American Hospital Association

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February 28, 2014

Submitted electronically to www.regulations.gov
(RIN 3170-AA41, Docket No. CFPB-2013-0033)

Monica Jackson
Office of the Executive Secretary
Bureau of Consumer Financial Protection
1700 G Street N.W.
Washington, DC 20552

Re: Comments on CFPB's Advance Notice of Proposed Rulemaking (Docket No. CFPB-2013-0033) Regarding Collection of Medical Debts

Dear Ms. Jackson:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Consumer Financial Protection Bureau's (CFPB) advance notice of proposed rulemaking (ANPR) seeking information and comments on a wide variety of debt collection issues. In particular, we want to ensure that CFPB recognizes the significant ways in which medical debt differs from other types of consumer debt, and accounts for those differences when issuing future rules or guidance, or setting CFPB policy. Those differences also directly bear on a number of questions CFPB poses in its ANPR.

OVERVIEW OF MEDICAL DEBT

In the hospital setting, medical debt arises from very different circumstances than other forms of consumer debt. Hospitals are, of course, providers of medical services. However, unlike most other service providers, because of the complex web of laws, rules and other circumstances that hospitals face when providing care, hospitals typically can collect only a very small portion of the initial bill (in the form of a co-pay), if anything, at the time services are rendered. In addition, hospitals are required by law to provide certain medical services without regard to a patient's ability to pay. As a result, hospitals must seek the majority of their reimbursement through a complex, post-visit billing process that typically involves working with numerous potential payers, including one or more insurance carriers and the patients themselves.

The length of time it can take to sort out a patient's bill can vary greatly depending on the complexity of the visit, the number of insurance carriers involved, whether any coverage disputes arise, the patient's financial resources, the availability of public or charitable assistance and other factors. Typically, this post-visit billing process involves numerous correspondences with both the patient and the insurance carriers. If an insurer denies a claim or requests more information, the hospital billing staff often must then gather more information from the patient and medical providers. If a patient has multiple insurers, the hospital must determine which services can be billed to which coverage.

Hospitals provide care every day, 24/7; they are the medical safety net for their communities. While hospitals are providing care to individuals, some patients may also be experiencing financial hardships. Patients may be uninsured, may not be covered for particular procedures or may have exhausted certain reimbursement limits. Even patients with insurance may be unable to pay the out-of-pocket expenses that their insurers will not cover. As a result, the post-visit billing period often involves hospitals working proactively with patients to help them find ways to pay their bills. This might include trying to resolve insurance coverage disputes or helping to identify sources of public or charitable assistance. When patients are unable to pay out-of-pocket expenses, hospitals may offer a payment plan that allows patients to pay down their bills in an affordable manner over time. Such plans do not typically involve interest rates or other charges. Despite these various efforts, hospitals still go uncompensated for a considerable amount of their services. An AHA survey of 5,000 community hospitals in 2012 found that those hospitals were uncompensated for $45.9 billion of care, or 6.1 percent of their expenses.

It can take weeks or months after a patient's hospital visit to determine how much a patient must ultimately pay out of pocket. Concepts that may be relatively simple in the context of consumer debt can be much more complicated in the context of medical debt owed to hospitals. For instance, the concept of when a mortgage payment, a credit card payment or a bill from a service provider to a consumer is "due" or "past due" may typically be straightforward and governed by a credit agreement. However, when a particular medical account becomes past due will depend on the post-visit billing process that must occur to determine how much the patient ultimately owes. Consequently, rigid definitions of terms and concepts such as "due," "past due," "delinquency," and "default" may be less applicable in the medical debt context than they would be in other areas in which financial responsibility is more straight-forward. Although mortgage lenders, credit card companies, service providers and others may be able to set a standard number of days past-due after which a debt is considered delinquent or in default, the hospital billing process varies too widely for hospitals to adopt any such strict definitions.

Although the term "debt collection" has sometimes been used to describe a hospital's entire post-visit process to seek reimbursement, that usage is overly broad and misleading. In reality, the bulk of how hospitals actually seek reimbursement as part of the post-visit process is not "debt collection" in the typical sense of having a debt collector contact a consumer demanding immediate payment, but rather is working through the billing process to submit insurance claims, determine out-of-pocket expenses owed, and work with patients to review their financial responsibility and options for financial assistance, if needed. It is generally only after the patient's ultimate out-of-pocket expenses have been determined, and the patient has been

notified of the amount due and given a certain amount of time to remit payment that the hospital will actually send the account to a debt collector. This is true even where the hospital centralizes or outsources the post-visit process.

IMPLICATIONS FOR CFPB

CFPB should carefully consider these unique attributes of medical debt in the hospital setting when issuing future rules or guidance, or setting CFPB policy. Several points about the nature of medical debt are particularly relevant for CFPB, and bear directly on several questions posed by CFPB in its ANPR.

