No. 19-14434

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

RICHARD HUNSTEIN
Plaintiff-Appellant

v.

PREFERRED COLLECTION AND MANAGEMENT. SERVICES, INC.
Defendant-Appellee

On Appeal from the United States District Court
for the Middle District of Florida
Case No. 8:19-cv-00983-TPB-TGW

BRIEF OF *AMICUS CURIAE* AMERICAN ASSOCIATION OF HEALTHCARE ADMINISTRATIVE MANAGEMENT IN SUPPORT OF APPELLEE'S PETITION FOR REHEARING *EN BANC*

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CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT

In accordance with FED. R. APP. P.26.1, the undersigned counsel states that *Amicus Curiae* American Association of Healthcare Administrative Management is an organization that has no corporate parent and in which no publicly-held company has an ownership interest.

Pursuant to 11th Cir. R. 26.1-1 through 11th Cir. R. 26.1-3, the aforesaid *Amicus Curiae* adopt the Certificate of Interested Persons and Corporate Disclosure Statement filed by Appellee Preferred Collection and Management. Services, Inc. at Pages 2-3 of its Petition for Rehearing and for Rehearing En Banc.

/s/ *Mitchell L. Williamson*
Mitchell L. Williamson

RULE 35 STATEMENT OF COUNSEL

I express a belief, based on a reasoned and studied professional judgment, that this appeal involves one or more questions of exceptional importance:

1. Whether 15 U.S.C. § 1692c(b) applies to communications with vendors who provide the ministerial services of printing and mailing letters.

2. Whether the transmittal of data to by a debt collector to a back-office vendor is a third-party communication in connection with the collection of a debt that is prohibited by 15 U.S.C. § 1692c(b).

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INTEREST OF THE AMICUS CURIAE

The American Association of Healthcare Administrative Management (AAHAM) is the premier professional organization in healthcare administrative management. AAHAM was founded in 1968 as the American Guild of Patient Account Management. Initially formed to serve the interests of hospital patient account managers, AAHAM has evolved into a national membership association that represents a broad-based constituency of healthcare professionals. AAHAM's membership consists of individuals representing over 1900 medical service providers including for-profit hospitals, non-profit hospitals, academic medical centers and medical groups providing patient services. The membership is identified as 1530 non-profit members, 109 for-profit members and 292 academic medical centers. 60-70% of the membership work in the revenue cycle department of their particular medical organization. Approximately 30% of the membership represents various vendors including mail operations and debt collectors. There are thirty national individual chapters covering the entire United States. AAHAM offers certification levels for professional advancement and provides courses pursuant to the Medicare Learning Network (MLN) Learning Management System under the auspices of The Centers for Medicare & Medicaid Services, ("CMS") which is part of the Department of Health and Human Services (HHS).

In 2009 AAHAM instituted its current Code of Conduct which consists of Ethical Standards and Rules of Conduct to which its members are expected to conform. AAHAM also created the Patient Financial Advocacy Pledge (the "Pledge"). Included in the Pledge are specific services AAHAM expects its pledge subscribers to provide.

WE PLEDGE

- To educate patients on healthcare financial language and terms to assist in making informed decisions.
- To assist the patient in qualifying for other programs such as medication assistance programs and insurance coverage.
- To educate patients on hospital financial assistance programs and assist in the application process.
- To offer payment plans as an option for balance resolution.
- To agree that no legal proceedings will be utilized until all other options have been attempted.

"Navigating Insurance Complexity Through Education"

Navigating

- Assist patients with knowing how to contact the correct hospital personnel for help with a specific question.
- Inform patients of programs and grants available and how to apply.
- Explain where the patient can find price estimates prior to their next service date.

Insurance

- Identify insurance coverage for patients that have not been billed.
- Explore other types of insurance that could be applicable.

Complexity

- Reduce the expense burden by offering monthly balance resolution options.
- Automatically qualify patients for financial assistance programs.

Education

- Educate patients on their insurance benefits.
- Coach patients on healthcare financial language so they can make informed decisions.

In order to fulfill the dictates of the above Pledge, medical providers, be they AAHAM members or not, need to be able to communicate with patients and other responsible parties. The most efficient manner is via mail.

Unforeseen medical expenses are a major issue for many Americans, causing many families to find themselves in debt. The major impact of medical debt on the American household was the thrust of a study done by the Board of Governors of the Federal Reserve System.

