INTERNATIONAL

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Via Electronic Delivery to 2024-NPRM-MEDICAL-DEBT@cfpb.gov

Comment Intake – 2024 NPRM FCRA Medical Debt Information
c/o Legal Division Docket Manager
Consumer Financial Protection Bureau
1700 G Street, NW Washington, DC 20552

RE: Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information (Regulation V) - Docket No. CFPB-2024-0023 or RIN 3170-AA54

Dear Director Chopra and CFPB Staff:

ACA International submits this comment letter in response to the Notice of Proposed Rulemaking – Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information (Regulation V) ("NPRM") issued by the Consumer Financial Protection Bureau ("CFPB" or "Bureau").

ACA International is the leading trade association for credit and collection professionals. Founded in 1939, and with offices in Washington, D.C. and Minneapolis, Minnesota, ACA represents approximately 1,700 members, including credit grantors, third-party collection agencies, asset buyers, attorneys, and vendor affiliates in an industry that employs more than 150,000 individuals worldwide.

ACA members include the smallest of businesses that operate within a limited geographic range of a single state, and the largest of publicly held, multinational corporations that operate in

every state. The majority of ACA-member debt collection companies, however, are small businesses. According to recent ACA member data, 35% of ACA members have 10 employees or fewer, 56% of ACA members have 25 employees or fewer, and 70% of ACA members have 100 employees or fewer.

As part of the process of attempting to recover outstanding payments, ACA members are an extension of every community's businesses. Medical expenses, associated with a complex process for identifying opportunities for insurance and other coverage, poses many challenges for consumers. In the case of healthcare revenue cycle management, ACA members are often in the best position to help consumers properly determine their options for payment. As part of this work, they take time to educate and explain the nuances of complex healthcare insurance, deductibles, and co-pays, and they advocate for consumers with the provider to ensure accuracy in billing. This work also includes developing workable payment schedules, which are often interest free, and spread out over multiple months, or even years. This helps consumers address their contractually owed obligations, without being sued or denied non-emergency care.

In the event that this Proposed Rule is mandated, most providers will likely shift to requiring cash up-front, which will require consumers to pay or finance large lump sums of money at higher credit-card interest rates. In conjunction with the CFPB's analysis showing an increase in litigation against consumers that will result from this Proposed Rule, it will inevitably cost the majority of consumers more money to receive medical care or address lawsuits than had the CFPB not interfered with the U.S. healthcare system with this Proposed Rule.

In years past, the combined effort of ACA members has resulted in the annual recovery of billions of dollars – dollars that are returned to and reinvested by businesses, and dollars that would otherwise constitute losses on the financial statements of those businesses. Without an effective

collection process, the economic viability of these businesses and, by extension, the American economy in general, is threatened. Recovering rightfully owed consumer debt enables organizations to survive; helps prevent job losses; keeps credit, goods, and services available; and reduces the need for tax increases to cover governmental budget shortfalls.

Each day, ACA members have hundreds of interactions with patients regarding their medical bills. They work collaboratively with these patients to find the proper resolution of each account and often help identify options like charity care or financial assistance. ACA members have worked with hospitals and hospital trade associations to develop best practices for healthcare revenue cycle management including credit reporting policies, 501(r) compliance, and communication of charity care policies from the provider to the patient.

This work that ACA members do requires skill and expertise. The financial component of a healthcare visit is a complicated process that many consumers do not understand how to navigate. Debt collectors in the healthcare space are some of the top experts in understanding the challenges presented with the financial component of a healthcare visit. The CFPB's rhetoric about these men and women who work to help patients on a daily basis is not only misguided, but it is dangerous. It is an unfortunate consequence of trying to score points through one-liners or tweets in an election year, rather than truly trying to understand, and improve, patient care through a transparent analysis of the existing issues in our healthcare industry. The CFPB is acting outside its jurisdiction as a financial services regulator and its ineptitude is apparent on the face of this Proposed Rule.

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I. THE MEDICAL DEBT REPORTING RULE AS PROPOSED IS UNNECESSARY AND WILL CAUSE MORE HARM THAN GOOD.

On June 11, 2024, the CFPB published a proposed rule (the "Proposed Rule") to in effect amend the Fair Credit Reporting Act ("FCRA"), to suppress information about medical debt from credit reports. The Proposed Rule has many fatal flaws. It purports to solve overarching concerns about medical debts—which problems do not actually exist—and it does not provide sufficient evidence or data to support its claims. Notably, the CFPB only provided 60-days for the comment process. Many providers did not have the opportunity during this short time frame, during two months over holidays in the summer, to fully analyze the proposal's economic impact. Since the CFPB explicitly does not have jurisdiction over medical providers, many are not aware of its activity despite the Bureau's encroachment into how medical care is provided.

ACA and its members empathize with concerns that healthcare in this country is too expensive and that work should be done in this area by the appropriate regulators and lawmakers. But the CFPB's Proposed Rule does not solve that core issue because it focuses on the final stages of a lengthy and complex process of delivering and paying for medical care. Expert analysis shows that the Proposed Rule's direct effect is to take away earned funds from the healthcare providers, including doctors who provide lifesaving care.

The CFPB is not the right entity to change American healthcare. Congress is the one body that can amend the law to create balanced change. And in doing so, Congress must account for

myriad factors beyond the CFPB's jurisdiction, such as mitigating harm to patients and ensuring access to quality healthcare. Moreover, the Proposed Rule violates controlling law by impermissibly attempting to rewrite federal statute, failing to meet Regulatory Flexibility Act requirements, and because it is arbitrary and capricious. Worse yet, the Proposed Rule itself will cause significant harm to consumers, medical providers and patients, businesses, creditors, and the financial markets generally. For the reasons outlined fully in this comment, the CFPB should withdraw the Proposed Rule.

A. <u>Based on the CFPB's Own Rationale, the Proposed Rule is Unnecessary and Better Addressed by the Enforcement of Existing Laws.</u>

The CFPB asserts that the rationale behind the Proposed Rule is to reduce the harm that medical debt causes to consumers who are trying to secure credit, including those who are applying for a mortgage.[1] Thus, the proposal is designed to help a tiny subset of consumers who (a) are otherwise creditworthy; but (b) due solely to unpaid medical debt accounts on credit reports are unable to get the loan that they deserve. The Bureau has not—and likely cannot—provide an estimate of the number of people who would benefit from the Proposed Rule. And this is a fundamental failing: the Bureau has no data that estimates the actual benefit of the Proposed Rule.

1. <u>The Litany of Problems about Medical Debt Credit Reporting is Fantasy.</u>

Instead, the Bureau has manufactured a litany of problems relating to the reporting of medical accounts on credit reports, but upon a closer look, the problems are chimera. First, relying on data that is more than ten years old, the Bureau concluded that medical debt information is less predictive of a consumer's payment behavior than other types of debt. Notably, the CFPB Director

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[1] *See Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information (Regulation V), Notice of Proposed Rulemaking*, 89 Fed. Reg. 51682, 12 C.F.R. § 1022 (June 18, 2024), *available at* https://www.federalregister.gov/documents/2024/06/18/2024-13208/prohibition-on-creditors-and-consumer-reporting-agencies-concerning-medical-information-regulation-v#p-628 (hereafter "NPRM").

and representatives of the agency have also publicly contradicted themselves on this topic and have claimed in press releases and Congressional testimony under oath that medical debt is "not" predictive.[2]

Despite these misleading assertions, the CFPB's research merely makes the unremarkable observation that the suppression of negative information about unpaid accounts on consumer credit reports will increase credit scores and consequently, loan approvals. Moreover, as outlined in research by Dr. Andrew Rodrigo Nigrinis (hereafter, "A. Rodrigo") attached here,[3] this inflated bump in credit scores will be minimal, and will also lead to a host of negative market implications and consumer harms.

The CFPB also alleges that the Proposed Rule resolves privacy concerns about consumers' medical information, ignoring the host of state and federal laws that already mandate privacy

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[2] Rohit Chopra (@chopracfpb), X (July 22, 2024) ("Research shows that these medical bills *aren't predictive* of a consumer's likelihood of making other loan payments.") (Emphasis added); Rohit Chopra, *Opinion: The Credit Reporting System Shouldn't Punish Americans for Getting Sick*, CNN Opinion (June 17, 2024), *available at* https://www.cnn.com/2024/06/17/opinions/medical-bills-credit-reports-chopra/index.html ("After the CFPB drew renewed attention to the issue two years ago, the credit reporting conglomerates also began to recognize its *limited predictive value* and removed some bills, like those below $500, from people's reports.") (Emphasis added); *Semi-Annual Report of the Bureau of Consumer Financial Protection before the House Financial Services Committee* given by Rohit Chopra, Director of the CFPB (June 13, 2024) ("…medical bills also go through the insurance system, so you are often left with a situation where things are still pending, but often parked on your credit report, and that's why many lenders actually don't even look at it, because they know that it's *not necessarily predictive* of your performance on other loans, and that that is what a lot of the research has shown.") (Emphasis added); *Id.* ("There's *not even much predictive power* of these medical bills.") (Emphasis added); CFPB Proposes to Ban Medical Bills from Credit Reports, CFPB (June 11, 2024), *available at* https://www.consumerfinance.gov/about-us/newsroom/cfpb-proposes-to-ban-medical-bills-from-credit-reports/#xd_co_f=YjU2ZWRiOGEtOGFiMC00NWJiLWE3YTQtYjg2ZTg1NTgyNzNi~ (statement by Director Chopra that "Medical bills on credit reports too often are inaccurate and have *little to no predictive value* when it comes to repaying other loans") (emphasis added); Prepared Remarks of CFPB Director Rohit Chopra on the Proposed Ban of Medical Bills on Credit Reports, CFPB (June 11, 2024), *available at* https://www.consumerfinance.gov/about-us/newsroom/prepared-remarks-of-cfpb-director-rohit-chopra-on-the-proposed-ban-of-medical-bills-on-credit-reports/ ("A decade ago, the CFPB found that medical debts were overly penalizing consumer credit scores, and we have consistently found that medical billing data on a credit report is *less predictive* of future repayment than other debts.") (Emphasis added); Natalie Campisi, *Biden Administration Rule Would Wipe Medical Debt from Credit Reports, Boost Credit Scores*, Forbes (June 12, 2024) (reporting instead that Director Chopra said the CFPB "consistently found that medical billing data on a credit report is *not predictive* of future repayment") (emphasis added).

[3] Separately attached, please see economic analysis provided by Dr. Andrew Rodrigo Nigrinis, a former enforcement economist at the CFPB.

protections related to healthcare issues.[4] Indeed, the Proposed Rule, as drafted, conflicts with a privacy regulation that already exists for medical information put in place by the United States Department of Health and Human Services ("HHS"). In 1996, this privacy regulation, known as Health Insurance Portability and Accountability Act ("HIPAA"), was passed by Congress, which gave oversight responsibility to HHS. Notably, HIPAA has already established privacy protections for medical information, which carve out financial information and expressly state that payment information should be permitted on credit reports.[5]

Finally, the CFPB asserts that the Proposed Rule will address a perceived financial practice whereby unscrupulous debt collectors allegedly place inaccurate medical debt on consumer reports, a practice known as "debt parking," to coerce payment of debts that the consumer does not actually owe. While the CFPB has claimed this is a widespread problem, there has been minimal to no enforcement activity in this area, despite the fact that the CFPB already has the ability to police any unscrupulous behavior. While each of the concerns cited above are valid in concept, the reality is that many of them are inflated or misguided, and others are already addressed by existing laws and regulations.

2. The Proposed Rule Causes Measurable Harm that Outweighs its Illusory Benefits.

First, the purpose of the FCRA is to ensure that consumer credit reports are accurate and complete. Medical debt, like all other consumer debt, has predictive value, as evidenced by recent

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[4] *See, e.g.*, Health Insurance Portability and Accountability Act ("HIPAA"), 45 C.F.R. Part 160; California's Confidentiality of Medical Information Act ("CMIA"), Cal. Civ. Code §§ 56, *et. seq.*; *see also* Washington My Health My Data Act, 2023 Wash. Laws 191 (a privacy-focused law that protects personal health data that falls outside the ambit of the HIPAA).

[5] *See* 45 C.F.R. § 164.501. The preeminent healthcare privacy regulation that has domain expertise in medical information considers consumer reporting agencies information to be acceptable under the efficient payment definition coincidently coincides with the FACT Act of 2003 definition of medical information. As such, the CFPB should consider this proposed regulation as duplicative, overlapping, and a conflicting requirement.

data and analysis, discussed below. Even if medical debt information is slightly less predictive than some other types of financial information, inclusion of this information is still necessary to ensure Congress's goal that users of consumer reports have a full picture of a consumer's financial liabilities, including any and all debt obligations. Moreover, to the extent that the Bureau is concerned about loan approvals, creditors use a range of factors to make credit eligibility determinations, including FICO 9. Thus the presence of a minor medical debt, standing alone, is unlikely to preclude a consumer from obtaining a mortgage for which they would otherwise be qualified based on a comprehensive review of their financial profile.

Additionally, as numbers of lenders have specifically outlined to the CFPB, if a consumer has a major medical obligation, it is also important for a later lender to know about this. More information helps ensure that consumers are not offered a loan that they cannot afford and promotes safety and soundness for financial institutions.[6] The CFPB has ignored comments from trade associations representing large banks, community banks, credit unions, and other lenders[7] that state that they use information about medical debt, and has tried to gloss over this inconvenient fact in its Proposed Rule. This apparent disregard for the safety and soundness of our financial institutions comes on the heels of a regional banking crisis, during and following which many consumers began to question the safety of their financial institutions. Indeed, in a public statement, Director Chopra highlighted that, "banks can still fail – and they can fail very quickly. And even when the failing bank isn't a Wall Street giant, the risk of contagion and crisis is real, as we saw

[6] *See* Ann Petros, *Incomplete Credit Histories are an Obstacle to Safe Lending*, CUInsight (July 26, 2024), *available at* https://www.cuinsight.com/incomplete-credit-histories-are-an-obstacle-to-safe-lending/.

