March 23, 2022

Mr. Mark Begor
Equifax
1550 Peachtree St. N.W.
Atlanta, GA 30309

Mr. Brian Cassin
Experian
475 Anton Blvd.
Costa Mesa, CA 92626

Mr. Chris Cartwright
TransUnion
555 West Adams St.
Chicago, IL 60661

Dear Mr. Begor, Mr. Cassin, and Mr. Cartwright:

On behalf of the Association of Credit and Collection Professionals ("ACA International" or "ACA"), we are writing to express serious concerns about the consequences of your decision to change the timeframe for including unpaid consumer debt on a credit report and to not include certain unpaid debt owed to medical providers ("Providers"), some of whom stood or stand on the front lines of the pandemic. ACA International is the leading trade association for credit and collection professionals representing approximately 2,100 members, including credit grantors, third-party collection agencies, asset buyers, attorneys, and vendor affiliates in an industry that employs nearly 125,000 employees worldwide.

ACA supports the goal to not have a consumer's credit report include bills that should have been paid by insurance companies ("Payors"). However, Equifax, Experian, and TransUnion's ("CRAs") actions are a misdirect from addressing the significant problem with Payors' claim payment processes and instead will harm medical caregivers on the frontlines of the pandemic. There is a false narrative that this is not legitimate debt, but as you are aware, the Fair Credit Reporting Act and other consumer protection laws would make it very unlikely that illegitimate debt would be included on a consumer's credit report. Your political posturing on this issue will punish providers, restrict services to low-income Americans, and weaken the credit ecosystems for both businesses and consumers. Taking away credit reporting as a tool in the collections process, which notably is the last option used when it comes to medical debt, will without question force certain Providers to turn to litigation sooner and more often to recover fees for services already provided. As outlined below, it will also lead to increased costs and less access to medical care for all consumers.

Changing the Time Period for Reporting from Six Months to One Year will Cause Consumers to Miss Insurance Deadlines

In your announcement, you indicate that the time before unpaid medical debt will appear on a consumer's credit report will increase from six months to one year from the date of delinquency. This is for the stated purpose of offering consumers more time to address their debt with Payors and Providers before it is reported. The six-month rule already harms consumers. Your actions blatantly disregard the significant harm that will come to that portion of the population who does not respond to regular collection attempts, such as calls and letters, and who find out about their medical debt from seeing it on their credit report. Societally, we have done an excellent job of promoting the need for consumers to read their credit report regularly and free of charge. Learning about a financial obligation on their credit report may be the first

time it clicks for a consumer that they really need to address this issue with their insurance company and act to avoid future litigation.

Many physician practices already have written into their managed care contracts that if a bill is not submitted to the insurance company within six months from the date of service, the insurance company does not have to pay that bill. That is why a group of stakeholders, including the Healthcare Financial Management Association ("HFMA") and ACA, in 2020 jointly published the 2nd edition of Best Practices for Resolution of Medical Accounts with input from consumer groups and providers.[1] These Best Practices further enhanced controls over credit reporting, and purposefully arrived at 120 days from the date of first discharge billing as an appropriate time for credit reporting to ensure accuracy in the final adjusted amounts as well as for the consumer to file a claim with the Payor if needed. The 180-day wait time was already a problem. Changing the goalpost to 365 days will remove the option for claiming insurance coverage for an even greater number of consumers, as most all other health care contracts have a provision that a timely-filed insurance claim is 365 days from the date of service. Beyond that, there is no legal obligation to pay the claim.

Then what happens? Your actions will put the full onus on consumers to pay the bill in full when the Payor will not. If the consumer cannot pay, and the insurance company will not pay, then the Provider will need to find a way to pass that cost on to everyone else. It may also lead to more Providers to require consumers to pay cash up front. Alternatively, Providers may move to groups that have a different economic model for more robustly passing those costs on to others. Either way, access to care is reduced or eliminated—even for people with good insurance. As an additional side effect, Providers might initiate a greater number of lawsuits as the only option to force consumers to pay for the services they received. This is a more expensive and time-consuming process than credit reporting that is played out in the public domain. While the largest Providers may not need to resort to litigation, smaller Providers may be forced to do so to keep their doors open and to continue to provide services.

