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The Consumer Financial Protection Bureau
Via Electronic Submission

Re: Docket No. CFPB–2023–0038: Request for Information Regarding Medical Payment Products

September 11, 2023

The New York City Department of Consumer and Worker Protection appreciates the opportunity to respond to the Consumer Financial Protection Bureau ("CFPB"), Centers for Medicare & Medicaid Services, Department of Health and Human Services ("HHS"), and Department of the Treasury's ("Treasury") (collectively, the "agencies") request for information regarding Medical Payment Products (Docket No. CFPB–2023–0038).

For over fifty years, the New York City Department of Consumer and Worker Protection ("DCWP") has carried out its mission to protect and enhance the daily economic lives of New Yorkers to create thriving communities. DCWP licenses more than 45,000 businesses in more than 40 industries, and it enforces key consumer protection, licensing, and workplace laws. By supporting businesses through equitable enforcement and access to resources, and by helping to resolve consumer and worker complaints, DCWP protects the marketplace from predatory practices and strives to create a culture of compliance. Through its community outreach and the work of its offices of Financial Empowerment and Labor Policy & Standards, DCWP empowers consumers and working families by providing the tools and resources they need to be educated consumers and achieve financial health and work-life balance. DCWP also conducts research on financial inequities, predatory practices, and best policies to combat these practices. Finally, DCWP advocates for public policy that furthers its work to support New York City's communities to protect consumers and workers and combat economic inequities.

Recently, DCWP has been focusing on medical debt—the causes of medical debt, the often-deceptive factors exacerbating medical debt, and the predatory practices used to collect medical debt in New York City. This important work includes closely monitoring policy, regulatory, and legal developments related to medical debt, such as transparency in pricing, access to financial assistance, billing practices, credit reporting, and collections practices.

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Background: The Medical Debt Landscape in New York City

Although the Affordable Care Act ("ACA") reduced New York State's uninsured population, more than one million New York State residents remain uninsured.[1] The Center of Migration Studies estimates that this includes at least 672,000 New York City residents.[2] However, whether insured or not, consumers in New York City are incurring record amounts of debt due to higher health costs—including premiums, deductibles, and copayments. According to a Kaiser Family Foundation Health Care Survey, about half of adults across the country who responded – including three in ten of those who do not currently have medical debt – are vulnerable to falling into debt, answering that they would be unable to pay a $500 unexpected medical bill without borrowing money.[3] Worse, nearly one in five survey respondents with medical debt think they will never be able to pay it off.[4] Clearly, the current medical billing and payment practice ecosystem is failing to address the health care cost crisis.

In New York City, all hospitals are nonprofit entities, which means every hospital receive large tax breaks at the federal, state, and local levels. These hospitals also receive funds from the State's $1.1 billion Indigent Care Pool ("ICP").[5] Despite this, a recent study by Community Service Society on 21 nonprofit hospitals in New York City revealed that close to half of these nonprofit hospitals received $727 million more in federal, state, and local tax breaks than they gave back to their communities in financial assistance or "charity care." According to the study, this excess amount would be enough to pay off the medical debt for every patient sued by a New York City hospital over the past five years.[6] New York's hospitals sued over 53,000 patients in just five years—many of whom should have been eligible to receive financial assistance.[7]

Meanwhile, the presence of medical payment products, such as medical credit cards or private installment payment plans, has proliferated. On the surface, these products may seem like an attractive and quick fix solution to both providers and consumers, but they may have dire financial and health consequences for communities in need. For example, these products have advertising and marketing that is designed to attract consumers with "no interest" financing. As a result of targeting those who are underinsured, under-

[1] Amanda Dunker, Elisabeth Ryden Benjamin, Patrick Orecki, "Narrowing New York's Health Insurance Coverage Gap" (2022) accessed at https://www.cssny.org/publications/entry/narrowing-new-yorks-health-insurance-coverage-gap
[2] Katie Kiefer Center for Migration Studies of New York, "The Health Insurance Gap in New York City: Promoting Citizenship for a Healthier Tomorrow" (2021) accessed at https://cmsny.org/citizenship-heacalth-nyc-kiefer-061721/
[3] Lunna Lopes, Audrey Kearney, et al. "Health Care Debt In The U.S.: The Broad Consequences Of Medical And Dental Bills – Main Findings" (2022) accessed at https://www.kff.org/report-section/kff-health-care-debt-survey-main-findings/
[4] Id.
[5] The New York State Hospital Financial Assistance Law (HFAL) requires that any hospital that receives funding have a financial assistance application and policy. N.Y. Pub. Health L. §2807-k (9-a).
[6] Lown Institute, "Are NYC hospitals earning their tax breaks?" (2022) accessed at https://lowninstitute.org/wp-content/uploads/2022/11/lown-fair-share-nyc-20221118.pdf
[7] Amanda Dunker and Elisabeth Benjamin, "Discharged Into Debt: New York's Nonprofit Hospitals Garnish Patients' Wages," Community Service Society, July 2022, https://www.cssny.org/publications/entry/discharged-into-debt-new-yorks-nonprofit-hospitals-garnish-patients-wages.