[7] *See e.g.*, Comments on the Small Business Advisory Review Panel for Consumer Reporting Rulemaking Outline of Proposals and Alternatives Under Consideration (Nov. 6, 2023), *available at* https://www.bhfs.com/Templates/media/files/PDFs/BPI%20CBA%20TCH%20Comment%20on%20CFPB%20SBREFA%20Outline%20for%20Rulemaking%20on%20FCRA.pdf (reflecting that the Bank Policy Institute (BPI), Consumer Bankers Association (CBA) and The Clearing House (TCH) raised concern, noting that removing certain credit attributes from the credit reporting system without conducting a thorough analysis "would create a real risk that banks would be unable to meet their consumer protection obligations or safety and soundness requirements").

with the failures of Silicon Valley Bank, Signature Bank, and First Republic Bank."[8] It is curious how the Bureau can acknowledge this reality, while simultaneously proposing a rule that will exacerbate these risks. Finally, as elucidated below, the CFPB's actions are arbitrary and capricious and it has not provided sufficient data or evidence to support its assertions, specifically it has provided no evidence that its actions do not impact safety and soundness of financial institutions or addressed concerns raised by lenders.

The Bureau rationalizes its Proposed Rule by asserting that consumer credit reports should not be shaded by debt obligations that a consumer did not willingly undertake. This argument fails logically. The CFPB's rhetoric claims that consumers should not be prevented from achieving the dream of home ownership because they got sick. But what makes medical care any different from unexpected auto or household expenses? Would a payment of a fine for a Driving Under the Influence violation not be a real debt because it was not planned for? No, of course not. Secondly, illness and injury are inevitable. People should be saving for the "rainy day" when medical expenses occur. The need for all persons to have medical care underlies the premise of the Affordable Care Act. The Bureau's rationale that unplanned expenses need not be paid is illogical and inconsistent.

Alternatively, consider a person who is struggling financially to meet their living expenses each month but must finance costly surprise home repairs, like a damaged roof or faulty water heater. Those consumers did not plan on incurring those debts either. Yet, the CFPB does not suggest we suppress those accurate debts from consumer credit reports. The suppression of any accurate and predictive data on consumer credit reports is not appropriate and, to the extent this

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[8] Statement of CFPB Director Rohit Chopra Member FDIC Board of Directors Regarding Proposals to Improve the FDIC's Options for Managing Large Bank Failures, CFPB (Aug. 29, 2023), *available at* https://www.consumerfinance.gov/about-us/newsroom/statement-of-cfpb-director-rohit-chopra-member-fdic-board-of-directors-regarding-proposals-to-improve-the-fdics-options-for-managing-large-bank-failures/.

suppression artificially inflates credit scores and results in loan approvals for those who are otherwise unqualified, the consequences are severe. Not only does this result directly harm those specific consumers, who are now at a higher risk of default due to being overleveraged, but the suppression of such data creates a slippery slope of economic harms to consumers, businesses, providers, and the credit markets generally.

Second, the CFPB's asserted privacy concerns are inflated and the CFPB's proposed solutions conflict with the text of the FCRA and impermissibly attempt to rewrite it. The FCRA already addresses privacy concerns: "a creditor shall not obtain or use medical information (other than medical information treated in the manner required under section 1681c(a)(6) of this title) pertaining to a consumer in connection with any determination of the consumer's eligibility, or continued eligibility, for credit."[9] Even where a consumer report includes medical debt information, the creditor cannot see any private health information that would provide them insight into a consumer's actual medical history, conditions, or treatment. That data is expressly prohibited on consumer reports. Therefore, there is no risk that a creditor can improperly consider a consumer's health status in making a credit eligibility determination.

Third, the Proposed Rule will cause harm to consumers, while doing nothing to help them with the actual costs of medical care. The CFPB did not engage with all stakeholders to address the affordability problem and has no jurisdiction over this type of healthcare policymaking. The CFPB's uninformed actions, wading into an area over which it does not have authority or expertise, may exacerbate America's problem of increasingly underinsured families by making it less attractive to have health insurance.[10] It may also lead to increased costs and increased litigation.

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[9] 15 U.S.C. §1681b(g)(2).

[10] In a recent poll during the ACA-Healthcare Financial Management Association Webinar on July 10, 2024, titled *Healthcare Credit Reporting Rule—What You Need to Know*, nearly 75% of the 165 respondents stated that there was a "moderate" or "high" chance the CFPB's Proposed Rule would impact a patient's view of the need for insurance,

HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION ("HFMA") PARTICIPANTS RESPONDED TO A SERIES OF POLLS.

ONE ASKED "WHAT OPTIONS DO YOU SEE YOUR OWN PROVIDER ORGANIZATION TAKING TO MITIGATE LOSSES FROM ELIMINATING CREDIT REPORTING—INCLUDING OVERALL BEHAVIOR CHANGES EVEN IF YOU DON'T CREDIT REPORT NOW?"

SEVENTY-TWO PERCENT OF RESPONDENTS STATED THAT THEY WOULD "REQUIRE FULL OR PARTIAL PAYMENT IN ADVANCE FROM PATIENTS FOR NON-EMERGENCY PROCEDURES."

Fourth, the Bureau's concerns with debt parking are overstated and unsupported by current data, as further discussed below. However, even if this were a genuine issue, current laws and regulations, including the CFPB's own Regulation F and the Fair Debt Collection Practices Act (the "FDCPA") sufficiently address such perceived financial abuses. For example, Regulation F, effective November 30, 2021, requires debt collectors to send notice to consumers prior to listing any collection account on their credit report.[11]

Instead of contorting statutory text under the guise of new regulations in a way that will directly interfere with the FCRA's guiding purpose of completeness and accuracy, and thus cause deleterious consequences for consumers, businesses, and the credit markets, the Bureau should focus on enforcing the laws and regulations that already sufficiently address these perceived issues.

B. <u>Summary of Direct Economic Impacts.</u>

The Proposed Rule will have a number of negative direct economic impacts on lenders, consumers, medical providers and patients, and small businesses. Most obviously, the suppression

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further worsening the slippery slope of un- or underinsured Americans. *See CFPB Proposed Rule on Medical Debt Credit Reporting*, ACA International (last visited Aug. 8, 2024), *available at* https://policymakers.acainternational.org/issue/cfpb-proposed-rule-on-medical-debt-credit-reporting/ (hereafter the "ACA-HFMA Poll"). A true and correct copy of the polling results is attached hereto as an exhibit.

[11] *See* 12 CFR Part 1006.

of medical debt information from consumer credit reports will place creditors in the unenviable position of making credit eligibility decisions in the dark. As the CFPB has boasted, its Proposed Rule would suppress $49 billion in consumer debt obligations. In practice, this means that $49 billion in consumer financial liabilities will be hidden from view, directly interfering with a lender's ability to meaningfully assess a consumer's creditworthiness and capacity to take on further debt.

The suppression of this data will lead some lenders to approve consumers for loans that they simply do not have the ability to repay. In turn, those consumers who lack the ability to repay but are granted a loan anyway will become overleveraged and will be forced to choose between which liability to satisfy with their finite resources. In the long term, these consumers will face collections, decreased credit scores, bankruptcy, and possibly even litigation associated with whichever debt they elect not to pay.

Meanwhile, more risk averse lenders will limit lending altogether, based on the general unreliability of consumer reports that are inherently incomplete. Therefore, another group of consumers will be harmed when they cannot obtain a loan because conservative lenders are forced to generalize risk data in the absence of specific medical debt reporting. These are the consumers that may have less credit history or smaller incomes, but their payment histories are immaculate. Yet, when their positive payment history on any debt that could be characterized as "medical," is hidden from view, they are denied a useful data point to show lenders that they are, in fact, creditworthy. Finally, as discussed in A. Rodrigo's research, the Proposed Rule will be unduly burdensome and expensive, harming small businesses, including many in rural and underserved communities.

C. Summary of Indirect Economic Impacts.

As explained in more depth in the economic analysis accompanying this comment letter, the Proposed Rule also has many foreseeable indirect economic impacts that the Bureau has not evaluated:

- A higher cost of credit for all borrowers because lenders will have to factor in the blind spots and costs associated with riskier lending and litigation associated with unclear rules.
- A watered down credit report, which limits any benefits to consumers who have worked to repair credit scores.
- Convoluted obligations for creditors under the Truth in Lending Act ("TILA") and Regulation Z, particularly under the ability-to-repay ("ATR") provisions, which will likely lead to increased litigation.
- Loss of income for medical providers due to non-payment for services. The loss in the first year is estimated to be $24 billion. The estimated range for the losses over time ranges from $82 billion to $655 billion.
- Litigation costs for medical providers to collect debts and for consumers facing that litigation will likely increase as the CFPB acknowledges and A. Rodrigo analyzes in his research.
- Increased costs for medical care for consumers as a whole, including those without health insurance and many in protected classes. Pre-payment may require financing through loans for co-pays and deductibles with higher costs of credit. Or providers may prohibit care entirely for children and family members if credit cannot be obtained for upfront costs.
- Restricted investments in underserved areas if it is harder to get paid for the services provided and providers choosing to close offices or leave rural or urban areas altogether.
- Safety and Soundness concerns for financial institutions that will be forced to lend with less accurate credit profiles and will be subject to disparate and confusing rules about voluntary information about medical debt.
- Risk of health insurance markets entering a slippery slope if young and healthy consumers who infrequently use healthcare forgo insurance because of the perception that they, in practice, do not need to pay for medical treatment.

II. THE CFPB LACKS THE LEGAL AUTHORITY TO PROMULGATE THE PROPOSED RULE.

Like any administrative agency, the CFPB must act within the scope of authority Congress delegated to it by statute. The Supreme Court's recent decision in *Loper Bright v. Raimondo*,

144 S. Ct. 2244 (2024) makes clear that agencies do not have the authority to rewrite or reimagine federal law promulgated by Congress. Congress has provided no clear grant of authority to the CFPB to eliminate medical debt from credit reports. In fact, as discussed below, there are several pieces of legislation attempting to do this that have not garnered the support necessary by Congress to become law.

Further, the CFPB's rulemaking must comply with the Administrative Procedure Act ("APA"),[12] which requires a reviewing court to set aside agency action under certain conditions, including when agency rulemaking is arbitrary or capricious.[13] When applying the arbitrary and capricious standard, courts generally focus on: (1) whether the rulemaking record supports the factual conclusions upon which the rule is based; (2) the rationality or reasonableness of the policy conclusions underlying the rule; and (3) the extent to which the agency has adequately articulated the basis for its conclusions. Reviewing courts' interpretations of the terms "arbitrary and capricious" have changed over time. Indeed, the Supreme Court's recent decision in *Loper Bright* significantly narrowed agency authority to interpret statutes, particularly where a statute is silent on a particular issue, requiring that "[i]n the business of statutory interpretation, if [the interpretation] is not the best, it is not permissible." 144 S. Ct. at 2266.

Any rulemaking in which the CFPB engages to implement a new rule or modify an existing rule faces two primary statutory requirements. First, the rule must conform to the authority set forth in the Consumer Financial Protection Act (the "CFPA"). Second, the agency must provide a "concise general statement of [the rule's] basis and purpose,"[14] reflecting rational and reasonable policy conclusions in the rulemaking record to support the change and thus avoid being overturned

[12] *See generally* 5 U.S.C §§ 551–559, 701–706, 1305, 3105, 3344, 5372, 7512.
[13] 5 U.S.C. § 706.
[14] 5 U.S.C. § 553(c).

as "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law."[15]

Here, the CFPB attempts to wade into an area of law whose statutory text is clear and whose congressional intent is unambiguous. Moreover, the current regulatory scheme governing Credit Reporting Agencies (the "CRAs") is not highly technical or complex, and the CFPB's attempt to rewrite the governing regulations is not in line with sound policy or law. For the foregoing reasons, the CFPB lacks authority to issue rules in this area.

A. **<u>The CFPB's Authority is Limited by Applicable Statutes.</u>**

The CFPB's authority for promulgating the Proposed Rule remains unchanged from when Regulation V was originally enacted by the Federal Trade Commission.[16]

1. <u>CFPB Authority Under the Fair Credit Reporting Act.</u>

The Bureau's authority to promulgate rules in this area is limited by the plain language of the FRCA itself. Section 604(g)(1)(C)[17] of the FCRA clearly authorizes CRAs to furnish consumer reports with medical information if they meet the requirement of subparts (A)-(C). Specifically, subsection (g)(1)(C) allows consumer reporting agencies, under the specified restrictions, to furnish medical information as it "pertains solely to transactions, accounts, or balances related to debts arising from the receipt of medical services, products, or devices." Thus, Congress has expressly allowed what CFPB seeks to disallow. Plainly stated, because Congress has already spoken on this precise issue, the analysis need go no further. The CFPB does not have authority to promulgate the Proposed Rule.

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[15] 5 U.S.C. § 706(2)(A).
[16] *See* 12 U.S.C. § 5512, 5581; 15 U.S.C. 1681a, 1681b, 1681c, 1681c–1, 1681c–3, 1681e, 1681g, 1681i, 1681j, 1681m, 1681s, 1681s–2, 1681s–3, and 1681 14, Pub. L. 108–159, 117 Stat. 1952.
[17] 15 U.S.C. § 1681b(g)(1)(c).

But even proceeding further in the analysis does not change the limits on the CFPB's authority. Section 604(g)(2)[18] does not supersede the express direction in 604(g)(1)(C). The entirety of subsection (g)(2) reads:

> Except as permitted pursuant to paragraph (3)(C) or regulations prescribed under paragraph (5)(A), a creditor shall not obtain or use medical information (other than medical information treated in the manner required under section 1681c(a)(6) of this title) pertaining to a consumer in connection with any determination of the consumer's eligibility, or continued eligibility, for credit.