Setting an Arbitrary Threshold for Debt will Harm the Smallest Medical Providers and Limit Access to Care, Especially in Rural and Underserved Areas

Your decision to no longer include past due medical legal obligations of under at least $500 starting in the first half of 2023 is a significant detriment to Providers. The biggest unintended consequence of not allowing medical debt under $500 to be credit reported will be the reduction in services from small Providers to low-income and middle-class Americans. Government regulators, particularly those involved in this discussion that do not have a background or expertise in health care issues, and consumer groups have a false impression of the real-world impact this would have when they asked only large Providers if this will hurt them. They may have heard "no" from a select sample because many of the largest Providers have vastly different economic models and can afford to raise prices on a larger base of patients, or negotiate better insurance contracts, compared to smaller Providers.

While less than $500 may seem like "small change" to large publicly traded companies like CRAs, bills for this amount can be a significant portion of a small or medium-size Provider's livelihood. This is particularly true for physicians such as mental health Providers serving rural and underserved areas through telehealth, and other physicians providing critically important services at lower costs. While the typical ophthalmologist bill is less than that of a major hospital, it does not mean that the ability to provide services to see should be taken for granted. Solo practitioners, including dentists, pediatricians,

[1] Best Practices For Resolution of Medical Accounts, available at https://www.acainternational.org/news/aca-international-and-hfma-release-new-best-practices-for-resolution-of-medical (September 2020).

and other Providers, typically have balances below the $500 range.

It is worth noting that these are the doctors who most rely on third-party debt collectors to recover the rightfully owed money for services they provided because they do not have the infrastructure for in-house collections. The amounts they collect often represent whether the doctor makes a profit or incurs a loss in running his or her business, including employing others. It might be possible for one bill for less than $500 to be written-off by a small Provider, but dozens of bills for this amount could take away from significant operational costs at a practice. Most Providers are just that: Providers, and not sophisticated financial institutions like banks. These are small businesses providing compassionate care to their community and this change will cause further lack of recourse to be paid for their services. If they cannot collect on their accounts and therefore incur ongoing losses that take away from running their business, they will not be able to provide these important services to our communities.

As noted above, it is common misinformation to think the largest hospitals speak for all Providers. For the small and medium-sized Providers, their economic model depends on the co-pay or deductible actually being paid. So, what choices do they have with the impact of your change? Again, they stop providing services to people who cannot pay cash up front, even when the consumer has insurance.

Notably, the Emergency Medical Treatment and Labor Act only covers emergency care; thus, Providers are free to choose payment policies that work for their business when it does not involve emergency treatment, including refusing to provide care. Another likely outcome is that Providers will join larger organizations that can afford to work with the changed economic model, perhaps abandoning rural and underserved areas as a result. By allowing only large balance medical debts on credit reports, you are in turn reserving this tool for only the providers that provide high-dollar services.

Basic economic principles make clear that low-income Americans will be harmed most when Providers constrict services, leading to higher costs and less access to medical care for all consumers. Taking the credit reporting tool away and disproportionately impacting smaller Providers, without first researching the long-term impact and without having all stakeholders at the table, is bad policymaking. We saw this demonstrated at the Consumer Financial Protection Bureau's recent virtual panel on medical debt in Georgia, which did not include representatives of small or medium-sized Providers, Payors, collection agencies, or other government agencies charged with the responsibility of activities that result in medical debt. Medical debt is a complex subject that many stakeholders in the financial services industry do not fully understand or have expertise in, and all relevant stakeholders must be involved in crafting solutions.

