UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Office of the Director
Bureau of Consumer Protection

February 4, 2009

Ms. Margaret Garikes
Director of Federal Affairs, American Medical Association
25 Massachusetts Ave., N.W., Suite 600
Washington, D.C. 20001

Dear Ms. Garikes:

I am writing in response to your correspondence in which the American Medical Association ("AMA") along with other medical associations challenge the position taken by the staff of the Federal Trade Commission ("FTC" or "Commission") regarding the applicability of the Identity Theft Red Flags Rule ("Red Flags Rule" or "Rule")[1] to physicians and related health care providers. In your letter, you assert that medical care providers are not covered by the Rule because they are not "creditors" as that term is defined in the law. In discussions with staff you also have suggested that even if health care providers were considered creditors in some circumstances, they should not be required to comply with the Rule because they already comply with regulations under the Health Insurance Portability and Accountability Act ("HIPAA"). And finally, you have expressed concern that application of the Red Flags Rule to health care providers could have unintended consequences on the practice of medicine.

After we received your initial letter, FTC staff arranged to meet with your staff and representatives from other health care provider organizations on November 19, 2008, to discuss the concerns raised in your letter. We found the meeting and the interchange of ideas informative and helpful, and came away with a greater understanding of your position and the manner in which health care professionals handle payment and credit issues. We welcome further dialogue, and believe that we can achieve an outcome that does not place undue or unnecessary burdens on health care professionals, but still meets the desired goal of the Rule to reduce the overall incidence and impact of identity theft, including medical identity theft.

As staff has discussed with you, we believe that the plain language and purpose of the Rule dictate that health care professionals are covered by the Rule when they regularly defer payment for goods or services. We also believe that implementation of the Rule will help reduce the incidence of medical identity theft; and that the burden on health care professionals need not be substantial. This letter will address each of these points.

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[1] 16 C.F.R. § 681.1 (2007).

Background of the Red Flags Rule

In part to respond to the disturbing increase in identity theft, Congress passed the Fair and Accurate Credit Transactions Act of 2003 ("FACTA"),[2] amending the Fair Credit Reporting Act ("FCRA").[3] Among the many provisions in FACTA was a mandate that the FTC, the Federal bank regulatory agencies, and the National Credit Union Administration (the "Agencies") jointly develop rules and guidelines for "financial institutions" and "creditors," both defined terms under the FCRA, regarding identity theft.[4]

Briefly put, the Red Flags Rule requires creditors and financial institutions ("covered entities") to conduct a risk assessment to determine if they have "covered accounts," which include consumer-type accounts or other accounts for which there is a reasonable risk of identity theft. If so, the covered entity must develop and implement a written Identity Theft Program ("Program") to identify, detect, and respond to possible risks of identity theft relevant to them. Such risks could include, for example, whether the manner in which accounts are opened could make them more susceptible to the perpetration of fraud, the entity's earlier experiences with identity theft, or types of suspicious activity relating to the opening of or access to an account. The entities then must specify how they will detect the warning signs – or red flags – that indicate an identity thief may be at work. This process might include examining a consumer's identification document or detecting unusual patterns with respect to use of an account. Finally, the Program must detail how to respond once the entity has detected a red flag. Responses might include refraining from billing the consumer whose identity was misused, ensuring that information relating to the identity thief is not commingled with information relating to the victim (e.g., medical records or consumer reports), or reporting an incident of identity theft to a law enforcement agency.

The Red Flags Rule is intended to address all forms of identity theft, including those involving the provision of health care.[5] Although identity theft most commonly is associated with financial transactions, there are increasing concerns about identity fraud in the context of medical care.[6] Medical identity theft can surface when a patient seeks care using the name or insurance information of another person, which can result in both

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[2] Pub. L. 108-159.

[3] 15 U.S.C. § 1681 *et seq.*

[4] A proposed rule was issued by the Agencies on July 18, 2006. Following a 60 day comment period and review of the comments received, the Agencies issued a final rule on November 9, 2007.

[5] *See* 72 Fed. Reg. 63718, 63727 (Nov. 9, 2007).