Thus, the plain text of section 604(g)(2) sets the objective of rulemaking authority in FCRA section 604(g)(2), but also imposes a restriction on the Bureau. Its reference to section 1681c(a)(6) provides that:

> Except as authorized under subsection (b), no consumer reporting agency may make any consumer report containing any of the following items of information: …The name, address, and telephone number of any medical information furnisher that has notified the agency of its status, unless— (A) such name, address, and telephone number are restricted or reported using codes that do not identify, or provide information sufficient to infer, the specific provider or the nature of such services, products, or devices to a person other than the consumer; or (B) the report is being provided to an insurance company for a purpose relating to engaging in the business of insurance other than property and casualty insurance.

Furthermore, the FCRA's section 604(g)'s legislative history and historical treatment does not support the CFPB's Proposed Rule. Congress repeatedly acknowledged that section 604(g) contemplates credit providers considering consumer applicants' medical debt in loan calculations. Restrictions on the use of the broader concept of medical information spurs from confidentiality and privacy concerns. For example, in summarizing the then-proposed amendments in the Fair and Accurate Credit Transactions Act (the "FACT Act") to the FCRA's governing of the financial system's treatment of medical information, House Report 108-263 explained, that in the context of "credit transactions furnished by a consumer reporting agency or authorized under certain laws

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[18] 15 U.S.C. § 1681b(g)(2).

or regulations pursuant to the provision of subsection [604](g)," "restrictions are imposed to limit the *redisclosure*" of any medical information. H.R. Rep. 108-263 (2003) (emphasis added). This explanation implicitly acknowledges that credit transactions will include medical information as provided in section 604(g), but that *redisclosure*—in other words unauthorized violations of a consumer's privacy and confidentiality—was prohibited. This same report also expressly notes that, subject to the required restrictions, medical information "may be included in a report for . . . credit purposes" "where the information is relevant for the purposes of processing or approving . . . credit requested by the consumer." *Id.*

And similarly, speaking in support of the FACT Act, Representative Paul Kanjorski also emphasized the regulation's focus on privacy concerns, noting the legislation would "improve the accuracy of and correction process for credit reports and establish strong privacy protections for consumers' sensitive medical information." Fair and Accurate Credit Transactions Act of 2003, 149 Cong. Rec. H8122-02 (2003) (also explaining that the legislation "contains important provisions to protect medical information that is present in financial services' systems and provides for confidentiality of medical data in all credit reports").

None of the other subsections within section 604(g) grant the CFPB the power it seeks to yield here. Section 604(g)(3)(C)[19] does not grant broad rulemaking authority. Under this provision the Bureau's authority is limited to the preceding language in 604(g)(3)(A)-(B)'s enumerated list. Similarly, section 604(g)(4)[20] only provides authority for regulations about redisclosure once information is received. And finally, section 604(g)(5)[21] authorizes regulations "that permit transactions under paragraph (2)" but only if they meets statutory demands.

[19] 15 U.S.C. § 1681b(g)(3)(C).
[20] 15 U.S.C. § 1681b(g)(4).
[21] 15 U.S.C. § 1681b(g)(5).

2. CFPB Authority Under the Dodd-Frank Act.

In 2010, Congress passed the Dodd-Frank Wall Street Reform and Consumer Protection Act (the "Dodd-Frank Act")[22] in response to consumer abuses in mortgages, credit cards, and other financial products. The Dodd-Frank Act made substantial changes to many of the statutes in the Consumer Financial Protection Act and, in Title X, established the CFPB. As part of those changes, the Dodd-Frank Act assigns to the CFPB some of the rulemaking and enforcement authority that the FTC and banking regulators previously held. It also grants the CFPB rulemaking authority regarding unfair, deceptive, or abusive practices.

Notably, the language in the CFPB's Enabling Act grants it the authority to "regulate the offering and provision of consumer financial products or services under the federal consumer financial laws."[23] The CFPB's jurisdiction is thus limited to "financial products" and "financial services." A consumer financial product or service is a financial product or service that is offered or provided for use by consumers primarily for personal, family, or household purposes. A financial product or service means one of a handful of specified activities (with certain exceptions):

- Extending credit and servicing loans;
- Extending or brokering leases;
- Providing real estate settlement services;
- Engaging in deposit-taking or funding custodial activities;
- Selling, issuing, or providing stored value cards or payment instruments;
- Check cashing, check collection, or check guaranty services;
- Providing payments or other financial data processing products or services;
- Providing financial advisory services;

[22] Also known as the Consumer Financial Protection Act (the "CFPA") or the CFPB's Enabling Act.
[23] 12 U.S.C. § 5491(a).

- Collecting, maintaining, or providing consumer report information or other account information;
- Debt collection related to consumer financial products or services; and
- Products or services permissible for a bank or financial holding company to offer that will impact consumers.

Moreover, the CFPB's rulemaking and enforcement authority related to consumer financial products or services is strictly limited to "covered persons." This includes only those who offer or provide a financial product or service, and anyone controlling, controlled by, or under common control with such a person who acts as a service provider for such a person.

Here, the CFPB's Proposed Rule goes far beyond the CFPB's statutory authority. While it is clear that the CFPB may regulate the offering and provision of debt collection, what the CFPB is now considering—whether and to what extent, medical debt appears on a consumer's credit report—goes far beyond the realm of mere debt collection. Indeed, while the intention behind the Proposed Rule is aimed at CRAs and creditors, the practical effect stretches beyond to impose a regulation of the entire American healthcare system. The Proposed Rule therefore does not fit within the definition of a "financial product" or "service," nor does it limit its reach to "covered persons," and the CFPB lacks jurisdiction to issue rules in this area.

To promulgate a rule under the CFPA, the Bureau would need to invoke its UDAAP[24] authority, but that justification is not presented here. The inclusion of accurate medical debt on a consumer's credit report is not unfair, deceptive, or abusive. Furthermore, the CFPA requires that, in promulgating any rule, the CFPB must consider the impact of the rule on consumer and small business access to credit.[25] As discussed in depth below, the Proposed Rule will significantly harm consumers and businesses by reducing access to credit. Finally, Dodd-Frank §1022(b) requires the

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[24] *See* 12 U.S.C. § 5511.
[25] *See* 12 U.S.C. § 1022(b)(2)(A).

promulgating agency to consult with other federal agencies—specifically the "appropriate prudential regulators."[26] While the CFPB may have in some way minimally "checked this box" with prudential regulators, it has done no significant research or data collection to study the safety and soundness or underwriting issues related to this Proposed Rule. Financial institution stakeholders specifically raised safety and soundness concerns during SBREFA and elsewhere, yet this is addressed nowhere in the Proposed Rule.[27] While the CFPB claims that numerous stakeholders supported its efforts during SBREFA, the discussion during it and the comments filed in response to it, show quite the opposite.

For example, the CFPB has asserted that credit unions do not use medical debt tradelines and therefore will not be harmed by the Proposed Rule. On the contrary, one credit union representative stated the following:

> Jim Wilmot from Arlington Credit Union… Starting with question 36, how do we use it? We are a mission-based credit union. We exist to make community impact and we do that by aggressive deep lending. We give lenders a lot of second and third chances and the most important factor in that is being able to see all of the information and have a great conversation in depth about the borrower's credit history. Seeing that entire credit history is important. How that benefits the borrower, we see delinquency three years ago and we match that up to a medical debt issue that just kind of completes the whole picture and gives us a better view of the borrower's ability to pay us back today. When we do see that medical debt experience three years ago and we see they were able to pay their debts and they didn't have that delinquency issue, that empowers us to be able to lend even more. So there's a lot of benefits to seeing that.
>
> We are one of so many different financial institutions and the variance is so large that I worry about the restriction of pieces of the puzzle, pieces of the borrower's credit history and then ways that we can use it. While we don't have any reference to medical data in our automated underwriting, we don't have any line items in our policy for manual reviews of underwriting that would put a maximum out there of three medical trade lines or a total of $5,000. There's other institutions that are

[26] *See* 12 U.S.C. § 5512(b)(2)(B).

[27] *See, e.g.*, *Final Report of the Small Business Review Panel on the CFPB's Proposals and Alternatives Under Consideration for the Consumer Reporting Rulemaking* (Dec. 15, 2023), *available at* https://files.consumerfinance.gov/f/documents/cfpb_sbrefa-final-report_consumer-reporting-rulemaking_2024-01.pdf (hereafter "SBREFA Report").

> mandated either in their mission or by their board, which is elected from their membership that has less of an appetite for risk. They are more credit averse, they are lending in different products, they're lending different amounts in different communities. And I would just hate to lump us all into one box with one set of data stream and then force us all to achieve our missions and our goals with just parts of the puzzle.[28]

As demonstrated by the commentary above, credit unions, like any other lender, depend on complete and accurate consumer credit reports to make lending decisions that appropriately factor consumer default risk, promote the missions of the financial institutions, and protect the depository accounts of other credit union members.

Similarly, the CFPB omitted key SBREFA comments from other industry representatives. For example, in explaining the use of medical collections accounts in underwriting, one SBREFA participant[29] explained:

> Hi. So I just wanted to provide some information about how we underwrite loans here at our bank with medical collections. So we consider medical collections a collection that results from a bill from a medical establishment. So it excludes any medical loans or credit cards that are established through a contract with reoccurring payments to pay off a medical debt. So those are reported as just regular trade lines. We don't count those as medical collections. And we underwrite medical collections the same way that Freddie Mac does, in that we don't include them. We don't consider them as part of our underwriting if they are reported as a collection. And so we just discount those altogether. I do know that other small banks, however, do consider those as part of their repayment because somebody with a large medical collection probably does have payment arrangements made and as part of Freddie Mac's underwriting requirements, if you are made aware of somebody having a payment arrangement made, like a written payment agreement in place, then we do have to consider that as part of... In their debt ratio. So that's how we currently underwrite it.[30]

The Bureau fixates on the statement that this particular representative does not factor in medical debt if that debt is already in collections. However, the CFPB wholly ignores the

[28] *See* Unofficial Transcript FCRA Rulemaking SBREFA Panel, Day 3, Comment by Jim Wilmot, Arlington Credit Union (Oct. 18, 2023).
[29] Those who participated in the SBREFA process are referred to as Small Entity Representatives ("SERs").
[30] *See* Unofficial Transcript FCRA Rulemaking SBREFA Panel, Day 2, Comment by Evelyn Schroeder (Oct. 12, 2023).

remainder of the comment, including the context in which it was made. As a threshold matter, the speaker does not state that they discount all medical debt, but only that which is now in collections. And critically, she highlights the fact that other financial institutions still utilize this information to underwrite loans because it is important for lenders to account for medical debt when a payment arrangement with a medical provider impacts the debt-to-income analysis.

Thus, the CFPB's creative approach to recreate the facts and record, and its decision to ignore many serious concerns raised and proceed with the Proposed Rule is further indication that it is not appropriately considering the Proposed Rule's scope, consequences, or costs versus benefits.

B. Case Law Limits the CFPB's Scope of Authority in Light of the Statutory Text Discussed Above.

In addition to the CFPB's enabling statute, the APA, and *Loper Bright*, the CFPB's rulemaking and enforcement authority is also limited by case law. It is well settled that "the words of a statute must be read in their context and with a view to their place in the overall statutory scheme." *Davis v. Mich. Dep't of Treasury*, 489 U.S. 803, 809 (1989). Sweeping grants of regulatory authority are rarely accomplished through "vague terms" or "subtle device[s]." *Whitman v. American Trucking Assns.*, 531 U.S. 457, 468 (2001). Indeed, courts must "presume that 'Congress intends to make major policy decisions itself, not leave those decisions to agencies.'" *West Virginia v. EPA*, 597 U.S. 697, 723 (2022) (quoting *United States Telecom Assn. v. FCC*, 855 F.3d 381, 419 (CADC 2017) (Kavanaugh, J., dissenting from denial of rehearing en banc)).

1. Recent Decisions Limiting CFPB Authority.

Recognizing these fundamental principles, the United States District Court for the Eastern District of Texas recently ruled that the CFPB exceeded its statutory authority to regulate unfair

acts or practices by updating its rules to direct the Bureau's examiners to scrutinize companies for discrimination and for how well companies introspected about statistical disparities in data concerning business practices. *See Chamber of Com. of United States of Am. v. CFPB*, 691 F.Supp.3d 730 (E.D. Tex. Sept. 8, 2023). Notably, the court came to this conclusion despite Congress directing the CFPB to ensure that "consumers are protected (1) from unfair, deceptive, or abusive acts and practices and (2) from discrimination." *Id.* at 741 (quoting 12 U.S.C. § 5511(b)(2)). The court reasoned that the issue was one of major economic and political significance, and permitting the CFPB to rule in this area "would have large implications for the financial-services industry." *Id.* at 740.

The CFPB's Proposed Rule here similarly transgresses administrative law. Specifically, while Congress has granted the CFPB rulemaking and enforcement authority over financial products and services (as it has for unfair, deceptive, or abusive acts and practices), it has clearly demarcated what these categories entail. The Proposed Rule changes go far beyond this statutory boundary. Moreover, the Proposed Rule would have major economic implications, and in situations such as these, courts must presume that Congress intends to make such major policy decisions itself. *See West Virginia*, 597 U.S. at 721.