> Out-of-pocket spending for health care is a common unexpected expense that can be a substantial hardship for those without a financial cushion. As with the small financial setbacks discussed above, many adults were not financially prepared for health-related costs at the time of the survey in 2019. During 2019, more than one-fifth of adults had major, unexpected medical bills to pay, with the median expense between $1,000 and $1,999. Overall, 18 percent of adults had unpaid debt from their own medical care or that of a family member.
>
> In addition to the financial strain of additional debt, 25 percent of adults went without some form of medical care due to an inability to pay,

> slightly up from 24 percent in 2018 but well below the 32 percent reported in 2013. Dental care was the most frequently skipped treatment (18 percent), followed by visiting a doctor (14 percent) and taking prescription medicines (9 percent) (figure 17). Going without medical care was more likely among adults who self-reported that they were in poor health. In 2019, 43 percent of adults in poor health went without medical care versus 20 percent of adults in good health.[1]

Hospital and physicians have experienced significant shifts of payment responsibilities from insurers to patients. This requires hospitals and physicians working more diligently than ever to recover from patients. According to a recent TransUnion study, an analysis revealed that patient balances after insurance rose from 8.0% of the total bill responsibility in Q1 2012 to 12.2% in Q1 2017. Specifically, commercially insured patients experienced a patient balance after insurance increase of 67% from $467 to $781. This trend led to an 88% increase in total hospital revenue attributed to patient balance after insurance over the 5-year period. [2]

Fortunately for patients, insurance coverage is not the only recovery that hospitals offer. Being able to provide patients with the information and means to take

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[1] Report on the Economic Well-Being of U.S. Households in 2019 - May 2020 https://www.federalreserve.gov/publications/2020-economic-well-being-of-us-households-in-2019-dealing-with-unexpected-expenses.htm

[2] Patient Balances After Insurance Continue to Increase in 2018, Driving Bad Debt and Uncompensated Care (transunion.com)

advantage of the various forms of financial assistance that may be open to those patients who cannot afford to pay is a win-win situation, good for the patients and good for the medical services providers. Without the ability to recover its expenditures, hospitals and other medical providers will be limited in the services they provide due to a lack of funds and resources.

Additionally, there are state and federal requirements regarding recoupment set forth by the Centers for Medicare & Medicaid Services ("CMS"), which is a federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards. CMS provides reimbursement to hospitals who provide services at a economic loss under any of these programs. However, pursuant to Section 310 of the CMS Provider Reimbursement Manual, a medical provider must make a "reasonable collection effort" to collect any funds due CMS.

> To be considered a reasonable collection effort, a provider's effort to collect Medicare deductible and coinsurance amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients. It must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. It also includes other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a

> genuine, rather than a token, collection effort. The provider's collection effort may include using or threatening to use court action to obtain payment. (See §312 for indigent or medically indigent patients.)

Section 310 (A) specifically provides for the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone and personal contacts. If the current panel decision stands, and the medical service providers are therefore forced to send less statements to patients, that will reduce the recovery of Medicare Bad Debt. CMS will then have to reimburse hospitals at $0.65 on the dollar for this reduction in recovery causing more harm to all tax payers as it is our taxes which support government programs.

The panel decision that is the subject of the petition for rehearing threatens to derail the ability of AAHAM members as well as non-member medical providers, to provide the above referenced critical financial information to patients and other responsible parties. It would also impede the recovery of amounts due to medical providers necessary to pay on-going expenses. It already has started to expose letter vendors and other third parties that AAHAM members have used to individual and class action claims under the FDCPA throughout the country. In more than 200 cases filed since the panel decision was issued, the panel decision is cited as the basis

for the claim against a vendor. The *Amicus* has a direct interest in this litigation and the organization has authorized the filing of this brief.

INTRODUCTION

FED. R. APP. P. 35(a) An *en banc* hearing or rehearing may be ordered if: (2) the proceeding involves a question of exceptional importance. AAHAM asserts that this matter involves a question of exceptional importance, due to the ramifications and unintended consequences of letting the decision stand.

DISCUSSION

It is not AAHAM's intent, to raise additional legal arguments, as it's fair to say that Defendant Appellee and other *amicus curiae* have covered those issues. AAHAM, as the sole entity representing the medical communities and its patients/consumers' interests, wishes to point out the true nature of the cost eluded to in the panel's decision below and the fact that those costs, in multiple ways, are more likely to be borne by the consumers whom the FDCPA was drafted to protect.

> It's not lost on us that our interpretation of § 1692c(b) runs the risk of upsetting the status quo in the debt-collection industry. We presume that, in the ordinary course of business, debt collectors share information about consumers not only with dunning vendors like Compumail, but also with other third-party entities. Our reading of § 1692c(b) may well require debt collectors (at least in the short term) to in-source many of the services that they had previously outsourced, potentially at great cost.

Hunstein v. Preferred Collection & Mgmt. Servs., 994 F.3d 1341, at *23 (11th Cir. 2021).

In a 2019 study prepared by TransUnion, one of the three major credit reporting bureaus, it was determined that 51% of all outstanding collection balances were related to healthcare/medical costs. The next highest grouping was banking and financial services, which accounts for only about 18%. The TransUnion study also found that 53% of all collection agencies, representing 4,505 agencies, collect on healthcare related debt. The study also established that agencies use letters sent via mail 95% of the time to interact with consumers.

I. Healthcare providers are subject to additional safeguards which guarantee they meet the privacy concerns addressed by the FDCPA which includes any third party vendors they engage

In answer to the Panels comment, "if Congress thinks that we've misread *§ 1692c(b)* —or even that we've properly read it but that it should be amended—it can say so." *Id.* at *23, AHHAM believes that the HIPAA laws do just that. HIPAA contemplates the type of third party disclosure which is the subject of the instant matter and set guidelines to allow it. In essence the Panels' decision, if left standing, would serve to negate a large portion of HIPAA.

