Testimony in Support of S.B. 395, An Act Concerning Medicaid Budgeting Methods and the Reporting of Medical Debt & S.B. 313, An Act Concerning Continuous Medicaid Eligibility for Children Under the Age of Six

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Human Services Committee

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Dear Senator Lesser, Representative Gilchrest, Senator Seminara, Representative Case, and esteemed members of the Human Services Committee,

Thank you for accepting this testimony in support of **S.B. 395, An Act Concerning Medicaid Budgeting Methods and the Reporting of Medical Debt** and in support of **S.B. 313, An Act Concerning Continuous Medicaid Eligibility for Children Under the Age of Six,** on behalf of Health Equity Solutions (HES), a nonprofit organization with a statewide focus on advancing health equity through anti-racist policies and practices. Our vision is for every Connecticut resident to attain optimal health regardless of race, ethnicity, or socioeconomic status.

S.B. 395, An Act Concerning Medicaid Budgeting Methods and the Reporting of Medical Debt

Medical debt is an escalating concern, which poses a significant threat to the financial stability and well-being of individuals, particularly those from continuously marginalized communities. It disproportionately affects Black and Latino/a individuals at rates exceeding the population average, compounding existing disparities in wealth and access to healthcare. As such, HES strongly supports Section 1 and Section 2 of S.B. 395, which seeks to prohibit the reporting of medical debt to credit rating agencies. Minnesota, New York and Colorado have already enacted this patient protection to prohibit hospitals and debt collectors from reporting medical debt to credit reporting agencies. Additionally, HES recommends the incorporation of measures to screen patients for hospital financial assistance and direct them to Office of Healthcare Advocate to address any outstanding medical bills, and allowing patients to purchase their medical debt at the rate collection agencies would purchase it at.

Unlike planned debts, such as mortgages, medical debt often results from unforeseen or emergency medical needs. It's a burden carried by those seeking care in dire circumstances — 72% of people attribute their medical debt to bills from one-time or short-term medical expenses associated with acute care, such as a single hospital stay or treatment for an accident at a hospital. The unpredictability of hospital costs compounds the problem; even when prices are publicly available, patients often face unexpected out-of-pocket expenses. Even among insured individuals, healthcare costs remain a significant barrier, with 42% of those purchasing insurance from Access Health CT struggling to afford rising healthcare expenses such as copays and deductibles. No one should be subjected to long-term financial insecurity imposed by the reporting of medical debt to credit rating agencies, amid already challenging circumstances following a hospital stay or accident treatment.

HEALTH EQUITY SOLUTIONS

Reporting medical debt to credit rating agencies exacerbates the financial burden faced by individuals already grappling with dire medical and economic circumstances. Once medical debt is handed over to collectors, individuals face a myriad of additional challenges, including diminished access to credit, an increased likelihood of bankruptcy, and the prospect of confronting costly and protracted collection litigation. While recent changes by national credit reporting agencies to not report medical debts under $500, have limited the impact of medical debt on credit scores, these measures fall short of adequately addressing the escalating scope of this pervasive problem. It does not help many Connecticut residents who currently get medical bills much higher than $500. Furthermore, a Consumer Protection Financial Bureau (CPFB) report on the impact of this decision finds that, "about half of all consumers who currently have medical collections on their credit reports will likely still have" them on there.

Medical debt is less predictive of future consumer credit performance than nonmedical debt. However, current practices in medical debt collections and reporting continue to cause significant harm to people with medical debt. Many patients have trouble navigating and accessing hospital financial assistance programs, due in part to the complexity of applying to those programs and a general lack of notification and guidance from hospitals. Many patients are coerced into paying invalid, unsubstantiated, or inaccurate medical bills by the threat or actuality of credit reporting of medical debt. Patients and their families can be barred from accessing the credit they need by reporting of medical debt on their credit reports, even though prior CFPB research shows that medical debt reported on credit reports is far less reliable and predictive of people's ability to pay their bills going forward. This practice not only threatens the integrity of the credit reporting system but also perpetuates systemic inequities, limiting access to credit and exacerbating financial hardships for communities of color and individuals with low-income.