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resourced, have limited bargaining power, and lack meaningful information on the payment terms and deferred interest, these payment methods have the potential to deepen financial insecurities and inequities for communities in need. DCWP is currently studying the presence and scope of medical payment products that are offered in New York City. Since medical debt is a problem plaguing too many New York City residents, we are concerned that these products will only exacerbate medical providers' conflation between payment plans, financial assistance, and private payment options.

The presence of medical debt collection in New York City is also significant, and one that DCWP is uniquely situated to regulate, since any entity working to collect debt in the City must be licensed by the Department. We have noted that medical debt collection has only increased in New York City: Almost one-fourth of all debt collectors currently licensed by New York City[8] collect medical debt. For years, New Yorkers have had to deal with extraordinary medical debt collections measures, including lawsuits, garnishing wages, and liens on their homes. Throughout the life cycle of medical debt – transparency in pricing, billing, access to "charity care," payment options (including medical payment products), collections, credit reporting, and lawsuits – the the financial implications of medical debt are difficult to manage, and the consequences are severe. Even after measures have been implemented to curb medical debt reporting, in July 2023, the Urban Institute studied credit report data of 600,000 consumers and calculated that hundreds of thousands of New York City residents have medical debt in collections on their credit reports.[9] The real number is likely even higher than this because debt from medical payment products and credit card debt may not be reported as "medical debt" on credit reports.

General Questions: Market-Level Inquiries

6: What are the health equity impacts of medical payment products and related billing and collection policies and practices?

Medical debt in collections unsurprisingly mirrors other racial, ethnic, and class inequities. By one account,New York State hospitals sued over 54,000 residents between 2015 and 2020, and these lawsuits disproportionately targeted people of color and/or those with low income.[10] In New York City, the Urban Institute calculated that the percentage of consumers with medical debt in collections who live in

[8] Of the 1,400 DCWP licenses issued to debt collection agencies from 47 states and 16 countries, approximately 340 reported collecting medical debt.
[9] Michael Karpman, Frederic Blavin, et al. "Medical Debt in New York State Varies Widely across Regions and Communities" (2023) accessed at https://www.urban.org/sites/default/files/2023-02/Medical%20Debt%20in%20New%20York%20State%20Varies%20Widely%20Across%20Regions%20and%20Communities.pdf.
[10] Elisabeth Ryden Benjamin, Amanda Dunker, "Discharged Into Debt: Medical Debt and Racial Disparities in Albany County" (2021) accessed at https://www.cssny.org/news/entry/discharged-into-debt-medical-debt-and-racial-disparities-in-albany-county

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communities with 50% or more people of color[11] is double that of those who live in communities with less than 30% people of color.[12] Safety net hospitals,[13] such as those within New York City's Health & Hospitals system, provide a disproportionate share of financial assistance to patients in New York City when compared to other hospitals. This disparate burden on essential safety-net hospitals causes additional financial strain on hospitals that serve disproportionately more low-income patients and communities of color. For the most part, the hospitals providing the most financial assistance tend to be hospitals in racially diverse, ethnically diverse, and low-income neighborhoods. For example, five out of the ten hospitals that provide the most financial assistance in New York State (Elmhurst, Queens Hospital Center, Jacobi, Lincoln and Harlem hospitals) are part of New York City's municipal hospital system.[14]

Financial health and health equity are inextricably linked. Research has shown that household financial debt has an impact on mental and physical health, including rates of depression and blood pressure.[15] The health equity costs of medical debt are profound. Patients may make life-altering decisions driven by mounting cost concerns, such as avoiding more and necessary treatments or medication. While wealth cannot guarantee good health, it does reduce specific stress and insecurities, which allows a patient to better focus on their well-being and return to health.

9(ii): Does a patient's use of a medical payment product exempt them from certain consumer protections, provider requirements, or group health plan or health insurance issuer requirements?