[6] There is no firm consensus on the definition of the term "medical identity theft," but for the purposes of the Red Flags Rule, "medical identity theft" means identity theft committed for the purpose of obtaining medical services. *Id.* at 63727.

false billing and the potentially life-threatening corruption of a patient's medical records.[7] A nationwide survey conducted for the FTC found that 4.5% of the 8.3 million victims of identity theft had experienced some form of medical identity theft, including the fraudulent use of their health insurance to obtain medical care or to obtain health insurance in their name.[8] The incidence of medical identity theft may be increasing.[9] The Department of Health and Human Services held a Town Hall meeting on October 15, 2008, to explore further the problem of medical identity theft and how it should be addressed in a health information technology environment.[10]

Given the potentially serious consequences for the health of victims, many physicians already evaluate their identity theft risk and develop, as appropriate, reasonable prevention programs. For example, some health care providers ask for photo identification at patient visits.[11] These steps are consistent with the objectives of the Red Flags Rule.

The Definition of Creditor

As noted earlier, the Red Flags Rule applies to creditors and financial institutions. It is the term "creditor" that is relevant to the coverage of medical practitioners. The definition of "creditor"[12] in the FCRA refers directly to the definition of "creditor" in the Equal Credit Opportunity Act ("ECOA").[13] The ECOA defines "creditor" as "any person who regularly extends, renews, or continues credit; any person who regularly arranges for the extension, renewal, or continuation of credit; or any assignee of an original creditor who participates in the decision to extend, renew or continue credit."[14] "Credit," in turn, is defined by the ECOA as "the right granted by a creditor to a debtor to defer payment of debt or to incur debts and defer its payment or to purchase property or services and defer

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[7] World Privacy Forum, *Medical Identity Theft: The Information Crime That Can Kill You*, May 3, 2006 at http://www.worldprivacyforum.org/pdf/wpf_medicalidtheft2006.pdf.

[8] Synovate 2006 Identity Theft Survey Report (November 2007) at http://www.ftc.gov/os/2007/11/SynovateFinalReportIDTheft2006.pdf.

[9] Michelle Andrews, *Thief vs. Patient: When medical identities get stolen, health and wealth are in danger*, U.S. News & World Rep., Mar. 17, 2008, at 48, *available at* 2008 WLNR 4569182.

[10] *See* http://www.hhs.gov/healthit/privacy/identytheft.html.

[11] Vicki Lee Parker, *Doctors' offices try to ward off medical identity theft,* The Raleigh News & Observer, Nov. 10, 2007, at D1, *available at* 2007 WLNR 22251087.

[12] As it does not appear that physicians currently engage in activities that would make them financial institutions under the FCRA, it is not necessary to discuss the definition in this letter.

[13] 15 U.S.C. § 1681a(r)(5).

[14] 15 U.S.C. § 1691a(e). *Accord* 12 C.F.R. § 202.2(l).

payment therefor."[15] The Agencies concluded that the plain language of the statute covered all entities engaged in the provision of credit, as broadly defined by the ECOA, and does not permit industry-based exclusions.

The focus of the Red Flags Rule on credit transactions is a logical one, because it is those types of transactions that identity thieves can most easily exploit. Identity thieves look for opportunities to obtain products or services that do not require payment up-front. The Agencies recognized, however, the potential burden that the Rule could impose on those creditors that had only a small risk of identity theft.[16] Accordingly, the Agencies designed a rule that is risk-based. The Rule, which requires the use of reasonable processes and procedures to detect, prevent, and mitigate identity theft, enables individual entities to structure their programs in ways that are commensurate with their risk; thus, high risk entities would tend to have more elaborate Programs, while low risk entities could have streamlined and less complex Programs. FTC staff expects that entities for which the risks of identity theft are minimal or non-existent will have a very low burden under the Rule.[17]

There is no bright line test however, that can categorically distinguish between high risk entities and low risk entities. Not only is the definition of an ECOA "creditor" activity-based, not industry-based, but so is the distinction between high and low risk entities. Thus, the nature and extent of identity theft risk that a particular industry or entity might face is relevant to the nature of the Red Flags Program it should adopt, but not to whether it is covered by the Rule in the first instance. For example, a small medical practice with a well-known, limited patient base might have a lower risk of identity theft, and thus might adopt a more limited Program than a clinic in a large metropolitan setting that sees a high volume of patients.