Racial inequities in income, wealth, and insurance coverage play a role in the prevalence and burden of medical debt. Reflecting the legacy of systemic racism and discrimination in employment, Black, Latino/a, and other communities of color, and people with low income across racial and ethnic categories are disproportionately in lower credit score bands than their white counterparts and are more likely to face limited credit or credit invisibility. For example, Non-white Americans are more likely to have more credit card debt than emergency savings: 58% Black Americans and 47% Latino/a Americans say they have more debt than savings compared to 30% white Americans. Additionally, majority-Black communities and majority–Native American communities have the lowest median credit scores and the highest debt-in-collection rates, subprime credit score rates, and use of nonbank loans. These racial disparities reflect historical inequities that reduced wealth and limited economic choices for communities of color.

In a state where 7% of Black adults and 8% of Latino/a adults had no health insurance compared to 3% of White adults, the burden of medical debt already falls disproportionately on communities of color. To exacerbate the situation, **medical debt is also reported on credit cards at a higher rate for people living in predominantly Black/ Latino/a communities.** The compounding effects of facing higher probabilities of grappling with medical debt continue to push Black, Latino/a, and other communities of color into financial instability and prevent them from accessing wealth-building opportunities, thereby widening the racial wealth gap. When a single major medical expense jeopardizes a person's ability to rent, purchase a home, get a job, or receive credit, it calls for urgent systemic change.

HES respectfully urges this committee to pass this equity-focused proposal and respectfully recommends the following changes to the language in S.B. 395:

- Require hospitals to **screen patients for hospital and other patient financial assistance programs** to address any outstanding medical bills, as in Minnesota.
- Require hospitals **to direct patients to the Office of the Healthcare Advocate**.
- Allow patients to **purchase their medical debt at the rate collection agencies would purchase it at**, if they choose to do so. Connecticut already has a similar approach to this suggestion, as it applies to property law. It is known as the right of equitable right of redemption, which is a defaulting mortgagor's right to prevent foreclosure proceedings and redeem the mortgaged property by discharging the debt secured by the mortgage within a reasonable amount of time (thereby curing the default).

April 1st – 6th, is Health Equity Week, a yearly reaffirmation of Connecticut's commitment to eliminate inequities and ensure all residents can achieve optimal health. This year, Health Equity Solutions is advocating for *Affording Equity*, to address the financial barriers that hinder access to resources that impact overall health outcomes. Prohibiting the reporting of medical debt is one key component of broader affordability efforts, including improving access to and strengthening the enforcement of hospital financial assistance policies, expanding access to health insurance, erasing existing medical debt, cost-growth benchmarking, addressing pharmaceutical costs, and limiting extraneous fees. We are grateful for the committee's consideration and ***respectfully urge the advancement of Section 1 and Section 2 of S.B. 395 to*** address and alleviate the consequences of medical debt for Connecticut residents. Passing this bill could also help people across the country – the more states do this, the more likely the Consumer Financial Protection Bureau will implement this nationally.

S.B. 313, An Act Concerning Continuous Medicaid Eligibility for Children Under the Age of Six

HES ***strongly supports S.B. 313***, which would provide continuous eligibility for the Medicaid program for children under the age of six, and help address critical gaps in healthcare access and promote health equity. During the early developmental years, infants and young children require consistent access to healthcare services, including regular screenings and check-ups, to ensure their optimal growth and development. Young children also need these visits to ensure any social, emotional, or developmental delays are detected early and before beginning school. By implementing continuous Medicaid eligibility, Connecticut would join other states like New Mexico and Oregon that have already implemented continuous Medicaid enrollment for children until age six, and New Mexico and North Carolina who have similar waiver proposals pending.

Continuous eligibility for children under six would promote health equity by minimizing gaps in coverage for children from families with lower incomes. Disparities in health outcomes disproportionately affect children of color, and uninterrupted Medicaid coverage helps address this issue. Additionally, children who are Black, Latino, or multi-racial are more likely to be enrolled in Medicaid/CHIP. By extending continuous eligibility until age six, Connecticut ensures that these children start school on an equal

footing with their white peers. It would also benefit families facing income fluctuations, who are disproportionately Black and Latino/a, and/or families with low income or limited education, as it prevents unnecessary disruptions in healthcare access and reduces the risk of irreversible harm to children's health. Families experiencing churning, a phenomenon where families move in and out of Medicaid due to income changes, must search for new in-network providers, navigate different cost-sharing rules, and adjust to varying coverage plans. This administrative burden not only complicates access to necessary care but also places additional stress on families already struggling to make ends meet. By implementing continuous Medicaid eligibility for children under six, Connecticut can alleviate this burden and ensure that children remain covered despite income fluctuations.

Thank you for the opportunity to submit this testimony in favor of **S.B. 395 and S.B. 313.** We can be reached with any questions at kmoquete@hesct.org.