Certain medical payment products—such as "deferred interest care cards" or private third-party administered payment plans—are intended to provide patients with more options to afford the high expenses of hospital care. However, these products come with great risks, which are often unclear to the patient at the time of care.

These products seem attractive because consumers may not understand the complicated terms. For example, CareCredit® advertises promotions that start off with 0% Annual Percentage Rate ("APR") for a certain period (usually 6, 12 or 18 months). However, it is not clear to consumers that the balance will

[11] People of color include those who identify as American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, more than one race, or some other race, excluding those who identify as non-Hispanic and white.
[12] Michael Karpman, Frederic Blavin, "Medical Debt in New York State" (2023) accessed at https://www.urban.org/sites/default/files/2023-02/Medical%20Debt%20in%20New%20York%20State%20Varies%20Widely%20Across%20Regions%20and%20Communities.pdf.
[13] Safety net hospitals is defined under state law. *See* Safety Net Definition (ny.gov).
[14] Amanda Dunker and Carrie Tracy, "An Ounce of Prevention: Reforming the Hospital Financial Assistance Law Could Save Pounds of Patient Debt" (April 2023) accessed at https://www.cssny.org/publications/entry/medical-debt-hospital-financial-assistance-ounce-prevention.
[15] Elizabeth Sweet, Aijit Nandi, et al. "The high price of debt: Household financial debt and its impact on mental and physical health" (2013) accessed at https://www.sciencedirect.com/science/article/pii/S0277953613002839.

often not be paid off until after the promotional period expires and the APR raises if they only make minimum payments. Notably, the standard APR for CareCredit® after the promotional period expires is 29.99% – higher than that of even the top rewards-earning credit cards.[16]

Medical payment products can be more attractive to hospitals because they shift the burden of managing costs from hospitals to patients, and hospitals get paid up front, thereby reducing their need to engage in billing and debt collection down the line. Yet, patients often do not recognize that these payment products as high-interest loans—when in reality, they are. Compounding consumers' confusion, these products do not provide basic consumer protections such as requiring plain-language and up-front warnings about potential interest rates (which far exceed those of normal credit cards), annual fees, and their impact on credit.

The Credit Card Accountability Responsibility and Disclosure Act of 2009 ("the CARD Act") was enacted to introduce important protections for consumers related to billing, fees, disclosures, and, in particular, interest rate changes. For example, the CARD Act requires that credit cards provide a minimum payment warning on each billing statement. This warning tells a consumer the total time it will take to pay off their credit card balance, and how much interest they will pay if they only make the minimum payments each month. The CARD Act also mandates that all credit card issuers give consumers at least 45 days advance notice of any interest rate hikes and requires accounts to be at least 12 months old before an issuer can raise the APR.[17] CareCredit® cards certainly are not compliant with this last protection because their APR sometimes raises after just six months. Since CareCredit® cards are not technically credit cards, it is very likely that they and other similar products are getting away with the precise type of conduct that the CARD Act was intended to combat.

Without safeguards and disclosures that usually are required for bank loans or typical credit cards (such as those under the CARD Act), patients making health decisions are potentially placed in coercive situations where patients may believe that they are receiving often-critical medical treatment, which requires immediate payment, and they desparately look for any on-the-spot solution that will allow them to pay. Hospitals and providers should not allow consumers to sign contractual obligations for significant amounts of money, time, and consequences without an opportunity to reflect on the financial transaction or consult with someone else. Due to the urgency of getting care, the consumer may be overwhelmed by stress at the care site and fail to pay close attention to potentially dangerous financial consequences of these products. Furthermore, there are no requirements for medical providers to explain to the consumer the potential dangers of opting to use payment products or for providing information regarding these products in non-English languages for immigrants and consumers with limited English proficiency who need medical care.

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[16] Chauncey Crail and Dia Adams, "How Does CareCredit Work" (2021) accessed at https://www.forbes.com/advisor/credit-cards/how-does-carecredit-work/

[17] *See* Credit Card Accountability Responsibility and Disclosure Act of 2009 | Wex | US Law | LII / Legal Information Institute (cornell.edu).

11: What are some best practices for health care providers who offer medical payment products in avoiding adverse financial and health impacts for patients?

Health care providers who offer medical payment products should ensure that patients or their caregivers, with appropriate patient authorizations, thoroughly review the terms of these potentially dangerous medical payment products, including deferred interest rates, annual fees, how to cancel the credit line, minimum payment warning, and late or non-payment penalties. These terms should be required to be presented in plain language and available in the language spoken by the consumer, and service providers should be required to answer any and all questions before accepting payment by the use of these products.