The CFPB's rulemaking authority has also been clarified in another recent case involving a statute that the CFPB administers. In *Consumer Finance Protection Bureau v. The Mortgage Law Group, LLP*, the United States District Court for the Western District of Wisconsin, ruled that the Bureau's regulations requiring attorneys to comply with certain state professional conduct rules were invalid because the rulemaking was in excess of the CFPB's authority. 157 F. Supp. 3d 813, 820 (W.D. Wis. 2016), *aff'd in part sub nom. CFPB v. Consumer First Legal Grp., LLC*, 6 F.4th 694 (7th Cir. 2021). Specifically, the court found that the CFPB's interpretation of the regulating

statute was not subject to deference under *Chevron* and was arbitrary and capricious because Congress never intended the CFPB to address issues related to attorney conduct and attorney-client relationships. *See id.*, at 824–25. The Court reasoned that the CFPB's authority under the CFPA and the Omnibus Act, as clarified by the Credit Card Act, gave the CFPB rulemaking authority only with respect to unfair or deceptive mortgage loan practices, and an attorney's violation of a state rule of professional conduct regarding client trust accounts does not automatically equate to an unfair or deceptive mortgage loan practice. *Id.*

Mortgage Law Group is instructive, because once again, through the Proposed Rule, the CFPB is attempting to regulate outside of its Congressionally proscribed bounds. The Proposed Rule goes far beyond the scope of mere debt collection and attempts to regulate the American healthcare system. Because the Proposed Rule's definition of medical debt is the first of its kind, which draws arbitrary lines in the sand such as including elective cosmetic procedures, it is also impossible to know the extent to which this Proposed Rule impacts certain medical providers. However, it is certainly clear that it does, and the CFPB does not have unfettered authority to promulgate rules in this area to impact any type of medical provider or part of the medical system, however it deems appropriate. The Proposed Rule is outside the CFPB's jurisdiction, and if challenged, it is highly unlikely that the CFPB's interpretation would be upheld, especially in light of *Loper Bright's* curtailment of the earlier *Chevron* deference analysis.

Indeed, the large amount of case law indicating that the CFPB's actions here are unlawful does not stop with the lower courts. Perhaps most importantly, each of the above cases was decided before the Supreme Court issued its opinion in *Loper Bright*. *See generally*, 144 S.Ct. 2244. Recognizing the limiting effect of that decision on the decades old *Chevron* test, it is now even more likely that courts will strike down any attempts by the Bureau to regulate industries beyond

the scope of its Congressional authorization. Accordingly, where the CFPB is attempting to regulate an area of the FCRA that has been thoroughly prescribed by Congress, as is the case here, the CFPB's interpretation and expansion is not likely to pass judicial scrutiny. Now, with the recent guidance of the Supreme Court, judicial analysis and rejection of the CFPB's Proposed Rule is even more certain.

As discussed above, Congress spoke directly to this issue in the FCRA; the CFPB does not have the delegated authority to promulgate the Proposed Rule. As a threshold consideration the FCRA is not ambiguous on this point. Section 604(g)(1)(A)–(C) clearly provides for the circumstances in which credit reporting agencies may furnish medical debt information. Thus, the CFPB is not owed judicial deference to its interpretation of 604(g)(2). But even if we were to accept the argument that the FCRA is ambiguous, *Loper Bright*'s negation of the directive that courts accept any "permissible" construction provided by an agency dooms the CFPB's Proposed Rule. *See* 144 S. Ct. at 2266. It is well settled, dating as far back as *Marbury v. Madison*, 1 Cranch 137 (1803), courts—not agencies—are tasked with using "every tool at their disposal to determine the best reading of the statute and resolve the ambiguity." *Id.* Plainly stated, the CFPB's Proposed Rule is not the "best reading of the statute" as it contradicts the plain language of the surrounding subsections. The tools of statutory interpretation as outlined above prove this.

2. <u>The Plain Language of the FCRA Does Not Support the Bureau's Proposed Rule.</u>

The specific grants of rulemaking authority in Section 604(g) of the FCRA, subparts (3)(C) and (g)(5)(A) are limited to restrictions on the uses of "medical information," and does not provide the CFPB with any authority to restrict "account" information included in consumer reports. Rulemaking authority under this section is clearly limited to how an entity may *share* or use "medical information," and not to the provision of any such information by a CRA. As a matter of

statutory construction, by its language, the agency's rulemaking authority in subsection (g)(3)(C) is exceedingly narrow—it only extends as far as to modify the limit on sharing medical information among affiliates in 15 U.S.C. § 1681a(d)(3) in three enumerated instances. This statutory grant is not capable of being stretched to cover consumer report contents generally. Limits on CRAs with respect to medical information are instead addressed by another section altogether: Section 604(g)(1)—cited differently, 15 U.S.C. § 1681b(g)(1).

Prior to transfer to the CFPB, prudential regulators wielded the rulemaking authority in this area of the law, none of whom had authority over CRAs. The transfer of this authority to the CFPB in the Dodd-Frank Act does not surreptitiously expand that authority. The general rulemaking authority granted to the CFPB under the FCRA (section 621(e)) is limited to those rules "necessary and appropriate to administer and carry out the purposes and objectives of [the FCRA], and to prevent evasions thereof or to facilitate compliance therewith."[31] The FCRA specifically permits a CRA to provide medical information related to "transactions, accounts or balances relating to debts arising from the receipt of medical services, products, or devices" so long as the information is properly coded to mask the provider or the nature of such services.[32] The FCRA does not prohibit a CRA from providing information on medical debts except as specified under Section 605, which excludes certain veteran's medical debt.[33] The FCRA does not otherwise prohibit a CRA from providing medical information except with respect to the reporting of coded information received from furnishers. The structure of the FCRA under Section 604 and 605 clearly demonstrates that restrictions on the information to be included in consumer reports are a matter for Congress to dictate, not the CFPB.

[31] 15 U.S.C. § 1681s(e)(1).
[32] 15 U.S.C. § 1681b(g)(1)(C).
[33] *See* 15 U.S.C. § 1681c(a)(7)–(8).

3. The Economic Impact of the Rule is a Major Question.

The CFPB clearly lacks the authority to make a rule that suppresses the reporting or furnishing of information about medical debts. The FCRA does not grant the CFPB broad discretion to dictate the types of information on consumer reports. Nor did it provide the CFPB specific authority over medical debt. The FCRA statutory text already imposes restrictions and limits on medical debt reporting and the statutory text both expressly and impliedly allows reporting of medical debt. Finally, Congress has granted federal agencies other than the CFPB authority over major questions of healthcare policy. As the Supreme Court has repeatedly acknowledged, "[e]xtraordinary grants of regulatory authority are rarely accomplished through 'modest words,' 'vague terms,' or 'subtle device[s].'" *West Virginia*, 597 U.S. at 723 (quoting *Whitman*, 531 U.S. at 468). Rather, "[a]gencies have only those powers given to them by Congress, and 'enabling legislation' is generally not an 'open book to which the agency [may] add pages and change the plot line.'" *Id.* (quoting E. Gellhorn & P. Verkuil, *Controlling* Chevron *Based Delegations*, 20 Cardozo L. Rev. 989, 1011 (1999)). Therefore, under the major questions doctrine, in order for an agency to convince a court that it has the authority it asserts, it must provide "'clear congressional authorization' for the power it claims." *Id.* (quoting *Utility Air Regulatory Grp. v. EPA*, 573 U.S. 302, 324 (2014)).

The Proposed Rule, requiring the suppression of accurate information about medical debts—paid or unpaid—promulgated under the CFPB's claimed authority would not survive analysis under the major questions doctrine. Under the major questions doctrine, the Supreme Court has rejected agency claims of regulatory authority when: (1) the underlying claim of authority concerns an issue of "vast 'economic and political significance;'" and (2) Congress has not clearly empowered the agency with authority over the issue. *Id.* at 716. The Supreme Court has explained that, in general, courts interpret statutory language "in [its] context and with a view

to [its] place in the overall statutory scheme." *Id.* at 721 (quoting *Davis*, 489 U.S. at 809). In cases where there is something extraordinary about the "history and breadth of the authority" an agency asserts or the "economic and political significance" of that assertion, however, the Court indicated courts should "hesitate before concluding that Congress meant to confer such authority." *Id.* (quoting *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 159–60 (2000)).

The Court has used the doctrine to reject agency claims of regulatory authority, including in regard to:

- the Internal Revenue Service's ("IRS's") decision that a federal healthcare exchange is "an exchange established by the State" for purposes of determining eligibility for tax credits (*King v. Burwell*, 576 U.S. 473 (2015));
- the Centers for Disease Control and Prevention's ("CDC's") nationwide eviction moratorium (*Ala. Ass'n of Realtors v. HHS*, 141 S. Ct. 2485 (2021) (per curiam));
- the Federal Communication Commission's ("FCC's") waiver of a tariff requirement for certain common carriers under its statutory authority to "modify" such requirement (*MCI Telecomms. Corp. v. AT&T Co.*, 512 U.S. 218 (1994)).

The CFPB's claim of authority over medical debt reporting is even more spurious than these provided examples. The CFPB can point to no statutory language that provides it the expansive power it claims, and ceding such authority would undermine congressional intent. For example, there is significant political/legislative discussion about free or government-paid healthcare and the Bureau's Proposed Rule is an attempt to circumvent the public debate on this issue.

The CFPB's pre-determined, politically-driven outcome on this topic is evidenced by its inclusion in political discussion for more than a year before the Proposed Rule was introduced, and before the CFPB attempted to bolster its data and research after SBREFA. For example, the CFPB was created as an independent agency, yet Vice President Kamala Harris—rather than the

CFPB—announced the Proposed Rule[34] a day before the Bureau put it out for public comment as required by the APA. A week later, at a campaign rally and several times before this, President Joe Biden cited this effort as a campaign promise.[35] Both the President and the Vice President have already stated that they will ban all credit reporting of medical debt before the comment period for the public to weigh in on this topic has even closed.[36]

As outlined in the attached economic analysis, the inappropriate step of talking about these issues in terms of political rhetoric first, and then engaging in Notice and Comment after the fact as required by the APA, has already led to economic harm. Beyond the questions at issue in this Proposed Rule is the larger problem of the underlying message to consumers that they do not need to pay their medical bills. As a result of the confusion created by the White House and CFPB by using press releases and tweets to move forward on this issue without first engaging in responsible analysis, many Americans already believe that they should not pay their medical bills. For example, TikTok has dozens of videos urging consumers not to pay their medical bills and describing work-arounds for not having medical debt reported.[37] These videos, and much of the other press and social media surrounding this issue, miss the important fact that even if not reported, medical debt is still legally owed and if not paid, could impact access to care or lead to

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[34] Press Release, *FACT SHEET: Vice President Harris Announces Proposal to Prohibit Medical Bills from Being Included on Credit Reports and Calls on States and Localities to Take Further Actions to Reduce Medical Debt*, White House (June 11, 2024), *available at* https://www.whitehouse.gov/briefing-room/statements-releases/2024/06/11/fact-sheet-vice-president-harris-announces-proposal-to-prohibit-medical-bills-from-being-included-on-credit-reports-and-calls-on-states-and-localities-to-take-further-actions-to-reduce-medical-debt/.

[35] Jeff Mason and Makini Brice, *"I'm Not Going Anywhere," Biden Says as Campaign Struggles*, Reuters (July 13, 2024), *available at* https://www.reuters.com/world/us/biden-faces-more-pressure-democrats-abandon-re-election-bid-2024-07-12/.

[36] The Biden-Harris Administration's declaration that a rulemaking effort is complete before the formal process has been fully completed should raise legal concerns. The rulemaking process is governed by the Administrative Procedure Act (APA), which requires agencies to follow specific procedural steps, including public notice, an opportunity for public comment, and a reasoned analysis of the rule. See for example, Harris recent tweet: https://x.com/vp/status/1819821219492823537?s=46

[37] *See e.g.*, @Cambiomoney, TikTok (Nov. 9, 2023), *available at* https://www.tiktok.com/@cambiomoney/video/7299577486969490731.

litigation. This and many of the other negative economic consequences that could result from this proposal, as outlined in the attached research are of great economic significance and importance, and it is very concerning that the CFPB is glossing over this in the name of election year politics.

4. Rulemaking in the Healthcare and Medical Debt Fields Lies with Other Federal Agencies.

Congress has enacted significant legislation addressing healthcare policy and has expressly delegated regulation and implementation of those policies to other agencies. And this is for good reason. As discussed above, the CFPB's involvement in medical care is tangential. Authority aside, the CFPB does not have the expertise or tools to implement policy that would significantly alter the landscape of medical services and payments. The CFPB has no role in the sale or delivery of medical services, the medical insurance market, or the medical billing system. This is by Congressional design and reflects Congress's intent that the CFPB only regulate financial products and services, not healthcare or medical products and services.

Indeed, Congress has squarely delegated the authority to make policy related to healthcare costs and spending to other agencies. For example, the recently passed No Surprises Act aims to reduce burdens by helping consumers understand healthcare costs in advance of care to minimize unforeseen medical bills.[38] The No Surprises Act delegated interpretive and rulemaking authority to the HHS, the Department of Labor ("DOL"), and the Treasury.[39]

Congress, through its passage of the No Surprises Act, makes several points clear: (1) it believes that legislation is needed to make sweeping changes in this market, not that agencies have unfettered unilateral authority; (2) in no place throughout the legislation did Congress elect to discusses debt collection, and thus did not identify that market as part of the problem; and (3) it

[38] *See, e.g.*, 26 U.S.C. § 9816.
[39] *See, e.g., Id.* § 9816(a)(2)(B).

identified certain agencies to address these issues and specifically did not include the CFPB. Unless and until Congress acts, nothing changes its directives on these issues.

Similarly, the Affordable Care Act, which contains comprehensive legislation aimed to reduce the cost of healthcare, streamline insurance claims, and increase access to quality medical care delegates rulemaking authority primarily to the HHS, but also to several other federal agencies, yet does not delegate any regulatory authority to the CFPB. Indeed, the Affordable Care Act specifically legislates requirements for the reporting and collection of medical debt but delegated the authority to interpret and enforce this provision to the IRS, not the CFPB. The fact that Congress has repeatedly determined that the CFPB is not an appropriate agency and/or does not have the appropriate powers and authority to implement healthcare policy shows that Congress did not intend to grant the CFPB the authority to do so, either under the FCRA or any other financial regulation.