Medical providers and their various vendors operate in a highly regulated environment. First and foremost, all covered parties must comply with the Health Insurance Portability and Accountability Act of 1996, ("HIPAA") which has strict regulations about the disclosure of patient medical records.

> By law, the HIPAA Privacy Rule applies only to covered entities – health plans, health care clearinghouses, and certain health care providers. However, most health care providers and health plans do not carry out all of their health care activities and functions by themselves. Instead, they often use the services of a variety of other persons or businesses. The Privacy Rule allows covered providers and health plans to disclose protected health information to these "business associates" if the providers or plans obtain satisfactory assurances that the business associate will use the information only for the purposes for which it was engaged by the covered entity, will safeguard the information from misuse, and will help the covered entity comply with some of the covered entity's duties under the Privacy Rule. Covered entities may disclose protected health information to an entity in its role as a business associate *only* to help the covered entity carry out its health care functions – not for the business associate's independent use or purposes, except as needed for the proper management and administration of the business associate.[3]

As a result of these requirements the contracts used by covered entities and their business associates or between the business associate (collection agency) and its subcontractors (mail vendors) contain language set forth by the U. S. Department of Health and Human Services to ensure the protection of patient information. [4]

[3] HIPAA Privacy, *45 CFR 164.502(e), 164.504(e), 164.532(d) and (e)*

[4] https://www.hhs.gov/hipaa/for-professionals/covered-entities/sample-business-associate-agreement-provisions/index.html

II. Confirming the Panels' Decision will likely cause harms to consumers

Almost all medical services, from hospitals to doctor offices, use collection agencies to recover lost revenue. It is estimated that 99.99% of all medical practices in one shape or another utilize a third-party agency to collect accounts on their behalf. However, there are significant differences between those collecting medical related debt and other forms of debt. In the case of medical debt, medical providers most often use the 3rd party agencies for billing purposes as well as for collections.

The Patient Protection and Affordable Care Act (the "ACA"), enacted in March 23, 2010, added new requirements codified under IRS Section 501(r) for organizations that operate one or more hospital facilities (hospital organizations) described in Section 501(c)(3) as charitable and non-profit facilities. Section 501(r)(6) requires a hospital organization to make reasonable efforts to determine whether an individual is eligible for assistance under the hospital organization's financial assistance policy (FAP) before engaging in extraordinary collection actions (ECAs) against that individual. This is done through statements to patients. By removing the ability to outsource statements, less timely mailings will occur directly harming patients who could have qualified because the time is of essence for patients to apply.

As a rule, medical facilities, be it hospitals, clinics or medical practice groups, are designed to provide medical services and healthcare, and devote their time and resources to that end. They have to rely on outside collection agencies, to handle the communications with patients regarding billing issues. To do otherwise could lead to a scenario where a hospital employee is tying up a phone line speaking with a patient regarding a bill, which is not the individual's expertise, while someone needing medical advice is waiting on hold. In the case of a large medical provider multiply that ten-fold. Or consider that same scenario taking place in a small rural hospital where there are only a handful of doctors, nurses and other necessary medical personal.

Medical providers rely on the ability to outsource the ministerial activities involved with mailing due to the fact that just as the medical providers focus on medical services, they understand that 3rd party mail vender focus on issues relating to mail services to ensure the greatest degree of efficiency and accuracy in getting the required information into the hands of patients and other responsible parties. They rely on other third parties to handle other forms of ministerial activities.

Should the panel decision stand, this would impact local dentists and chiropractors the same as it would for rural hospitals, critical access hospitals and health systems.

Each of these entities that rely on collection agencies that would have to change operationally. Many local agencies are likely to be forced out of business with the additional burdensome approach to recovery. The downstream effect is that many doctors would potentially go without recovered revenue and it is the consumer who will end up paying the costs in the end.

CONCLUSION

Respectfully, AAHAM urges the Court to grant rehearing *en banc* and, upon such rehearing, affirm the decision of the district court.

Dated: June 1, 2021

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

In accordance with Federal Rule of Appellate Procedure 32(g)(1), I certify that the foregoing *amicus* brief complies with the type-volume limitation of Rule 32(a)(7) because, excluding the parts of the document exempted by Rule 32(f), it contains 2555 words.

This brief complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and type-style requirements of Federal Rule of Appellate Procedure 32(a)(6) because it has been prepared in a proportionately spaced typeface using Microsoft Word in 14-point Times New Roman font.

Dated: June 1, 2021

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CERTIFICATE OF SERVICE

I certify that on the 1st day of June, 2021, I electronically filed the foregoing Brief of Amicus Curiae The National Creditors Bar Association in Support of Appellee's Petition for Rehearing and for Rehearing *En Banc* with the Clerk of the Court for the United States Court of Appeals for the Eleventh Circuit by using the appellate CM/ECF system.

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

Dated: June 1, 2021

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