Regulations and Policy Already Address the Issues Trying to be Solved in a Vacuum by the CRAs

As noted, industry stakeholders have already developed Best Practices for credit reporting.[2] Additionally, the U.S. Department of the Treasury ("Treasury") and the Internal Revenue Service published 501(r), which addresses medical debt and credit reporting. The U.S. Department of Health and Human Services ("HHS") oversees the Center for Medicare and Medicaid Services, which already provides input on debt collection practices. HHS also oversees the Center for Consumer Information and Insurance Oversight ("CCIIO"), which has responsibility for ensuring the Patient Protection and Affordable Care Act ("PPACA") best serves the American people. HHS is the federal agency with oversight responsibility of health insurance companies. HHS, the Treasury and the Department of Labor oversee the Consolidated Appropriations Act, which includes the No Surprises Act—aiming to protect consumers from surprise billing concerns related to insurance issues.

[2] *Id.*

Furthermore, the Department of Veterans Affairs also put into place procedures to wait to use credit reporting until other account resolution options are used, like what is outlined in the ACA and HFMA best practices, but in no way limits timeframes or amounts. The PPACA also provides for free or reduced-cost medical care for low-income and middle-class Americans when obtaining services from nonprofit Providers. This is either mandated by state law or determined by each Provider in their charity care policy. Moreover, consumers with incomes below 400% of the Federal Poverty Level, which is about $111,000 per year for a family of four in 2022, typically have coverage and options for free or reduced-cost medical care as a result of the PPACA. This is just a very small picture of the laws and regulations managing health care administration. If Americans are unaware of their benefits under the PPACA then that is a vastly different problem to solve and changing credit reporting is not the solution.

We have not seen credible analytical research that articulates how, or if, your arbitrary actions add to the existing body of policies in a way that would improve consumer outcomes for those seeking medical care. Unfortunately, it is clear that a simple economic analysis would prove that disrupting the credit cycle and making broad assumptions that Providers, especially small and medium-size organizations, can absorb costs will instead lead to significant harm for low-income consumers. The CFPB's recent report, "Medical Debt Burden in the United States," unfortunately fueled false narratives by making significant assumptions based on flawed anecdotal information.

Due to the major changes in the marketplace after the implementation of 501(r), as well as the National Consumer Assistance Plan, data before 2017 does not tell the real story of how consumers and Providers make decisions today. The COVID-19 pandemic has further changed consumers' and Providers' behavior. Other laws attempting to change the existing landscape for medical care, specifically the No Surprises Act, which is included within the Consolidated Appropriations Act of 2021, are complex. Measuring the impact of these changes is critical before guessing or making political capitulations not steeped in accurate data or research.

This is a Slippery Slope for Credit Providers, Who Will Not Have the Correct Information about Consumer Obligations and a Full Credit Profile

Credit reports that do not account for financial obligations, including past-due medical bills, increase the chance of future credit grantors extending credit that a consumer cannot afford. Your $500 arbitrary limit is a very slippery slope as there will be significant lobbying to get you to raise this amount over time. As that happens, this will drive increases in bankruptcies, stress and harm through additional costs for consumers, and inappropriate losses to credit grantors, ultimately causing harm for all credit users. You are watering down the accuracy and validity of credit reports.

Singling out the medical community because consumers may not have planned for those bills is unfair. Medical Providers should not alone shoulder the burden of unplanned expenses. If all unplanned expenses were not included in the credit reporting system, such as the work of a plumber or the services of a mechanic, where would those professions be, and what value would a credit report have? The harm this slippery slope begins to cause is significant, and it does nothing to solve policy issues related to health care in America. Ensuring that medical bills that should have been paid by insurance companies actually get paid is an important societal goal. However, tinkering with credit reporting is one of the least effective ways imaginable to accomplish this goal and solve the real issues, and will be harmful to all members of the credit-based economy, especially those consumers who will no longer have access to needed health care services from small and medium-sized Providers.

Sincerely,

Scott Purcell
Chief Executive Officer
ACA International

Cc: Francis Creighton, Chief Executive Officer, Consumer Data Industry Association
Director Rohit Chopra, Consumer Financial Protection Bureau