Additionally, the priority in which payment options are offered to the public by nonprofit hospitals should be standardized. This ensures that financial assistance programs are always offered before any medical payment product or private third-party payment plan is suggested, particularly when the patient is uninsured or underinsured, on Medicaid, or cannot afford to pay for the entire health care cost.

All billing, payment, financial assistance, and medical payment product information and forms should be offered to patients in their primary spoken language. Finally, healthcare providers should affirmatively determine if the patient has diminished capacity to consent at the time of signing up for a medical payment product. If so, the provider should not accept any payment from a medical payment product for that patient during that time.

11(ii) & (iii): What actions should the agencies take to develop and encourage uptake of these established best practices? Are there examples of actions or best practices at the State or local level to which the Federal government should look?

The agencies should promulgate rules to require that all hospital intake (during the patient registration and/or admission process), billing, and discharge personnel receive training on the hospital's financial assistance program and receive ongoing updates to the law at the federal, state, and local levels related to financial assistance programs.

The agencies should likewise promulgate rules requiring hospitals to offer financial assistance plans as a primary payment option for those who are uninsured, underinsured, on Medicaid, or cannot afford to pay for the health care cost. The rules should also require that this be done prior to offering or accepting a hospital or private third-party payment plan or a medical payment product.

This year, the New York State Senate and Assembly passed the Fair Medical Debt Reporting Act (A.6275A/S4907A), which, if it becomes law, would protect patients from having their credit damaged or even ruined due to the reporting of medical debt to credit reporting agencies. While the primary credit reporting agencies have voluntarily agreed to not report medical debts below $500, this largely does not

protect patients in New York State and other localities, where health care prices are much higher on average—and where Black and Hispanic communities carry much higher amounts of debt than their white counterparts.[18] Governor Hochul has not yet signed this into law, but the intent of this legislation should be considered by the agencies as they explore whether it is feasible to seek Federal legislation or rulemaking with the similar goal of protecting patients from having medical debt impact their credit.

Additionally, this last session, the New York State Legislature included measures in the State budget which, when they go into effect in 2024, will create one common financial assistance application for use by all New Yor State hospitals that receive Indigent Care Pool Funds. The Legislature also introduced the Ounce of Prevention Act (S1366/A6027), which would and modernize the eligibility rules for financial assistance under state law, cap interest on medical debt, eliminate asset testing, and implement other guardrails and measures to improve the transparency, accessibility and utilization of financial assistance in the state. Currently, the application and eligibility screening processes for financial assistance programs at nonprofit hospitals in New York (and likely around the country) represent enormous barriers for patients—who are often in need of immediate attention, in pain, and overwhelmed—to avail themselves of "charity care." DCWP would welcome Federal regulations that standardize how nonprofit hospitals offer and provide financial assistance to communities. This includes the requirement to use a standard uniform Financial Assistance Program Application that is easy to access and submit and the requirement to provide enrollment information and assistance at the patient's point of care. Streamlining eligibility rules under the ACA, mandating uniform application forms and processes, and ensuring that various options exist for submitting forms, should not be the goal just here in New York. We urge the agencies to explore the potential for rulemaking to incentivize—or mandate—similar practices nationwide.

Finally, language barriers often further obscure payment terms of medical payment products. As part of its consumer protection enforcement, DCWP requires businesses to provide disclosure of payment terms to consumers in the language that their transaction is negotiated. Deferred payment options are the fine print that many people do not understand. According to a Wallet Hub survey, over half of the persons surveyed did not understand the terms of the deferred interest arrangement..[19]

DCWP applauds HHS's efforts to nationally examine whether patients with Limited English Proficiency (LEP) are experiencing challenges in financing their healthcare costs based on language proficiency, or if they are a targeted population for deception. Given NYC's large and diverse populations, including immigrants and people who speak languages other than English, a longstanding concern for DCWP is whether LEP consumers are targeted for deceptive practices. In New York City, nearly two million people

[18] Community Service Society of New York, Action Alert, "End Medical Debt, Protecting patients by stopping unfair billing practices" accessed at https://www.cssny.org/campaigns/entry/end-medical-debt
[19] Aline Comororeanu, "Deferred Interest Study: Which Retailers Use It?" accessed at https://wallethub.com/edu/cc/deferred-interest-study/25707#key-findings

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— approximately 25 percent of the population — are LEP.[20] DCWP conducted a study that found that LEP consumers tend to experience poverty at greater rates than English-proficient persons, and they are also likely to face greater challenges navigating the debt collection system.[21] DCWP also encourages attention be paid to those who are deaf or reduced hearing capacity, including the 208,000 New York City residents who fall within this category according to the 2014 census.[22]

13(iv): What types of consumer complaints have States and localities received?

