Ranking Member Pat Toomey (R-Pa.)
Opening Statement
Full Committee Hearing
March 29, 2022 at 10:00 AM

Thank you, Mr. Chairman.

Pricing risk accurately is critical to the safety and soundness of financial institutions, and to consumers' ability to access affordable credit. Because when borrowers default, lenders have to absorb the costs. That's why lenders generally look at information about credit history—it helps them estimate the risk of default and price loans.

Lenders who cannot access information that they consider predictive of risk are likely to restrict their lending to the borrowers with the thickest credit files, seek out relevant proxies for the credit information they aren't able to obtain, or increase the price of loans to all borrowers in order to capture the uncertainty and risk.

This hurts all consumers, including low-income families and those without a long credit history. For all of those reasons, the government should not suppress the reporting of accurate credit information.

Unfortunately, so-called consumer groups and allies have sought to remove info from credit reports and thereby make them less accurate. I'm afraid such actions will have unintended consequences.

Today's hearing title is the "Growing Burden of Medical Debt." It's an interesting but inaccurate title. Evidence suggests medical debt is actually falling, not growing.

According to the CFPB's own estimate, medical debt in collections last year was $88 billion. That's a nominal reduction of 10% over the last 3.5 years.

Another study showed that average medical debt in collection fell by 40% in the last decade. Yet over the same period, medical spending increased 70%—over 50% per capita.

Now, there are likely many reasons for a decline in medical debt. A primary driver was the improving economy. After tax reform in 2017, those with the lowest wages —those most likely to have medical debt—were making the biggest gains in income.

Another driver of the decline was the enactment of Obamacare and Medicaid expansion. Researchers estimate that for every $25 spent on Medicaid expansion, medical debt in collections decreased $1.

There are many aspects that have made me question the wisdom and efficacy of Medicaid expansion, including its cost and the lack of evidence that it improved health outcomes. But, unsurprisingly, if you're willing to spend massive amounts of other people's money, you can transfer individuals' debts onto the taxpayers.

So all available evidence suggests there is no "growing" burden of medical debt. In fact, the scale of medical debt is often misunderstood. Debt in collections represents less than 1% of all household debt. Two-thirds of medical debt collections are under $500. Bankruptcy from medical debt is extremely rare.

And medical debt is not strictly an American phenomenon. Every healthcare system in the developed world includes out-of-pocket payments.

According to the WHO, even before Medicaid expansion, the likelihood that out-of-pocket expenses would exceed a quarter of one's income was roughly as rare in the US (0.8%) as Canada or the UK (0.5%), and rarer than in Italy (1.1%), Spain (1.8%), Korea (3.9%), or Switzerland (6.7%).

Recently, credit reporting agencies announced changes that will reduce the amount of medical debt that appears on consumer credit reports going forward.

Now, if a credit reporting agency decides to exclude this information, I don't think it's the government's role to meddle with such a decision. However, if credit reporting agencies had collectively decided the opposite—that every one of them would begin at the same time to add consumers' medical debt info onto reports—I suspect the howls and protests about greed and collusion from the usual suspects would have been deafening.

What appears to have occurred here was that a political campaign, which included the CFPB, bullied lenders and credit rating agencies into removing this information. This kind of misuse of power by the administrative state has grown all too common. And it's an example of how Congress has become far too comfortable with the executive branch seizing the Article I lawmaking authority.

We need to be very careful that any actions considered to address symptoms—in this case debt from a health condition—don't make matters worse. This new credit reporting agency policy doesn't actually lower the cost of medical care. In fact, it will either raise costs or reduce access.

It may end up discouraging people from paying medical bills. That could lead to health care providers finding ways not to treat individuals without an obvious means to pay. And by eliminating one metric in a credit rating, it may cause credit rating agencies to use other metrics that are less accurate, which could actually hurt low income populations more.

These kind of downstream effects wouldn't be shocking given that the entire effort to micromanage credit ratings is coming from an agency that has no expertise on complex medical billing and health care systems.

It should remind us that intervention into the market—no matter how noble advocates may think they are being—will have consequences. And interventions should come after careful deliberation by the people's representatives, not diktats from unelected bureaucrats.