MEDICAL DEBT COLLECTION BY HOSPITALS DOES NOT TYPICALLY INVOLVE A "CONSUMER FINANCIAL PRODUCT OR SERVICE"

In the initial section of the ANPR, CFPB states that it is seeking "comment on whether proposed rules should exclude certain types of debts or subject them to different requirements." CFPB has acknowledged that debt arising solely from a bill for services rendered, rather than an "extension of credit," is not a "consumer financial product or service" and recognized that medical debt often falls into this category in its October 2012 final rule defining larger participants for the consumer debt collection market. **The AHA agrees with this determination and encourages CFPB to expressly recognize that hospitals do not typically "extend credit" to patients and therefore do not generally offer or provide "consumer financial products or services" in connection with their billing and collections' practices.**

Hospitals do sometimes offer payment plans to patients who cannot afford to pay their out-of-pocket expenses at once. When hospitals do offer payment plans to a patient, they do so "exclusively for the purpose of enabling that consumer to purchase such nonfinancial good or service directly from the merchant, retailer, or seller." (12 U.S.C. § 5517(a)(2)(A)(i)). Moreover, unlike the types of extensions of credit subject to mandatory supervision under the Dodd-Frank Act (*e.g.*, mortgage, student and payday lending) hospital payment plans typically do not impose an interest rate or other type of finance charge. (See 156 Congressional Record S 2498, 2502, April 21, 2010, statement of Sen. Christopher Dodd stating that the Dodd-Frank Act was not intended to apply simply where a provider offered a payment plan.) In other words, hospitals offer such plans only to permit patients to pay for the hospitals' services in a more flexible and affordable way. Providing flexible payment options is another way for hospitals to assist patients who may otherwise have difficulty affording care.

TERMS LIKE "DELINQUENCY" AND "IN DEFAULT" IN THE CONTEXT OF MEDICAL DEBT COLLECTION SHOULD NOT BE REDUCED TO A SPECIFIC NUMBER OF DAYS PAST THE DATE OF BILLING

CFPB's ANPR requests information on how proposed rules should define certain terms such as "in default." As stated, defining these terms based on the passage of time from the date of billing does not offer the flexibility needed in the medical debt collection process. While such a hard

and fast definition may be appropriate for other types of consumer debt, it is often impossible to predict how long after a bill is "due" that a patient's ultimate liability for out-of-pocket expenses will be determined. There is no meaningful number of days after a hospital visit or other point that a bill can consistently be considered "in default" or "delinquent." **Thus, we strongly recommend that CFPB avoids any across-the-board definition of these or similar terms based on a specific number of days past due.**

Similarly, CFPB should not define "collections," "debt collector" or similar terms in a way that encompasses hospitals' post-visiting billing activities. These are not collections' activities in the standard sense, but rather an essential process for both the hospital and patient to resolve coverage issues, review financial options and determine the patient's liability.

CFPB SHOULD RECOGNIZE THE CONSUMER PROTECTIONS IN THE IRS'S REQUIREMENTS FOR 501(C)(3) HOSPITAL DEBT COLLECTION PRACTICES

As CFPB considers any potential rules, policy or guidance, it must carefully review existing regulations in the debt collection landscape to ensure that it is not creating confusion or redundancies. In particular, the AHA wants to ensure that CFPB fully considers the provisions and effects of the Internal Revenue Service's (IRS) oversight of tax-exempt hospitals and the debt collection rules for 501(c)(3) hospitals when determining how creditors should handle consumer disputes.

Questions 39 through 52 of the ANPR ask about policies and procedures for verifying debts and responding to consumer disputes under the Fair Debt Collection Practices Act (FDCPA) and the Fair Credit Reporting Act. Although hospitals are not subject to the FDCPA as first-party creditors, they would be affected by any validation rules imposed on the collections agencies with whom they contract. Separately, CFPB has expressed concern about medical debts sometimes being reported to credit reporting agencies (CRA) before patients have a reasonable opportunity to understand what portion of the total bill they owe. CFPB should be aware that many of its concerns as they may apply to 501(c)(3) hospitals are being considered and addressed by the IRS's proposed debt collection rules.

In brief, Section 501(r)(6) of the Internal Revenue Code forbids non-profit hospitals from engaging in "extraordinary collection actions" before making "reasonable efforts" to ascertain whether a patient is eligible for the hospital's financial assistance policy. (See 77 Federal Register 38148 June 26, 2012.) Extraordinary collection actions include reporting to credit agencies, as well as selling the debt or pursuing a legal remedy. Among other provisions, the IRS's proposed rule includes detailed requirements of the steps a hospital must take within a 120-day period before taking any extraordinary collection actions.

The IRS's proposed rules will require hospitals to make efforts to evaluate patients' eligibility for financial assistance based on their medical bills and financial circumstances, prior to reporting the debt to a CRA. Those efforts often will necessarily include validating the patient's bill and explaining charges and liabilities to the patient, and may address many of CFPB's concerns about insufficient validation and premature reporting.

CONCLUSION

The AHA greatly appreciates the opportunity to engage with CFPB on issues of medical debt collection and the unique challenges and circumstances that hospitals face in this field. We hope that CFPB will use the AHA as a resource for information and comments in order to understand better how hospitals work, the challenges they face in the debt collection landscape, and how any proposed CFPB actions will affect our members. If you have any questions, please contact me at (202) 626-2336 or mhatton@aha.org; or Maureen Mudron, deputy general counsel, at (202) 626-2301 or mmudron@aha.org.

Sincerely,

/s/

Melinda Reid Hatton
Senior Vice President and General Counsel