payment products because an insurance company cannot execute its own coverage policies fairly, accurately, or in a timely manner.

In addition, provider networks are often limited. For example, many pediatric patients are told by health care providers they are not in-network with a particular insurance company because the insurance company has restricted the network or has a lengthy and cumbersome process for granting “in-network” status to an out-of-network provider. In other cases, the payment rates offered by the plan are so low that accepting it would result in significant and inappropriate financial losses for the health care provider. Many practices have had to limit the number of patients they can accept per payer due to low payment rates to remain solvent. This further limits access to services for those who are unable to pay out-of-pocket. In any scenario, the patient is either permanently or temporarily blocked from accessing coverage for needed health care services and may turn to a medical payment product. ASHA has long advocated for open networks that maximize access to patients who need audiology and speech-language pathology services. Subjecting a plan beneficiary to a medical payment product due to an artificially or inappropriately limited provider network or low provider payment rates is unconscionable.

Payment for audiology and speech-language pathology services is extremely low, and continues to fall year after year, across payers, failing to keep up with inflation. Since 2020, Medicare payment for these services has fallen by more than 5% each year. State Medicaid program payments have also continued to decline for a variety of reasons (e.g., state balanced budget requirements). Private payers have also continued to cut rates, often citing Medicare coverage and payment policies as a rationale. The totality of Medicare cuts that audiologists and speech-language pathologists (SLPs) have faced over the last several years are often artificial—such as federal “PAYGO,” Medicare budget neutrality requirements, sequestration, and balanced budget mandates—and are not based on the

actual cost of care. Payers can no longer consider the implications of their contractual rates in a vacuum.

The combination of cuts makes it challenging, if not impossible, for audiologists and SLPs to cover the cost of providing care. As a result, many providers are unable to enter into contracts with payers, which leads to increased financial exposure for patients. Without appropriate payment for these services, patients may be forced to utilize a medical payment product—despite having insurance coverage—due to the lack of in-network providers.

As highlighted in the RFI, the Administration is interested in understanding if medical payment products are more likely to be used by subpopulations. Studies show that people of color and people with disabilities are more likely to have medical debt. Given this, it is probable that medical payment products are disproportionately used by people with disabilities or people of color, further reinforcing the negative consequences of medical debt for these populations.²

In addition, many patients who require gender-affirming care, including but not limited to voice therapy, are precluded from accessing that care either by state law, payer policy, or both. The number of transgender Americans is approximately 1.4 million people—a relatively small but still significant number.³ These services are essential to ensure quality of life and safety for the patient. Gender-affirming care costs are not insignificant for an individual—between approximately \$25,000 - \$75,000—but when incorporated into an insurance plan's coverage policy, this care has limited financial implications for the plan and its policyholders.⁴ These costs can also include travel (e.g., transportation, hotel) and personal care services to assist patients without community support after a surgical procedure.

According to the Human Rights Campaign, when the city of San Francisco decided to include payment and coverage of gender-affirming care services for city employees, it imposed an additional per-employee per-month surcharge to offset the expected additional expenditures. By 2006, it had only spent \$386,417 of the \$5.6 million it had collected from this surcharge. It ended the surcharge completely.⁵ Exposing plan beneficiaries to the cost of gender-affirming care seems unreasonable given the comparatively minimal cost for such services. However, without this coverage, patients may feel compelled to utilize a medical payment product; thereby, increasing their financial exposure and compounding the physical and emotional strain associated with being gender nonconforming. In fact, questions arising about paying for these services were so ubiquitous that *Forbes* recently published an article to help identify sources of financing for these services outside of insurance coverage including home equity lines of credit, credit cards, medical credit cards, and personal loans.⁶ This reinforces the detrimental impact of limited coverage policies associated with gender-affirming care and the negative widespread impact of medical payment products for this patient population.

ASHA encourages state and federal policymakers to impose safeguards for individuals in need of gender-affirming care to limit their financial and health risks, including establishing standards for gender-affirming care coverage. Safeguards should protect patients from the predatory nature of medical payment products.

II. REQUEST FOR INFORMATION

C. HHS-Specific Questions

1. *What actions should HHS consider taking to address problematic practices related to medical credit cards or loans, particularly as they relate to patients eligible for or enrolled in Medicare, Medicaid, or the Children's Health Insurance Program, or patients enrolled in Affordable Care Act Marketplace plans?*

ASHA recommends HHS works to ensure that coverage policies implemented by marketplace plans, Medicare, Medicaid, and CHIP—including those administered by managed care plans—have developed equitable coverage policies to address the full range of physical and mental health needs of their beneficiaries.

We also suggest that HHS develop and enforce policies that preclude unfair practices such as narrow networks and prior authorization request processes that inappropriately and unnecessarily delay care. After such policies are developed, ASHA urges HHS to engage in robust oversight and enforcement activities to ensure payers are following the policies.

Thank you in advance for your attention to our comments. If you have any questions, please contact Sarah Warren, MA, ASHA's director for health care policy for Medicare swarren@asha.org.

Sincerely,



Robert M. Augustine, PhD, CCC-SLP
2023 ASHA President

¹ Department of Health and Human Services Office of Inspector General. (2023). *High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care*. <https://oig.hhs.gov/oei/reports/OEI-09-19-00350.pdf>.

² Kaiser Family Foundation. (2022). *The Burden of Medical Debt in the United States*. <https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states/#:~:text=Medical%20debt%20occurs%20across%20demographic,to%20owe%20significant%20medical%20debt>.

³ Mount Sinai Business Insider. (2019). *The Staggering Costs of Being Transgender in the US, Where Even Patients with Health Insurance Can Face Six-figure Bills*. <https://www.mountsinai.org/about/newsroom/2019/the-staggering-costs-of-being-transgender-in-the-us-where-even-patients-with-health-insurance-can-face-sixfigure-bills-benji-jones>.

⁴ Human Rights Campaign Foundation. (n.d.). *Are Gender-Inclusive Health Insurance Benefits Expensive?* [https://www.thehrfoundation.org/professional-resources/are-transgender-inclusive-health-insurance-benefits-expensive#:~:text=The%20total%20costs%20of%20transgender.drugs%20\(%24250%2C000%20per%20patient\)](https://www.thehrfoundation.org/professional-resources/are-transgender-inclusive-health-insurance-benefits-expensive#:~:text=The%20total%20costs%20of%20transgender.drugs%20(%24250%2C000%20per%20patient)).

⁵ *Ibid.*

⁶ Medine, T.. (2022). *How To Afford Transgender Surgery Expenses*. Forbes. <https://www.forbes.com/advisor/personal-loans/transgender-surgery-cost/>.