C. The CFPB has No Reason to Regulate the Healthcare Field and Associated Medical Transactions.

The CFPB does not have the authority, expertise, or proper tools to regulate the medical, healthcare, and insurance industries. This authority does not fall under Regulation V. When Congress passed the FCRA, it did so with a narrow and explicit prerogative: to promote fair and accurate credit reporting.[40] It did not intend for the Act to be used to regulate non-financial products and services simply because they are purchased on credit.

The CFPB itself has acknowledged that medical debt does not fall under its purview. Financial services and products play a limited role in the healthcare and medical services industries, and the CFPB has a correspondingly limited authority to regulate or implement policies in those fields. And indeed, the CFPB has previously recognized that it lacks authority to regulate

[40] *See* 15 U.S.C. § 1681(a)(1).

within the medical industry by specifically excluding medical debt from its definition of "large market" participants in the consumer debt collection market. While promulgating regulations of large market participants, the CFPB stated that it has authority to regulate the debt collection market because that "is a market for financial products and services under the Act" but that debt arising from medical expenses should be excluded because it is "unrelated to consumer financial products or services."[41]

While a consumer may use a financial product to pay for medical care, and debt incurred for that care may be reported to a CRA, payment providers and credit agencies have no role in the underlying transaction that gives rise to the consumer's obligation to pay for that transaction. Determinations of when, how, and at what price a consumer may purchase medical goods or services is entirely outside the scope of the CFPB jurisdiction. And this is not unique to the healthcare industry. The CFPB plays no bigger role in determining what healthcare services a consumer receives than it does what pair of shoes that consumer chooses to buy, even if each is purchased on credit. And if that consumer defaults on both debts, the result will be the same—a debt collection tradeline will be reported in the same manner and have the same effect on a consumer's credit whether that debt was from a trip to the emergency room or the purchase of Manolo Blahniks. In short, the statutory laws that Congress has authorized the CFPB to effectuate through rulemaking were not intended to create broader policy; the CFPB's attempts do to so exceed its statutory authority.

Similarly overstepping the boundaries of its granted authority, and as further detailed below, in many of its public statements the CFPB takes aim at complex insurance coverage related to healthcare. It is undeniable that insurance coverage is a nuanced and complicated process that

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[41] 77 Fed. Reg. 9597 (Feb. 17, 2012).

has caused many headaches for consumers. That is why there are certain Congressional Committees and agencies such as the HHS, DOL, and the Treasury, are tasked with creating laws and regulations surrounding insurance. And as noted above, Congress recently passed the No Surprises Act to address some of these issues. Indeed, the "research" and data that the CFPB cites for its interest in this issue was collected years before this sweeping law that already addresses many of the issues with medical billing practices the CFPB raises about the healthcare system.

Further, the CFPB's suggestion that medical bills are often inaccurate, leading to unjust debt collection practices, fails to appreciate the realities of the American healthcare system. Indeed, this assertion overlooks the complexity of healthcare billing, and the significant efforts made by providers, third party agencies, and debt purchasers to ensure accuracy. In fact, Medicare and Medicaid, which are highly regulated government programs, generally do not encounter major issues with paying these bills. The root cause of many disputes is a result of questions about insurance coverage, rather than errors in the bills themselves. Again, these issues are not appropriately resolved through sweeping regulation that seeks to suppress accurate information.

Credit reporting laws are not intended to combat high medical costs or simplify insurance coverage. The CFPB's authority to promulgate rules under Regulation V is limited to rules which effectuate the FCRA's purpose, which is narrow and entirely unrelated to healthcare policy or insurance issues. Rather, the FCRA's stated purpose is to support the needs of commerce by providing fair and accurate credit information.[42] Manipulation of what consumer information can appear on a credit report based on external policy considerations is directly contrary to that purpose and exceeds the CFPB's grant of authority. Congressional intent regarding the role of the CFPB is clear: first, the FCRA simply does not authorize the CFPB to make industry specific credit

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[42] *See* 15 U.S.C. § 1681(a)(1).

reporting regulations; second, the FCRA does not authorize the CFPB to regulate the healthcare industry; and third, Congress has specifically delegated rulemaking power in the healthcare and medical industries to other specialized agencies. Other stakeholders including the American Hospital Association ("AHA") have worried that, "It is also possible that this proposal may incentivize patients to forego paying bills for care that they received and for which they have been determined liable. However, it is not possible to quantify the cost of either of these potential consequences."[43]

The risk that the Proposed Rule will cause an unquantifiable number of people to elect not to pay their bills for medical services already rendered should, standing alone, be enough to give the CFPB pause about the economic impacts of this Proposed Rule. Relatedly, the risk of patients choosing not to have health insurance will undoubtedly come with a significant price tag. As noted in a recent Wall Street Journal Article, "[t]he new rule would also eliminate the incentive to carry health insurance, which could raise the costs for those who do. Why would a young, healthy person pay hundreds of dollars every month for insurance is he needn't pay for the cost of an emergency or unexpected illness if he doesn't carry insurance?"[44] Similarly, the CFPB has not studied what impact the Proposed Rule will have on Medicare co-pay or deductibles, which could have a massive economic impact on Medicare if consumers choose not to address these obligations.

Thus, the predicted loss of revenue for medical providers has no solution proffered with this Proposed Rule. The CFPB is unilaterally defunding hospitals and medical service providers without making any financial provisions to cover their losses.

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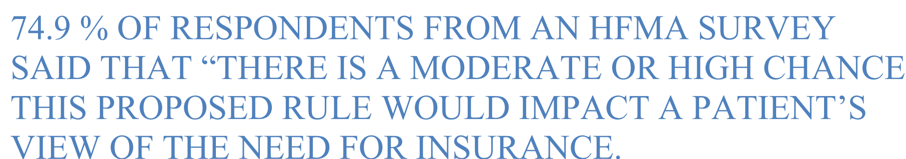
[43] Ashley Thompson, *AHA Letter to the Consumer Financial Protection Bureau on Consumer Reporting Rulemaking and Medical Debt*, American Hospital Association (Oct. 30, 2023), *available at* https://www.aha.org/lettercomment/2023-10-31-aha-letter-consumer-financial-protection-bureau-consumer-reporting-rulemaking-and-medical-debt.

[44] *Another Round of Debt Forgiveness*, Wall Street Journal Editorial Board (Sept. 25, 2023), *available at* https://www.wsj.com/articles/cfpb-rule-medical-debt-forgiveness-biden-administration-589d1d16.

Following the SBREFA process, on October 30, 2023, AHA submitted a comment letter which explained how trends in health insurance coverage are driving an increase in medical debt, including inadequate enrollment in comprehensive healthcare coverage, growth in high-deductible and skinny health plans that intentionally push more costs onto patients, and misleading health plan practices that confuse patients' understanding of their coverage.[45] The CFPB has not conducted any economic analysis to evaluate the extent to which the Proposed Rule exacerbates this gap in healthcare coverage.

As these concerns about increasing lack of insurance, shifting insurance costs onto those who do have it, and the consequential rise in medical debt, come to fruition, many will suffer the consequences. The CFPB should study these risks and their attendant economic impact to determine whether there are alternatives that better serve consumers, patients, providers, and any



others who are likely to be impacted by these results.

Finally, another economic risk not considered by the CFPB is that the payer community may raise prices on health insurance now that the CFPB's Proposed Rule creates an imbalance that undermines the fine-tuned work and compromise between the payors and their related state regulators, to determine prices and what the balance is that should be paid for by the patient as a co-pay or a deductible, and the amount that should be paid for by insurance. This imbalance

[45] American Hospital Association, *AHA Letter to the Consumer Financial Protection Bureau on Consumer Reporting Rulemaking and Medical Debt* (October 30, 2023), *available at* https://www.aha.org/lettercomment/2023-10-31-aha-letter-consumer-financial-protection-bureau-consumer-reporting-rulemaking-and-medical-debt

contemplates significant economic impacts and the CFPB has not acknowledged this risk, let alone sufficiently evaluated the impact on patients, providers, and other small businesses. This is a harm that could be experienced by every person in the country who purchases a health insurance policy today that has a co-pay and deductible amount.

1. The FCRA Does Not Grant the CFPB Authority to Treat Medical Debt Differently than Other Consumer Debts.

The CFPB does not have the authority to unilaterally determine what types of consumer debt can be reported and used by creditors. The FCRA grants the CFPB the authority to "prescribe such regulations as may be necessary and appropriate to administer and carry out the purposes of [the FCRA]."[46] The stated purpose of the FCRA is to create rules and procedure for credit reporting that balance the need for access to complete and accurate credit reports with the consumer's interest in privacy and fair access to credit products. Congress did not delegate how to strike this balance to the CFPB. Rather it enacted a law that that makes consumer information broadly reportable, with the exception of specifically enumerated categories of protected information.

The CFPB asserts that it is authorized to prohibit reporting or use of medical debt in order to lower the burden of healthcare costs consumers because the FCRA already limits the use of medical information. This is a misreading of the statute. The CFPB's Proposed Rule states its proposed rulemaking is necessary because: (1) "[m]edical debt collection tradelines appearing on consumer reports can have negative consequences for consumers, including impacting consumers' ability to obtain credit (or to obtain it at favorable rates) after experiencing, for example, a medical emergency" and (2) that medical debt collection tradelines appearing on consumer reports "can also be used as leverage by collectors to coerce consumers to pay sometimes spurious or false unpaid medical bills." But these concerns have no specific tie to medical debt. Any consumer with

[46] 15 U.S.C. § 1681s(e)(1).

a high amount of consumer debt on their credit report will have more difficulty obtaining new credit; and any debt tradeline can be used as leverage for repayment by a creditor. Indeed, the ability of credit reporting allows creditors to limit their risk by not lending to or imposing higher rates on people with a large amount of debt are features, not bugs, of the credit reporting system created by the FCRA.

As ACA pointed out, and as the Wall Street Journal published, in *Credit Reports Remove Some Old Medical Debt* (Personal Journal, July 12),

> [T]he Consumer Financial Protection Bureau's John McNamara is reported as saying that debt collectors will delete medical debts when consumers question them because they have little faith in their accuracy. That isn't true.
>
> Collection agencies work with reputable healthcare providers to ensure accurate billing. ACA International is the association of credit and collection professionals. Members use comprehensive compliance programs to ensure that only legally owed debts are reported. We acknowledge healthcare's complexity, including complicated insurance. ACA members have strong controls to respond to legitimate disputes and mitigate errors.
>
> The CFPB's claim that inaccurate amounts are reported as a coercive measure is, again, false. The CFPB has not provided any data supporting this allegation. The free market has no incentive for such illegal behavior. If this were common practice, healthcare providers would stop working with collection agencies, and we'd incur significant legal liability. There's no evidence either has come to pass.
>
> Arbitrary changes hurt patients. Delaying reporting to one year enables insurance companies to deny claims for untimely filing. This, and not reporting debts under $500, negatively affects healthcare providers' revenue, resulting in reduced access to care for the low-income as providers move to more upfront payments. Congress didn't provide for unelected CFPB staff to make healthcare-policy decisions; it's a slippery slope. Americans deserve greater access to affordable healthcare, not less.[47]

Congress empowered the CFPB to regulate the use of medical information consistent with the overall purpose of the statute—to protect consumer privacy while preserving creditor access

[47] Scott Purcell, *Medical Debt, Collection Agencies and CFPB*, Wall Street Journal (July 20, 2022), *available at* https://www.wsj.com/articles/medical-debt-collection-agencies-cfpb-healthcare-costs-access-11658283956.

to accurate debtor information.

2. Congress has Explicitly Spoken on Limitations to Medical Debt Reporting.

In contrast to the Bureau's ultra vires Proposed Rule, Congress's concerns regarding the furnishing and use of medical information are much narrower. First, Congress has identified the issue as a privacy concern—medical data is sensitive, and the specifics of a consumer's healthcare needs, as reflected by the medical services they receive or medications and devices they purchase, should not be publicly available. Second, and relatedly, is the concern that personal medical information could be improperly used as the basis for employment or credit decisions. Based on these concerns, Congress included Section 604(g) in the FCRA—a section titled "Protection of medical information"—setting out how and when medical information may be obtained and used in connection with credit decisions. Section 604(g)(2), which is part of that structure governing the use of medical information by creditors, states that:

> Except as permitted pursuant to paragraph (3)(C) or regulations prescribed under paragraph (5)(A), a creditor shall not obtain or use medical information (other than medical information treated in the manner required under section 1681c(a)(6) of this title) pertaining to a consumer in connection with any determination of the consumer's eligibility, or continued eligibility, for credit.

The "manner" as "required under section 1681c(a)(6)" dictates that the information must be "restricted or reported using codes that do not identify or provide information sufficient to infer the specific provider or the nature of such services, products, or devices to a person other than the consumer."[48] Thus, the FCRA allows creditors to obtain or use medical information—including medical debt—to make credit determinations so long as that information is not reported in a way that would allow the creditor to obtain information about the consumer's specific medical treatment or condition. Additionally, this distinction makes practical sense. In addition to the

[48] 15 U.S.C. § 1681c(a)(6).

arguments already laid out above regarding the need to report a consumer's full and accurate credit history, there is no practical way to prevent creditors from obtaining or using medical information. For example, many consumers pay for medical services with a credit card. When that credit card balance is reported, a creditor has no way of knowing if that debt is medical or not, and the distinction makes no difference to the impact that that debt will have on the consumer's ability to obtain additional credit.

Finally, that Congress only intended to delegate to the CFPB the authority to regulate reporting of medical debt to the extent required to protect the privacy of consumers need not be inferred—it is explicitly stated. Indeed, Section 604(g)(5) grants the CFPB the authority to promulgate rules to permit creditors to obtain or use medical information that would otherwise be prohibited under Section 604(g)(2) as is necessary "to protect legitimate operational, transactional, risk, consumer, and other needs . . . consistent with the intent of paragraph (2) to restrict the use of medical information for inappropriate purposes." Notably, Congress has not granted the CFPB authority to further limit the use of medical information at all. Instead, the FCRA authorizes the CFPB to allow *more* medical information to be reported. And it clearly does not authorize the CFPB to regulate any specific industry or to reduce the burden of debt on consumers—it authorizes the CFPB to create regulations necessary to facilitate complete and accurate credit reporting.