In interpreting the ECOA, courts and federal agencies have recognized its broad remedial nature, including the broad scope of the terms "credit" and "creditor."[18] It can be presumed that Congress was aware of these interpretations when incorporating the ECOA's definitional language into the FACT Act.[19] The Board of Governors of the

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[15] 15 U.S.C. § 1691a(d). Regulation B, which elaborates on the ECOA, defines "credit" in similar terms: "the right granted by a creditor to an applicant to defer payment of a debt, incur debt and defer its payment, or purchase property or services and defer payment therefor." 12 C.F.R. § 202.2(j).

[16] For example, see the FTC burden estimate analysis at 72 Fed. Reg. 63741.

[17] *Id.* at 63742.

[18] *See Brothers v. First Leasing*, 724 F.2d 789, 793-94 (9th Cir. 1984); *Williams v. AT&T Wireless Servs.*, 5 F. Supp. 2d 1142, 1147 (W.D. Wash. 1998).

[19] *See Dresser Industries, Inc. v. United States*, 238 F.3d 603, 614 n.9 (5th Cir. 2001) ("a fundamental principle of statutory construction is 'that Congress is presumed to be aware of judicial interpretations of the law, and that when Congress enacts a new statute incorporating provisions similar to those in prior law, it is assumed to have acted with awareness of judicial interpretations of prior law.'") (citation omitted).

Federal Reserve Board ("Federal Reserve Board"), which has the authority to promulgate regulations and interpretations of the ECOA, *see* 15 U.S.C. 1691(b), has confirmed this broad interpretation of these terms. In accordance with its authority to interpret ECOA terms, the Federal Reserve Board promulgated an implementing regulation, known as Regulation B, as well as an Official Staff Commentary to Regulation B, to serve as a guide to compliance with the ECOA. As the agency with governing authority over the statutory scheme, the Federal Reserve Board's interpretations of the ECOA merit substantial deference.[20]

In its Official Staff Commentary to Regulation B, the Federal Reserve Board makes clear that the terms "creditor" and "credit" under the ECOA should be interpreted broadly so as to include all entities that defer payments, even in the normal course of a traditional billing process.[21] As the Official Staff Commentary states, "[i]f a service provider (such as a hospital, doctor, lawyer, or merchant) allows the client or customer to defer the payment of a bill, this deferral of a debt is credit for purposes of the regulation, even though there is no finance charge and no agreement for payment in installments."[22] This interpretation must be granted deference under the *Chevron* principles.[23]

The Federal bank regulatory agencies, including the Federal Reserve Board, recently reaffirmed this interpretation of the term "creditor." In the preamble to the rules under FACTA covering the use of medical information in credit determinations, those agencies explained that "[c]reditors include depository institutions as well as entities that are neither depository institutions nor affiliates of depository institutions, such as independent finance companies, loan brokers, **health care providers**, and automobile dealers." (emphasis added).[24]

Courts and commentators that have considered the Official Staff Commentary to Regulation B also have acknowledged this broad interpretation of the term "creditor." For example, in *Barney v. Holzer Clinic, Ltd.*,[25] the court cited the Official Staff Commentary in recognizing that medical service providers could be ECOA creditors under certain circumstances. Although the court ultimately held that the plaintiff Medicaid recipients did not qualify as "debtors" under the ECOA because the state "has primary and exclusive responsibility to pay for medical services given to Medicaid

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[20] *See Chevron, U.S.A. v. Natural Resources Defense Council*, 467 U.S. 837, 844 (1984).

[21] Official Staff Commentary, 12 CFR 202.1(a)-1 (recognizing that the term "credit" under the ECOA is intentionally broader than the definition of "credit" under the Truth in Lending Act and applies to any "deferral of the payment of a debt.")

[22] Official Staff Commentary, 12 CFR 202.3.

[23] *See* 467 U.S. at 844.

