New best practices for reporting bad debt

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Five years ago credit bureau reporting (CBR) was a powerful tool in a hospital’s bad debt program collection toolkit. Today, it has less of a positive impact on a hospital’s overall cash collection results due to stronger consumer protections enacted in recent years. The Consumer Financial Protection Bureau (CFPB), for one, has stepped up its oversight of healthcare debt that is reported on consumer credit reports by collection agencies. In fact, the CFPB has pushed the three credit bureaus harder than ever to expand and enforce the Fair Credit Reporting Act (FCRA) requirements and hold debt information furnishers to a much higher standard.

For example, a hospital or its collection agency may not mention anything about credit reporting in initial patient letters, as such language is deemed to overshadow the Fair Debt Collection Practices Act’s (FDCPA) 30-day validation period in which consumers are allowed to request proof of their debt. Over the last few years, many more stringent guidelines that govern how records can be reported to the credit repositories have been established, making it harder to comply with and participate in the reporting programs.

Stringent guidelines are making it harder to comply with and participate in credit reporting programs.

Redesigning CBR strategies

Credit report disputes are increasing and are becoming more challenging to address. These disputes require a significant amount of staff overhead and technical support to manage due to complicated CFPB and FCRA rules. Hospitals cannot rely as heavily on CBR reporting to strengthen their collection results because of those factors.

For example, even if the hospital or its agency provides highly accurate information to the credit reporting bureaus, new regulations require the reporting organization to send two additional letters to the consumer when a dispute is received. The first letter notifies the consumer that their dispute has been received and is in review, while the second provides an update of the findings to the consumer related to the validity or non-validity of the disputed debt and the next action they can expect.

These efforts can be timely and costly for hospitals and agencies, which are forced to increase administrative and technical oversight for compliance and support teams.

As a result of increasing consumer protection and other industry changes, hospitals should consider implementing the following CBR guidelines to reduce administrative and legal burdens.
1. Wait longer to report bad debt
Healthcare organizations may not report a bad debt defaulted account to the three credit bureaus until a minimum of 31 days have passed since the consumer received an initial validation statement by mail. We recommend waiting 75 days after the bad debt placement date before reporting bad debt to the credit bureau. Reporting any earlier may increase the number of unnecessary disputes sooner in the process that have to be addressed. By implementing this delay, you will allow those consumers that have intent on paying to properly address their concerns and ultimately an appropriate payment arrangement. This will also decrease the amount of consumer disputes that simply come as a result of the automated electronic credit bureau alert notifications most consumers are signed up to get due to heightened awareness around credit fraud.

2. Provide a patient-friendly payment program
Hospitals should not report those consumers who have agreed to participate in an approved payment arrangement as long as the consumer continues to pay down the account under the original terms. It is also a more patient-friendly approach to allow those who have the good intention of paying a bad debt account in full, or with a payment plan, to make those arrangements without having their credit impacted. Reporting the consumer could lead to more unnecessary work efforts prompted by a dispute and unnecessary patient complaints.

3. Consider a small balance threshold
Finally, only report individual balances greater than a specific predetermined amount to credit repositories to reduce the number of small-dollar disputes and patient complaints as consumers attempt to clean up the number of reported credit items on their credit history. This will help prevent a backlog of reviews if you are struggling to keep up with the volumes of disputes on small balance accounts as a result of automated credit alerts many consumers receive. In a healthcare program with a more patient friendly focus, this will also help support that program by limiting the amount of small dollar credit items hitting that consumer’s credit report.