DCWP receives consumer complaints via its Consumer Services unit. Once it receives these complaints, it attempts to mediate the complaint on the consumer's behalf to satisfactory resolution, refers the complaint to the legal unit for further investigation, or refers the consumer to another appropriate agency. Thus, for many—if not most—complaints related to medical services, consumers would likely be referred to the City or State departments of health. However, DCWP does accept and attempt to resolve or investigate complaints related to debt collection practices, as well as deceptive or otherwise problematic conduct associated with the use of payment products. In 2022 alone, DCWP received and attempted to resolve almost 150 complaints related to debt collection practices.

Over the past five years, DCWP also received at least a dozen complaints about billing or debt collection practices related to a Synchrony Bank or CareCredit card[23], and in 2022, DCWP received numerous complaints about medical debt collection practices.

14: Where medical payment products are causing harm, what are some specific levers for regulatory oversight and enforcement by Federal agencies that regulate financial products or health care providers?

Health care providers should be required to offer payment options in the order of what is in the best interests of the patient. Financial assistance exists at all New York City hospitals and non-profit hospitals across the country for patients who are struggling to pay or may struggle to pay for their medical care. It is critical that Federal agencies focus on the nonprofit hospitals' capacity—and obligation—to provide these options in the most transparent and accessible way possible, whether it is clear advice in multiple languages, easy enrollment, and/or integrating informational opportunities at hospital admittance or departure.

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[20] Alexandra Pinilla and Adam Blumenkrantz, "Lost in Translation, Findings from Examination of Language Access by Debt Collectors" (2019) accessed at https://www.nyc.gov/assets/dca/downloads/pdf/partners/LEPDebtCollection_Report.pdf
[21] Id.
[22] Daniel Krieger, "Deaf and Hard of Hearing Fight to Be Heard" (2016) accessed at https://www.nytimes.com/2016/03/27/nyregion/deaf-and-hard-of-hearing-fight-to-be-heard.html#:~:text=According%20to%20a%202014%20census,deaf%20or%20hard%20of%20hearing.
[23] DCWP referred most of these complaints to the FTC or to the CFPB but did successfully mediate three of the complaints.

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The current reality is that there exists a perverse incentive for hospitals to encourage the use of medical payment products, the hospitals' payment options, or other private third-party payment options, over financial assistance. This is because most of these products provide instantaneous payment to the medical provider. Local, state, and federal agencies must create and enforce regulations that *dis*incentivize hospitals from making misrepresentations about medical payment products and financial assistance options.

Further, the agencies should ensure that meaningful financial assistance disclosure and application forms are not buried in broad-ranging and dense forms for the patient to read or complete. The agencies should also ensure that these documents are reviewed by the patient in a non-cursory fashion similar to other consent and registration forms that the consumer is required to complete before receiving treatment.

The application process for financial assistance should be comparable to—if not easier than—applying for a risky medical payment product, which can be completed in minutes. Besides the modest but significant strides made in price transparency and "no surprise" billing, there is also a need to have additional transparency on how financial assistance is made available and awarded by hospitals. Data about how much financial assistance is used to pay for services in compared with the proportion of payments hospitals receive from medical payment products should also be reported by hospitals.

The medical payment products themselves should be subject to further regulation. For example, accelerator and acceleration clauses--which trigger higher interest rates or require the entire debt to be paid, respectively, when patients who have a payment plan miss one payment--should be prohibited in any medical payment product agreement, including third party payment plans.[24]

CFPB-Specific Questions

1: What actions should the CFPB consider taking to address problematic practices related to medical credit cards or loans, including debt collection and credit reporting practices?

DCWP has begun to monitor how medical credit cards and loans are advertised and marketed to consumers, the accessibility and transparency of their more dangerous terms, as well as how medical providers advertise or market the use of these products. We urge the CFPB to investigate and penalize hospitals or medical providers for:

- Providing misleading, confusing, or deceptive information to patients regarding availability of financial assistance—including but not limited to conflating financial assistance programs with payment plans or deferred interest products.