[24] Fair Credit Reporting Medical Information Regulations, 70 Fed. Reg. 70666 (Nov. 22, 2005).

[25] 902 F. Supp. 139, 141 & n.3 (S.D. Ohio 1995).

patients,"[26] the court stated as follows: "The ECOA does not discuss whether medical service providers can be creditors, but the Federal Reserve Board categorizes delayed billing for medical services as a type of credit."[27] Similarly, one recent legal treatise on the subject explains that "[b]ecause credit under the ECOA involves any simple deferral of payment, even if there are no finance charges or installments, the ECOA applies to many transactions where the consumer pays after receiving the goods or services, such as doctor and hospital bills, bills from repair persons and other workers, and even a local store where a customer runs up a tab."[28]

This interpretation of "creditor" to include certain health care providers is consistent with the broad anti-discrimination purpose behind the ECOA. The law was intended to eradicate discrimination in all credit-related situations, including the deferral of payments for medical products or services.

Accordingly, based on the authority cited above, the FTC staff believes that professionals, including physicians, who regularly bill their clients, customers, or patients for their services after those services are rendered, are "creditors" under the ECOA. Indeed, Congress would need to exclude physicians explicitly from FACTA's definition of creditor for them to be excluded from the Red Flags Rule.

You suggest that physicians do not view themselves as creditors under the ECOA because they submit claims to health insurance carriers. This fact, however, does not change the fundamental credit aspects of the transaction.[29] When a physician submits a claim to an insurance carrier first and then bills any remaining unpaid amounts to the patient – whether she does so as a courtesy to the patient or because she is required to do so as a matter of contractual or state law – the physician is deferring the consumer's payment of his or her share of the claim (i.e., the physician is billing the patient after having provided the patient with medical services). Indeed, in many such instances, patients provide written acknowledgment that they are responsible for any amounts unpaid by insurance when they enter into a relationship with a physician. Moreover, as a matter of sound business practice, physicians typically avail themselves of their full rights to pursue unpaid bills, including reporting medical debts to consumer reporting agencies. Thus, although the primary responsibility of physicians is to provide health care, they also are conducting a business – a business that provides services for which payment may be deferred.

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[26] *Id.* at 141.

[27] *Id.* at 141, n.3. *Cf.*, *Williams*, 5 F. Supp. 2d at 1145 (looking to the Official Staff Commentary of Regulation B in holding that the plaintiff's application for cellular telephone service constituted credit because it involved "the purchase of services and deferral of payment for those services.")

[28] Theodore Eisenberg, 1-5 Debtor-Creditor Law § 5.02 (Matthew Bender & Co., Inc., 2008).

[29] *Mick v. Level Propane Gases, Inc.*, 183 F. Supp. 2d 1014 (S.D. Ohio 2000) (The court found that in determining whether an entity is a "creditor" under the ECOA, "[i]t is the nature of the service transaction at issue that is determinative.")

In further support of your position that physicians are not creditors, in your letter you cite to *Riethman v. Berry*,[30] a case involving the issue of whether a law firm was an ECOA creditor. Although the court found that the defendant attorneys were not creditors under the ECOA, the *Riethman* court did not cite or refer to the Official Staff Commentary of Regulation B. This omission is significant because, as discussed above, this Official Commentary explicitly includes lawyers and physicians within the definition of incidental creditor for purposes of the ECOA, and these conclusions should be granted substantial deference.

You also rely on *Shaumyan v. Sidetex Co.*[31] This case is not factually relevant to the issue of whether physicians who defer payment for medical services are creditors under the ECOA. *Shaumyan* involved a home improvement contract that provided for the plaintiffs to make an initial deposit and then additional payments as the work progressed, with payment for the total cost of the contracted work due upon completion of the work.[32] The court held that this arrangement was not a credit transaction under the ECOA because it did not involve deferred payment for work; instead, it involved incremental, "substantially contemporaneous" payments made as the work progressed.[33] Unlike the facts presented in *Shaumyan*, it is our understanding that physicians generally do not bill patients in increments as work progresses; to the contrary, they bill patients after the services have been completed, sometimes allowing patients to pay in installments. This type of delayed payment is not the type of "substantially contemporaneous" payment at issue in *Shaumyan*.