Within the past year, several members of Congress who voiced support for the CFPB's efforts in this area, introduced legislation seeking to make statutory changes to achieve the CFPB's stated goal in promulgating the Proposed Rule. This begs the question why these advocates for the CFPB's work would feel the need to introduce legislation at the same time this rulemaking process is happening, making a statutory change, if they truly believed the CFPB is on solid legal footing to move forward as is. As Congresswomen Katie Porter (D-CA) stated, her bill, the Medical Debt

Relief Act, "demonstrates Congress' support for the CFPB using its existing authority to put these principles into federal regulations, and would cement these principles into law."[49] Here Porter makes the important distinction between the actual law and her support for regulations. It is clear, by the timing and content of this legislation, that the CFPB knows what its legal limitations are and is attempting to garner support from friends in Congress to catch up with its attempt to go beyond its authority. Congressional legislation, unlike federal rulemaking used as a guise to write new law, includes protections such Congressional Budget Office scoring to determine the impact on the economy. As outlined in A. Rodrigo's research, the CFPB has done no analysis to determine how this change impacts other parts of the healthcare revenue cycle such as collection of co-pays and deductibles.

In sum, prohibiting creditors from using or obtaining information regarding medical debt is entirely inconsistent with the FCRA. Congress has clearly stated that the FCRA is intended to set a procedure for fair and accurate credit reporting. This intent forecloses the possibility that the FCRA also intended to allow the CFPB to use credit reporting as a tool to effect policy changes in healthcare or any other non-financial industry.

3. Congress's Limits on Medical Debt Reporting Preclude Further and Inconsistent Regulation by the CFPB.

Congress has already considered issues related to medical debt and has explicitly spoken on those issues. As discussed above, Congress prohibits reporting medical information that could allow third parties to determine what type of medical product or service the consumer received.[50] This statutory texts reflects the stated policy goal of protecting privacy while also implicitly allowing medical debt reporting. Also, in 15 U.S.C. § 1681c(a), Congress specifically excluded a

[49] Press Release, *Rep. Porter, Sen. Merkley Reintroduce Bill to Protect Americans from Medical Debt* (Oct. 20, 2023), *available at* https://porter.house.gov/news/documentsingle.aspx?DocumentID=574.
[50] *See* 15 U.S.C. § 1681b.

narrow category of medical debt. That is, CRAs may not report medical debt owed by veterans for medical services received more than a year before the report was created. Again, this reflects a legislative policy determination that carves out an exception for veterans, and only for veterans, not other categories of consumers.

Congress clearly considered the impact of medical debt reporting and specifically chose not to exclude all categories of medical debt from consumer reports, even though it could have if that was its intent.[51] In the context of the FCRA's stated purpose of providing accurate credit reports, the choice not to exclude reporting of medical debt reflects a policy determination: medical debt is the type of information necessary to provide fair and accurate credit reports.

The Bureau's Proposed Rule raises a major question concerning the balance between accurate credit reporting, consumer privacy, and fairness. And notably, the FCRA does not delegate to the CFPB the authority to unilaterally upend this balance by deciding without any mandate or guidance from Congress that medical debt—or any other category of consumer debt—is uniquely harmful to consumers. Those decisions are inherently legislative; the FCRA does not provide any indication that Congress intended to delegate them to the CFPB. *Cf. West Virginia*, 597 U.S. at 723–24 (requiring an administrative agency to point to "clear congressional authorization" for the power is claims).

Congress did not intend for the CFPB to use its authority under FCRA to impact healthcare policy or mitigate the effect of healthcare policy on consumers. The legislative intent of the medical debt limitations in the FCRA is to prevent a scenario where a consumer's access to credit is limited or impacted because the creditor denied a line of credit to that person because of their specific medical needs or condition. This is entirely distinct from the harm the CFPB seeks to

[51] *See, e.g.*, 15 U.S.C. § 1681c(a).

prevent by eliminating the reporting or use of medical debt all together. The CFPB's Proposed Rule makes clear that the Bureau's concern is that consumers have large amounts of medical debt and having debt reduces access to credit. This purpose is entirely inconsistent with the legislative purpose of the FCRA.[52]

Alternatively, the CFPB acknowledged in the Proposed Rule itself that exceptions are needed because lenders garner value from knowing about medical debt in certain situations. Indeed, the CFPB acknowledges that there should be an exception when, "[m]edical information relating to income and benefits include, for example, the dollar amount and continued eligibility for disability income, workers' compensation income, or other benefits related to health or a medical condition that is relied on as a source of repayment," the CFPB acknowledges an exception should apply.[53] Consumers benefit when lenders have a fuller picture of a consumer's financial situation, as highlighted by the CFPB's own important, albeit arbitrary, exceptions.

D. The Proposed Rule Defies the FCRA's Stated Purpose.

1. The FCRA Does Not Authorize the CFPB to Suppress and Prohibit the Use of Accurate Data.

In FCRA's very first line, Congress codified its finding that "the banking system is dependent upon fair and accurate credit reporting."[54] "Accurate" credit reporting is that which correctly identifies the transactions, accounts, and debts of the consumer. A report that does not reflect significant debts owed by a consumer is, by definition, inaccurate. By finding that the banking system depends on accurate reporting, Congress has expressed its intent to create a system under which all valid debts, including those incurred for medical expenses, appear on a consumer's

[52] *Cf.* 15 U.S.C. § 1681(a)(1) (finding that "[i]naccurate credit reports directly impair the efficiency of the banking system").
[53] *See* NPRM.
[54] 15 U.S.C. § 1681(a)(1).

credit report. While it is arguably not "fair" that consumers are burdened with medical debt in the first instance, that is not the fairness that Congress contemplated or intended to address through the FCRA. Our banking system does not "depend" on a credit reporting system that only reports debts incurred out of choice rather than necessity. Rather, it depends on creditors having access to the information necessary to accurately predict—or *fairly* calculate—the risk associated in lending to a particular individual. Ability to repay, amount of outstanding debt, past payment history, and history of default are essential to that prediction, regardless of how the debt was incurred.

A procedure that prevents agencies from accurately reporting the amount of debt owed by a consumer and thus inhibits lenders from issuing credit based on an accurate assessment of a consumer's finances neither meets the needs of commerce for consumer credit nor results in a system that is fair and equitable to consumers. The stated purpose of the FCRA is to "require that consumer reporting agencies adopt reasonable procedures for meeting the needs of commerce for consumer credit . . . in a manner which is fair and equitable to the consumer, with regard to the confidentiality, accuracy, relevancy, and proper utilization of such information."[55] If creditors are not able to accurately assess the default risk of consumers, the result will be: (1) consumers will be allowed to take out more credit than they can repay, resulting in default or bankruptcy, and (2) creditors will increase the cost of credit for all consumers to account for the increased risk in lending. Neither of these outcomes benefits consumers.

The CFPB twists language in the statute and incorrectly and argued in its SBREFA Proposal that Congress, "has raised concerns with the presence of medical debt information on credit reports."[56] In fact, the CFPB incorrectly added the term "debt" and "debt collection" to a statutory provision that instead references "medical information." The CFPB is rewriting the

[55] 15 U.S.C. § 1681(b).
[56] SBREFA Proposal at 17.

statute to contrive an argument about medical debt credit reporting that is clearly not backed by the legislative history or Congressional intent.

2. The Proposed Rule Undermines the FCRA's Goal of Promoting Fairness in the Financial System.

The rationale provided by the CFPB in promulgating the Proposed Rule emphasizes negative reporting of medical debt to safeguard consumers, recognizing that medical debt is often unforeseen and not a product of deliberate financial choice. However, the Bureau ignores the consequences to consumers when positive information about paid accounts is also suppressed. The Proposed Rule does not allow the positive reporting of payments on medical debt, which could otherwise reflect a patient's responsible repayment efforts. This omission raises significant questions about the overall fairness of credit reporting in this context. If consumers who have timely paid their medical debts have that positive payment information suppressed and hidden from view when applying for credit, they are harmed.

E. The Proposed Rule is Arbitrary and Capricious.

The APA mandates that courts set aside as unlawful agency action, findings, and conclusions found to be:

- "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;"
- "contrary to constitutional right, power, privilege, or immunity;"
- "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right;" or
- "without observance of procedure required by law."[57]

The Proposed Rule is poised to fail under this review.

Because the Bureau, in promulgating the Proposed Rule, "has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the

[57] 5 U.S.C. § 706(2).

problem, [and] offered an explanation for its decision that runs counter to the evidence before the agency," the Proposed Rule is arbitrary and capricious. *Motor Vehicles Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). It is axiomatic that an agency "must examine the relevant data and articulate a satisfactory explanation for its action including a 'rational connection between the facts found and the choice made.'" *Id.* (quoting *Burlington Truck Lines v. United States*, 371 U.S. 156, 168 (1962)). As described throughout this letter, the Bureau has relied on outdated data to support its conclusions, ignored recently enacted standards and procedures in the credit industry (*see, e.g.,* section (VI)(A)), and seemingly ignored data inconvenient for its position (*see* attached analysis by A. Rodrigo). Specifically, while the Bureau posits that medical debt information is not predictive of a consumer's ability and willingness to pay of a line of credit, even the Bureau's own study shows otherwise. Medical debt is at least somewhat predictive of ability and willingness to pay off debt and recent reliable studies show that consumers with unpaid medical debts pose materially greater credit risks than those who do not carry medical debt.

Courts have overturned agency action under the APA based on a determination that the agency abused its discretion where the agency: relied on conclusory reasoning, *see Tripoli Rocketry Ass'n, Inc. v. Bureau of Alcohol, Tobacco, Firearms, and Explosives*, 437 F.3d 75 (D.C. Cir. 2006); failed to respond to significant arguments submitted during the public comment period, *see U.S. Telecom Ass'n v. FBI*, 276 F.3d 620 (D.C. Cir. 2002); and failed to explain its decision to reject a salient alternative regulatory strategy, *see Pub. Citizen v. Fed. Motor Carrier Safety Admin*, 374 F.3d 1209 (D.C. Cir. 2004). Here the CFPB has ignored data provided by stakeholders and disregarded proposed alternatives, proceeding through a perfunctory process for the Proposed Rule as if it had already determined the appropriate substance of the policy. As previously outlined,

in coordination with the White House, the CFPB effectively announced the outcome of the rulemaking process at political events before it even began.

The Proposed Rule fairs no better if a court were to review the policy as a change to existing policy. "Agencies are free to change their existing polices as long as they provide a reasoned explanation for the change." *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 221 (2016). Furthermore, an agency must be cognizant of reliance interests that have accumulated based on the prior policy and provide a reason "for disregarding facts and circumstances that underlay or were engendered by the prior policy." *Id.* at 222 (quoting *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515–16 (2009)). The CFPB as previously outlined blatantly disregards the credit industry's reliance upon accurate and complete reporting of consumers' credit history and debt obligations—a fundamental tenant of a functioning credit system that has even been expressly recognized in the FCRA's text.[58]

F. <u>The Proposed Rule Likely Violates Constitutional Protections.</u>

Creditors enter into private contractual relationships with debtors when they extend them a loan. Relatedly, creditors enter into private contractual relationships with debt collectors when they hire those debt collectors to ensure recoupment of their loan. With the Proposed Rule, the CFPB is unlawfully interfering with the rights and interests these actors. For example, by attempting to regulate the relationship between debtors and creditors, the CFPB's conduct likely represents an impermissible intrusion into private contractual relationships which has both due process clause and takings clause impacts.

The Proposed Rule deprives creditors of cognizable property interests with insufficient process and thus violates constitutional due process protections. As a threshold inquiry, creditors

[58] See 15 U.S.C. § 1681(a)(1).

clearly have cognizable property interests in their investments—in the repayment of the loans they extend. *See, e.g.*, *Obduskey v. McCarthy & Holthus LLP*, 586 U.S. 466, 468–69 (2019) (discussing creditors' property interests in the context of mortgages). Second, the Proposed Rule risks depriving creditors of the repayment of their investments because it will undoubtedly lead to overleveraged consumers defaulting on their debt obligations. And finally, the CFPB did not completed the process due for this deprivation of a protected interest. *See generally*, *Mathews v. Eldridge*, 424 U.S. 319 (1976); *Indus. Safety Equip. Ass'n v. Envtl. Prot Agency*, 837 F.2d 1115 (D.C. Cir. 1988). As plainly laid out above, the CFPB did not comply with the requirements under the APA—the process that Congress expressly devised.

The Proposed Rule may also constitute an unlawful regulatory taking. For over a century, courts in the US have recognized that regulations—even those short of physical takings—may violate the prohibition against governmental takings of private property without just compensation. *See, e.g.*, *Pennsylvania Coal Co. v. Mahon*, 260 U.S. 393, 414–15 (1922) (finding taking where a state statute made it "commercially impracticable to mind certain coal," which had essentially "the same effect for constitutional purposes as appropriating or destroying" the property interest). Just as in *Mahon*, the CFPB's Proposed Rule risks making the extension of financing "commercially impracticable."

This issue is significant relative to the debt buying aspect as the U.S. Constitution's Contract Clause prohibits laws from impairing existing contracts. Many agreements between healthcare providers and financial institutions are predicated on the assumption that credit reporting is permissible. Should regulations change suddenly, restricting or altering the ability to report, this could be challenged as an unconstitutional impairment of existing contracts.