[24] New York State's Hospital Financial Assistance Law bans hospitals from having accelerator clauses in their repayment plans. Yet, an audit conducted by the New York State Department of Health in 2021 revealed that 37 of 172 hospitals still used these clauses, which trigger higher interest rates when patients miss any payment. *See* HFAL_Issue_Brief_V10.pdf (nexcesscdn.net).

- Failing to ensure that any private payment product offered on-site provides transparent and accurate information to consumers.

DCWP is revising its own rules governing debt collection practices, and we suggest that the CFPB consider imposing stricter guidelines as well. For example, the current Federal rule only limits phone calls to seven times per week per debt; we are proposing to limit the debt collector's outreach based on cumulative communications—including email and text messages—for all debt accounts associated with one consumer to a total of three times per week.

Further, the CFPB could consider heightening what is required to verify disputed medical debt, especially debt arising from a hospital required to have a financial assistance program.

6: How can the CFPB use its authorities to ensure people with medical bills in collections, including medical payment product debt, are screened for eligibility for financial assistance and other benefits?

As DCWP intends to propose in its amended rules, the CFPB should mandate that if, at any time during the debt collection process, the consumer indicates that a public or private insurance plan, a third-party payor, or a financial assistance policy should have covered some or all of the charges on the medical debt, or that the debt is as a result of a lack of price transparency at the time the services were rendered, or a violation of federal, state or local law, then the debt collector must treat the consumer's communication as a dispute and verification request on their medical debt. Additionally, before the debt collector can resume collection activities on such disputed medical debt, the debt collector should be required to verify that, if the provider was a non-profit hospital covered by IRS Regulations, the debt collector should be required to verify that the covered hospital met its obligations relating to providing financial assistance to the debtor if they were eligible.

HHS-Specific Questions

7: How might HHS improve patient understanding of options for covering the cost of medical treatments? At what points in the care process could patients be provided with information about their financial obligations and payment options?

Patient understanding of options should follow the basic principles of financial knowledge and decision-making:

- Information is best understood and analyzed before a decision is actually required. The availability of payment options should be made clear to patients as early as possible (e.g. the medical provider obtains the payer information and verifies who is likely to pay for costs).
- Affirmatively asking patients how they would like to be updated on their medical bills as their treatment changes. It can be asked at the relationship onset, such as how the patient prefers to discuss the impact of costs throughout the process or only at specific treatment milestones.

- Verifying with patients who else is a caregiver, and whether the patient is comfortable speaking about costs with such a caregiver, which allows the patient *to share the responsibility* of information gathering and understanding of difficult concepts and process. Other trusted individuals with appropriate authority, such as healthcare proxies, guardians, powers of attorney, and those given HIPAA rights, may also know of the patient's other financial and health goals.
- Providers should clearly explain why they are seeking demographic and financial background information. Medical providers should be clear that the data is confidential to the administrative offices and will have no impact on care.
- Information should be available in the language (addressed above for LEP individuals) and format most easily understood by the patient and other authorized caregivers. Where possible, DCWP encourages hospitals to emphasize plain language in all communications, language skills should be reviewed for specific grade-level proficiencies, and when it is not, a general emphasis on plain language design should be made.
- Consent on tablets and screens should only be permissible once the patient notes that they prefer a digital format to provide consent. If requested, an individual should be available to explain these documents in-person to the consumer if they have additional questions and concerns.

HHS should mandate that healthcare providers respect a 60-day minimum waiting period before accepting payment from a medical payment product as a result of emergency services, hospitalization, or other life-threatening medical treatment.

Treasury-Specific Questions

1*: *What policy actions should Treasury consider taking to address problematic practices related to medical credit cards or loans, including debt collection and credit reporting practices, to conform with the existing tax laws and regulations pertaining to tax-exempt hospitals?

Treasury should do the following to ensure that nonprofit hospital practices conform with existing laws and regulations pertaining to tax-exempt hospitals:

- Mandate that any nonprofit hospital payment plans be reasonable in duration and only be offered after financial assistance and any other insurance or public third-party payer options have been exhausted.
- Ensure that any hospital payment plan extending more than 36 months should not be allowed without a requirement to reassess whether the patient qualifies for financial assistance.
- Require that before promoting or marketing a medical payment product, nonprofit hospitals ensure that the hospital charges consumers based on the consumer's income and ability to pay and that repayment terms allow the consumer to pay the debt fully by the end of the promotional period. Nonprofit hospitals should also have a follow-up assessment of these factors with the patient after any promotional period since many have zero payments and/or "no interest" charged upfront.

Respectfully Submitted,

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New York City Department of Consumer and Worker Protection