Finally, you assert that physicians who bill for services after the services are rendered are not creditors under the Red Flags Rule because health care providers were not explicitly referenced in the Rule "among the trades or businesses identified as creditors." Although it is true that health care providers are not enumerated in the short list of examples, that does not lead to the conclusion that such practitioners are not covered. The listed examples were not intended to be exhaustive, but merely illustrative, as indicated by the statement that the term "includes" the enumerated businesses.[34]

Developing Appropriate Programs for Physicians

You have asserted that physicians should not have to comply with the Red Flags Rule because they have devoted substantial resources to complying with HIPAA's

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[30] 287 F.3d 274 (3d Cir. 2002).

[31] 900 F.2d 16 (2d Cir. 1990).

[32] *Id.* at 17.

[33] *Id.* at 18.

[34] *See Puerto Rico Maritime Shipping Auth. v. ICC*, 645 F.2d 1102, 1112 n.26 (D.C. Cir. 1981) ("It is hornbook law that the use of the word 'including' indicates that the specified list . . . that follows is illustrative, not exclusive.") (citation omitted)).

privacy and security requirements and because they maintain an ethical obligation to protect patient confidentiality. This argument misapprehends the purpose and application of the Red Flags Rule. We certainly recognize the importance of HIPAA's privacy and security requirements and the essential role data security plays in protecting individuals' health information from compromise and misuse, as well as physicians' ethical responsibilities in this area. But, notwithstanding physicians' reasonable efforts to prevent them from doing so, identity thieves have a variety of means of obtaining personal information. A comprehensive approach to combating medical identity theft, therefore, must include measures aimed not only at preventing the compromise of patient information, but also at preventing or mitigating the misuse of that information if it is compromised. The Rule is designed to prevent identity theft primarily by ensuring that organizations are alert to signs that an identity thief is using someone else's identifying information fraudulently to obtain products or services, including services such as medical care. Thus, the Red Flags Rule generally complements rather than duplicates the HIPAA data security requirements.

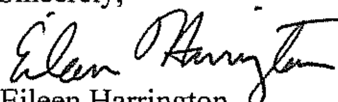
In meeting with you, and in your correspondence, you noted your concerns about the impact of the Red Flags Rule on the practice of medicine, including concerns that physicians will begin to demand payment up front or abandon the practice of medicine altogether. We are, of course, sensitive to the concern that the Rule requirements could be burdensome for health care providers, potentially leading to unintended costs for consumers.

Given the risk-based nature of the Rule's requirements, as a practical matter, however, we do not believe that the Rule would impose significant burdens for most providers. As discussed above, the Red Flags Rule is designed to be flexible and tailored to the degree of identity theft risk faced by the particular physician; in many cases, that risk may be minimal or non-existent, such that a simple and streamlined program would be adequate. For example, for most physicians in a low risk environment, an appropriate program might consist of checking a photo identification at the time services are sought and having appropriate procedures in place in the event the office is notified – say by a consumer or law enforcement – that the consumer's identity has been misused. Such procedures might include not trying to collect the debt from the true consumer or not reporting it on the consumer's credit report, as well as ensuring that any medical information about the identity thief is maintained separately from information about the consumer. These types of simple practices are already becoming more commonplace in many physicians' offices.

As you are aware, the Commission recently granted entities subject to its jurisdiction a six-month forbearance period before it will begin enforcement of the Rule. This action was taken in light of the fact that a number of industries and professions had been unaware of their coverage by and responsibilities under the Rule. In the meantime, FTC staff has continued its outreach efforts to help covered entities come into compliance with the Rule, including working with a number of trade associations that have chosen to develop model policies or specialized guidance for their members.

FTC staff would be pleased to assist the AMA in helping its members to comply with the Red Flags Rule in the least burdensome manner possible. We are also willing to work with the AMA to ensure that physicians are receiving accurate information about the Rule to counteract any misinformation that may be circulating from other sources. We believe that a collaborative approach of this sort could be highly effective in helping physicians minimize the occurrence and consequences of medical identity theft.

Sincerely,



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