Indeed, the Proposed Rule registers as a taking when analyzed under the well-known three-part test the Supreme Court articulated in *Penn Central Trans. Co. v. City of New York*, 438 U.S. 104 (1978). Under *Penn Central*, courts consider: (1) the economic impact of the regulation on the plaintiff; (2) the degree to which the regulation interferes with the plaintiff's investment-backed expectations; and (3) the character of the governmental action. *Id.* at 124. The Proposed Rule, in practice, erases the value of not only the medical debt obligations for consumers, but also the value of that information. For the former, consumers will no longer have an incentive to pay off the debt, and for the latter, creditors will lose all value in that information, a critical component to assessing the risk associated with any given lender. Second, the Proposed Rule upends service providers and creditor's investment-backed expectations. Not only have financing providers literally invested in individuals based on a full view of their credit history and outstanding debt obligations, should consumers become overleveraged, some creditors will not receive repayment on the extended loans. Medical debt has been a critical part of the financing market; the CFPB's Proposed Rule is not one that creditors could have anticipated. And finally, as described above, the CFPB has sought to promulgate the Proposed Rule without compiling or contemplating a full record that reflects the impact of the Proposed Rule and the consequences of its proposed policy. Rather than acting in the public interest, the Proposed Rule, among the various anticipated consequence detailed in this comment letter, is likely to create a credit crunch and raise the price of credit for all consumers. *Cf. Penn Central*, 438 U.S. at 125.

G. The CFPB Cannot Force Application of State Law Through the Proposed Rule.

1. The CFPB's Attempted Bootstrapping of State Laws into a FCRA Rule Violates the 10th Amendment.

The Proposed Rule at 1022.38 provides that a CRA may only provide medical debt information if "the [CRA] is not otherwise prohibited . . . including by a State law."[59] This provision has the effect of making a violation of a state law a violation of the Proposed Rule. Under the 10th Amendment, the CFPB does not have any authority to enforce state laws.[60] The CFPB does not have any authority to determine whether or not state laws are preempted by the FCRA. That power rests with Congress and the courts. Notwithstanding the CFPB's "guidance" regarding preemption, it is the role of the judiciary, not the CFPB, to say what the law is.

H. The CFPB's Rulemaking Process is Procedurally Flawed, on a Truncated Timeline, and Fails to Include Key Industry Stakeholders.

In addition to all the substantive deficiencies discussed at length above, the Proposed Rule was promulgated through a rulemaking process that is insufficient under the APA. The notice and comment period itself is very short, and does not provide adequate time for many commenters to meaningfully consider the costs and implications of the Proposed Rule. The Bureau presumably published the Proposed Rule in this timeframe to rush adoption of the regulations before a change in political administration. In fact, as noted by A. Rodrigo is his attached economic analysis, the Bureau sought comments on its Proposed Rule and asked for economic data and information no fewer than 34 times in the NPRM. This implied acknowledgment that the CFPB lacks the economic data to support the Proposed Rule, coupled with the 60 day timeline suggests that the Bureau does not have the economic information necessary to propose this rule. Nor did it carve

[59] *See* NPRM.
[60] *See* U.S. Const. amend. X.

out enough time for it to consider incoming data and economic information from industry stakeholders and those who will be directly or indirectly impacted by the Proposed Rule.

Relatedly, the implementation date is unfeasible. As noted by the SERs during the SBREFA discussions, the proposed 60-day implementation timeframe is unreasonable because the Proposed Rule would require significant changes in terms of FCRA compliance, which would include obtaining legal advice, training employees, and taking additional steps to comply with the requirements of the Proposed Rule.

Additionally, the CFPB has not adequately considered the impact of the Proposed Rule on the application of other regulations in the healthcare industry. For example, CMS regulations impose strict guidelines on how medical debt can be sold, ensuring that these practices do not compromise patient care. The interplay between CMS and CFPB regulations creates a complex landscape for managing medical debt. Healthcare providers and debt purchasers must navigate these regulations carefully to ensure compliance, especially in areas related to reporting and collection practices. The Bureau has not considered any of these issues and their impact on consumers, patients, healthcare providers, financial institutions, and other small businesses operating within this industry.

Compounding these problems, the CFPB failed to include key industry stakeholders who will invariably be affected by the Proposed Rule. For example, the CFPB did not include providers and payors in the SBREFA process or the informal panels. These voices are critical to understanding the impact of the Proposed Rule on small businesses and the healthcare system generally. Indeed, as noted by the U.S. Small Business Administration Office of Advocacy, "the CFPB has underestimated the number of small entities that may be impacted" by the Proposed

Rule.[61] The Office Advocacy explained that by its own calculations, "according to the Federal Financial Institutions Examination Council ("FFIEC") and the National Credit Union Administration ("NCUA"), there are 3,434 small banks out of 4,624 total (74.3% of all banks) and 4,201 small credit unions out of 4,702 total (89.3%). This totals 7,635 small depository institutions, which is substantially higher than the CFPB's estimate of impacted institutions." This calculation only considers financial institutions, and does not include other impacted small entities such as other nonbank lenders, healthcare providers and payors.

By rushing this Proposed Rule to accommodate political concerns, proceeding in the absence of current and meaningful data, and further excluding key impacted industry stakeholders, the Bureau has failed to comply with both the spirit and the letter of the APA, as well as other administrative requirements such as the Regulatory Flexibility Act, the SBREFA process, and the economic certification requirements under each. As the SBA Office of Advocacy highlighted in its comment, "The CFPB prepared a certification and an initial regulatory flexibility analysis (IRFA) for the proposed rule. Advocacy asserts that neither the certification nor the IRFA complies with the requirements of the RFA."[62]

III. THE PROPOSED RULE WILL HARM CONSUMERS AND SMALL BUSINESSES.

Apart from the legal deficiencies and constitutional infirmities discussed above, the Proposed Rule will cause substantial harm to both businesses and consumers. Various portions of the Proposed Rule lack clarity, which will undoubtedly lead to confusion about who is covered by the FCRA going forward and what compliance obligations apply to whom. This uncertainty will

[61] *Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information*, Letter from Major L. Clark, III, Deputy Chief Counsel Office of Advocacy SBA, to Hon. Rohit Chopra, Director of the CFPB (Aug. 5, 2024).
[62] SBA Office of Advocacy Letter (Aug. 5, 2024).

create significant compliance burdens, increased costs (which will likely be passed onto consumers), as well as regulatory and litigation risk. This burden will undoubtedly be significantly borne by small businesses, particularly medical and healthcare providers. Interpretation of the phrase "medical information" will create sweeping and unintended negative consequences in all credit markets.

A. The Proposed Rule Undermines and Conflicts with the Purpose of the FCRA.

As detailed above, Congress enacted the FCRA to ensure fair and accurate credit reporting. This is important because accurate and complete credit reporting facilitates the efficient functioning of credit markets.[63] Those who have consistently repaid their debts and have sufficient Debt to Income ("DTI") ratios to meet their liabilities qualify for ongoing credit. And those who have a poor history of repayment behaviors or simply lack a sufficient DTI to accommodate their various obligations will be offered less credit or on more stringent terms.

The Proposed Rule runs afoul of the FCRA's guiding purpose. Specifically, the Proposed Rule exaggerates the results of outdated and flawed economic studies to say that one type of debt, medical debt, is nonpredictive of consumer risk. Based on this unfounded premise—but without conducting any formal studies—the Bureau then assumes that the reporting of medical debt harms consumers and prevents them from obtaining credit to which they would otherwise be entitled. Then, based on an exaggeration and an assumption the Bureau proposes that medical debt tradelines should be suppressed on consumer reports so that potential lenders cannot consider those debt obligations when making credit eligibility determinations.

As a threshold matter, the Bureau's determination that medical debt should be afforded fewer protections and different treatment than other types of debt is arbitrary and capricious, not

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[63] *See* 15 U.S.C. § 1681.

to mention likely unconstitutional. As discussed more below, the Bureau's Proposed Rule relies on a skewed reading of data that is over ten years old and fails to consider any of the recent regulations that have been implemented to address the Bureau's perceived failings of the healthcare system. Additionally, even the arguably obsolete data on which the Bureau relies acknowledges that medical debt information has *some* predictive value of credit risk. The predictive weight observation has already been corrected with private market adjustments that acknowledge that medical debt in some instances does not need to be as heavily weighted, but that it should be considered.

The Bureau ignores the already-in-place private market solution and takes the unsupported position that medical debt data has no value in credit risk predictions. On the contrary, medical debt data, like any other debt obligation or financial data is critical to the determination of a consumer's capacity to take on more debt and repay that debt in a timely and consistent manner. Thus, the suppression of medical debt information on consumer reports will directly contravene the stated purpose of the FCRA and its goal of ensuring fair and accurate credit reporting.

As another indicator of arbitrariness, the CFPB's efforts on medical debt directly conflict with some of its recent efforts on issues like Buy Now Pay Later ("BNPL"). The CFPB states in this regard that it wants BNPL accounts credit reported:

> Until recently, few BNPL lenders furnished information about consumers to the nationwide consumer reporting companies (NCRCs). This lack of furnishing could have downstream effects on consumers and the credit reporting system. It could be bad for BNPL borrowers who pay on time and may be seeking to build credit, since they may not benefit from the impact that timely payments may have on credit reports and credit scores. It may also impact both BNPL lenders and non-BNPL lenders seeking to understand how much debt a prospective borrower is carrying.[64]

Here, the CFPB acknowledges the problems when lenders do not have a full picture of a

[64] Martin Kleinbard and Laura Udis, *Buy Now, Pay Later and Credit Reporting*, CFPB (June 15, 2022), *available at* https://www.consumerfinance.gov/about-us/blog/by-now-pay-later-and-credit-reporting/.

consumer's credit portfolio. Indeed, in the BNPL context, the CFPB seems concerned about consumers who pay on time and fulfill their legal obligations. And while that dynamic is also present with medical debt, the CFPB does not give the issue credence. The CFPB has not studied or addressed how consumers who address their medical debt payment obligations will be impacted. It is irresponsible and arbitrary for the Bureau to not protect all consumers, including those who do pay their medical debts, in favor of sweeping regulations whose only benefit will be for a small minority of consumers who cannot afford to pay their medical bills but would otherwise qualify for credit from other lenders.

For those consumers who truly cannot afford to repay medical bills, there are a host of public programs to help them. Congress has the ability to debate and add to these programs if they are not sufficiently working. However, starting at the back end of the process will not solve the larger problem of unaffordable healthcare. It will instead harm many other consumers, under the CFPB's same line of reasoning for BNPL. As the Wall Street Journal correctly points out, "Last week the CFPB announced a rule-making to remove medical debt from credit reports. The agency invokes sympathetic stories of sick patients with large medical bills, but the rule isn't necessary to help them and its perverse incentives will hurt others."[65]

As another example of the arbitrariness of the Proposed Rule, a recent North Carolina law, which the Biden Administration lauded, mandates that medical providers consider the total debt of the consumer when making determinations for charity care. North Carolina's medical debt relief program requires the provider: "Relieve all medical debt deemed uncollectible dating back to Jan. 1, 2014, for any individuals not enrolled in Medicaid with incomes at or below at least 350% of

[65] *Another Round of Debt Forgiveness*, Wall Street Journal Editorial Board.

the federal poverty level (FPL) or for whom ***total debt*** exceeds 5% of annual income."[66] Here, it is evident that North Carolina recognizes the importance of understanding a consumer's total debt, including medical debt, for purposes of a thorough DTI analysis. The value of this information in the debt forgiveness context applies equally to potential extensions of credit.

1. Fair and Accurate Credit Reporting.

As Congress recognized in the opening lines of the FCRA, our entire financial market depends on accurate credit reporting. This is because when a potential lender or creditor evaluates whether to extend credit to any particular person, they must have a complete picture of the applicant's financial profile. Certainly, this inquiry considers an individual's borrowing and repayment behaviors. But, critically, it also shows what liabilities that individual already carries. If a consumer report omits certain information, then potential creditors are left without the information they need to assess repayment and delinquency risk. The Bureau takes the position that medical debt is less predictive, or depending on the day of the week even non-predictive, of consumer risk. However, the reality is that medical debt, like any other type of consumer debt, must be considered when evaluating the creditworthiness of any particular applicant.

For example, if a consumer has $24,000 in medical debt that they are supposed to be paying in monthly installments of $1,000, this information is critical to other potential lenders. If the same consumer goes to a dealership to purchase a new vehicle, the lender will be able to see that any financing it offers should account for that existing $1,000 per month liability. However, under the Proposed Rule, this medical debt obligation would be invisible to the dealership lender. The result would be that the lender may be willing to extend more credit than the consumer can actually

[66] *CMS Approves North Carolina's Medical Debt Relief Incentive Program*, Press Release, North Carolina Department of Health and Human Services (July 29, 2024), *available at* https://www.ncdhhs.gov/news/press-releases/2024/07/29/cms-approves-north-carolinas-medical-debt-relief-incentive-program.

afford, because the lender does not know about the prior obligation. If the consumer then took on the additional debt for a vehicle, they could easily become over leveraged. Now, the lender is at risk of non-repayment, and the consumer is at heightened risk of delinquency across all their financial obligations. All of this results from inaccurate and incomplete financial information.

2. The Proposed Rule Will Result in Increased Inaccuracy in Credit Reports.

As detailed by several Small Entity Representatives ("SERs") during the SBREFA panel discussions, incomplete financial data creates inaccurate consumer reports. When lenders and creditors cannot rely on the information provided in consumer reports, they either refuse to extend credit altogether or use other, less particularized methods, to ascertain credit worthiness on a statistical basis. This risks excluding certain groups from the credit-driven economy and people who can no longer set themselves apart through their historically positive payment behaviors. It also increases the risk that lenders and creditors are forced to rely on statistical information that may further promote systemic biases in the financial markets, further excluding individuals who would otherwise have been extended credit.

For example, take an individual who lives in an older and less affluent area. This hypothetical person has $10,000 in medical debt but has consistently any timely paid their monthly obligation and is almost finished paying it off. Under the Proposed Rule, this medical debt tradeline, along with all its positive payment history, would be erased from the individual's consumer report. Now, potential creditors have less information about this individual and will be forced to rely on less predictive and potentially biased information about this person. Indeed, a potential creditor may take the risk under ECOA and only be able to consider this person's statistical probability of repayment based on their demographic information, where they live, and generally whether people in that area are good about repaying their debts. Now, the consumer suffers because, while their own payment history is exemplary, they have no way to distinguish

themselves from others is their statistical group who may have less positive repayment history. All this consumer's efforts to be responsible and honor their debt obligations are for naught, and now they will be assessed in a way that ignores the reality of their financial situation and repayment behaviors.

Not only does this reality harm the consumer who has been financially responsible, it also creates a direct disincentive for consumers to pay their medical debts. If all the money poured towards paying off their medical debt is invisible to lenders, why bother making payments at all? A reasonable consumer would elect to spend that money elsewhere, paying down other debts, or putting it in savings. Credit reporting efficiencies are based on a carrot and stick approach. People want to pay their debts so that they are attractive to lenders and qualify for superior credit offers. Likewise, people want to avoid becoming delinquent on their debts because they understand that negative marks on their consumer reports will hinder their eligibility for credit in the future. The Proposed Rule ignores these realities.

B. The Proposed Rule Will Hurt Access to Credit in the Market Generally.

Reporting incomplete financial data will undoubtedly lead to a credit crunch, disproportionately impacting consumers and small businesses, damaging economic mobility for many. When lenders and creditors are faced with incomplete credit data, their risk increases. This translates to more stringent underwriting standards and subsequent reductions in lending activity. Some of ACA's members have expressed that they will need to utilize increased cost of living assumptions, meaning they will be forced to inflate the anticipated monthly expenditures for any given creditor, in credit underwriting to offset the inherent risk associated with having an incomplete consumer credit profile. In essence, they will have to assume that everyone has medical debt, and increase the price of borrowing for all consumers.

C. The Proposed Rule Will Harm Many Businesses, and Especially Small

Businesses.

The Proposed Rule is also deficient because it lacks the clarity necessary for companies to understand the scope of its requirements. The Proposed Rule states that medical debt information means medical information that pertains to a debt owed by a consumer to a person whose primary business is providing medical services, products, or devices, or to such person's agent or assignee, for the provision of such medical services, products, or devices. While this definition helps provide some parameters, it still has a number of arbitrary components such as including cosmetic procedures but not including veterinarian services. The breadth and scope of "medical" services could be hotly debated. There are still other unresolved questions about what is included and how this will be interpreted by a variety of industry and stakeholders that will add compliance and operational burdens and complexities for small businesses.

1. Compliance with the Proposed Rule Will Be Unduly Expensive.

Given the nonspecific nature of the Proposed Rule, as well as uncertainty about who it covers, it is difficult for companies to ascertain the full scale of their compliance costs. However, what is clear is that the sweeping coverage and regulatory changes contained in the Proposed Rule will be significant and will harm many small businesses. One category of small businesses that stands to lose the most are those providing medical and healthcare. Doctors, dentists, physical therapists, etc. will undoubtedly suffer severe consequences under the CFPB's Proposed Rule. Debtors will be less likely to pay for their services rendered as incentives for them to do so are negated. Small financial institutions and lenders will also face several complex compliance questions and related litigation threats. Given the broad language in the current Proposed Rule, any lender, creditor, debt collector, data broker, insurance company, service provider (medical or otherwise) and anyone who shares or uses consumer data and reports, could be significantly and

directly impacted.

Among other costs, numerous SER commentators explained that the current Proposed Rule would require substantial financial investment, both as an initial matter and for ongoing compliance. Many small businesses would need to hire additional staff to meet the compliance burdens. They would also need to hire legal counsel to help guide them through the regulatory morass. Computer programs and software will need to be updated and companies will need to invest in different technologies. Many will be forced to renegotiate contracts with vendors and third parties to accommodate the changing nature of each business and how they are covered by the FCRA. A conservative estimate from some of ACA's members suggest that initial compliance costs will exceed one hundred thousand dollars, with annual follow-on compliance costs.

For ACA's members, the cost has already been demonstrated as shown in the attached economic analysis, and is expected to compound substantially. As the CFPB has acknowledged, nearly 93% of companies in the debt collection industry fall within the definition of a "small business."

2. The Proposed Rule Will Result in the Reduction or Elimination of Small Businesses.

For many small businesses, the Proposed Rule will result in their reduction or elimination. As mentioned by multiple SERs during the SBREFA panel discussions, when compliance costs become too burdensome, small businesses pay the highest price. They are often forced to reduce offerings or cut entire business lines and products. In the worst case scenarios, they either go out of business completely, or they are acquired by a larger company that has the ability to absorb the compliance burdens. This leads to market and industry consolidation, whereby only the biggest companies, who already utilize vertical integration, are able to survive. Small businesses, that operate through the use of many vendors and third parties, will simply be unable to compete.

The trickle-down effect also hurts consumers. Where a consumer might have previously had better access to care, they are now dependent on large companies that may not have a meaningful presence in their community. And even for those who still have physical access to care, the reduced competition in the market drives up consumer pricing, meaning that some will be prevented from accessing care because of increasing consumer costs.

The compliance burden is not the only part of the Proposed Rule that will harm small businesses. The practical effects of the medical debt tradeline prohibition will also create significant financial harms to small businesses, some of which have not been included in the SBREFA process. For example, as discussed in the economic analysis below, medical providers have already seen a marked reduction in successful collection efforts based on the CFPB's public opinion that medical debt should not be reflected in consumer reports. As multiple SER commentators noted, many consumers believe that if a debt is not reflected on their report, they do not have to pay it. And even for those who do understand that they still have a financial obligation to repay, there is minimal incentive to pay their medical debts if it will not go on their consumer report and impact their future eligibility for and access to credit. The result is that medical providers, who have become creditors by nature of allowing consumers to finance their healthcare procedures, are put into a position where there is no incentive for consumers to actually pay their bills.

D. The Proposed Rule Will Harm Patients and Consumers.

As discussed above, when lenders, creditors, or even medical providers are evaluating whether to extend financing to a particular consumer, they are handicapped in this process when they only have access to incomplete and inaccurate consumer information.

1. The Proposed Rule Will Cause Lack of Access to Credit for Critical Care.

When medical debt is eliminated from consumer reports, many consumers believe that it is not owed. And even for those who understand they still have an outstanding debt liability, there is no incentive to pay it. The result is that many medical providers will see a marked decrease in their collection efforts. While many healthcare providers currently allow their patients to finance services, these providers will be forced to eliminate this option in favor of pre-payment. If doctors and other healthcare workers are unable to collect payment after services have been rendered, they will undoubtedly stop offering services in advance of payment.

During the ACA-Healthcare Financial Management Association ("HFMA") Webinar on July 10, 2024: *Healthcare Credit Reporting Rule—What You Need to Know*, participants responded to a series of polls. One asked "What Options Do You See Your Own Provider Organization Taking to Mitigate Losses from Eliminating Credit Reporting—Including Overall Behavior Changes Even if You Don't Credit Report Now?" Seventy-two percent of respondents stated that they would "Require full or partial payment in advance from patients for non-emergency procedures."[67] This sentiment is echoed in a recent Wall Street Journal article that highlights the struggles that families face when providers require advance payment for non-emergent treatment.[68]

This means that those consumers who cannot afford the out-of-pocket costs for care will be forced to use high-cost financing methods like credit cards and payday loans, or in the worst case, forego medical treatment altogether. This predictably will hurt consumers generally, but will disproportionately harm traditionally underserved minority and rural communities the most. Consumers who do not have the means to pay for an entire procedure upfront risk being denied

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[67] *See* ACA-HFMA Poll.

[68] *Hospitals Are Refusing to Do Surgeries Unless You Pay in Full First,* Wall Street Journal Editorial Board (May 9, 2024), *available at* https://www.wsj.com/health/healthcare/hospitals-pay-before-treatment-patients-c477e2d6.

access to care. And then, what may have been a small or preventable issue, could grow into a life-threatening emergency, necessitating a trip to the emergency room. This course of action not only puts the person's health more at risk, it increases the cost of care significantly for all consumers. And because hospitals are not able to turn away life threatening emergencies, those providers are forced to absorb even higher costs of care (which otherwise could have been prevented), that are then passed onto society in the form of higher healthcare costs generally. Contrary to the Bureau's stated goal of reducing healthcare burdens, the Proposed Rule will exacerbate the issues that already exist in the healthcare industry.

2. The Proposed Rule Will Result in the Reduction or Elimination of Healthcare Services Altogether.

In addition to care denial caused by lack of credit and financing options, the Proposed Rule and its associated costs will also harm consumers by eliminating their physical access to healthcare. In many communities, including those in rural areas, there is a dearth of healthcare access. Small towns and disadvantaged communities are less likely to have large medical facilities, including hospitals. They are also less likely to have specialists in critical areas like oncology. It is not uncommon for these locations to only be served by small medical providers. If the cost of compliance becomes too great, these small healthcare providers will be forced to close or merge with a large company, leading to further market consolidation. For example, a recent article predicts that more than 700 rural U.S. hospitals are at risk of closure due to financial problems, with more than half of those hospitals at immediate risk of closure.[69] Indeed, since 2005, 104 rural hospitals have closed, with another 89 facilities no longer providing inpatient services, according

[69] Molly Gamble, *703 Hospitals at Risk of Closure, State by State*, Hospital CFO Report (Aug. 5, 2024), *available at* https://www.beckershospitalreview.com/finance/703-hospitals-at-risk-of-closure-state-by-state.html?origin=BHRE&utm_source=BHRE&utm_medium=email&utm_content=newsletter&oly_enc_id=8907D3324467B2S.

to data compiled by the University of North Carolina's Cecil G. Sheps Center for Health Services Research.[70] Thirty-seven of those 104 closures have occurred since 2020, highlighting the amplified financial challenges that rural hospitals and health systems face amid persisting workforce shortages, rising costs, and leveling reimbursement.[71]

The continuing closure of these practices will mean reduced access for consumers. Consumers will then be forced to drive excessive distances to reach care. While this may be a matter of inconvenience for those who have the luxury of time, it could mean life or death for others. It is easy to see how having to drive 45 minutes to reach a hospital could discourage some from seeking preventative care or be too long for some healthcare emergencies. Alternatively, if the medical need is great enough to warrant flight for life, the consumer is saddled with excessive costs for that emergency transport. Even for those small businesses and providers that remain in a community, they may have insufficient staff or funding to be open more than a few days a week. Again, consumers are the ultimate losers in this situation. This will lead to no care for the most at-risk consumers where small businesses have closed locations or entire lines of business. Indeed, rural and impoverished areas will be hurt the worst, further exacerbating existing disparities in access to healthcare.

3. The Suppression of Certain Financial Liabilities Provides an Incomplete Credit Profile for Lenders Risking Allowing Consumers to Overleverage Themselves.

Finally, consumers will also be hurt by a system that allows them to overleverage themselves. When any type of creditor evaluates the creditworthiness of a potential borrower, they are not only looking at repayment history and spending behaviors. They also attempt to understand

[70] *See* Alan Condon, Rural Hospitals in Crisis Mode, Hospital CFO Report (Nov. 2, 2023), *available at* https://www.beckershospitalreview.com/finance/rural-hospitals-in-crisis-mode.html.
[71] *Id.*

the totality of a consumer's financial liabilities. If a monthly payment obligation is not reflected in a consumer report, that consumer's DTI ratio will be artificially deflated.

For example, if a consumer has medical debt of $50,000 dollars that they are paying in monthly installments of $1,500 per month, this significantly impacts their ability to take on new debt. If this consumer applies for a mortgage, it is critically important for the mortgage lender to know the actual financial liabilities of the consumer. If the lender cannot see, and is therefore unaware of, the $1,500 monthly payment obligation, the lender may approve the consumer for more than they can afford to pay on a monthly basis. The CFPB has taken the position in the Proposed Rule that creditors are able to meet their obligations under the Truth in Lending Act/Regulation Z or comparable state and local laws, such as California's Property Assessed Clean Energy Programs ATR requirements, by asking generalized questions that do not solicit specific inquiries about medical debts from consumers and relying upon consumers volunteering this information. This creates significant moral hazard, compliance, and safety and soundness risks because without identifying that the question includes medical debt as prohibited by CFPB, many consumers may not understand that such obligations should be considered under the ATR analysis. This risk is bolstered by the fact that the CFPB's public rhetoric and messaging around medical debt suggests to consumers that their debt is not considered in credit reports, therefore indicating that consumer reports are of questionable value. Further, under the proposed rule, one can now consider it voluntarily. Accordingly, those with more knowledge into the recent legal landscape or those with connections in legal and financial communities may understand that they can withhold that information. Meanwhile, certain consumers may be less aware of recent developments in the legal and financial world and may not be aware that they don't have to volunteer the information. Ultimately, the result could lead to potential disparate impact claims because certain consumers

may offer this information, not knowing any different, while others may understand that they do not have to provide this information. In the end, this would artificially deflate the DTI ratio and they would get approved instead of the people who are forthcoming with their debt obligations As previewed in the legal analysis section above, the CFPB cannot promulgate rules in a way that makes compliance with other legal obligations opaque. The exceptions outlined above related to eligibility for disability income, workers' compensation income, or other benefits related to health or a medical condition that is relied on as a source of repayment are complex, and are very likely to lead to compliance challenges and/or litigation when there is an accidental violation.

Moreover, the above example illustrates the very real risk that lenders will unknowingly permit consumers to overleverage themselves and enter a risky financial situation where they simply cannot meet their ongoing debt obligations—medical or otherwise. This in turn will harm consumers by increasing their delinquency and default risks, which will then hurt their credit scores. Even if the CFPB were correct in saying that medical debt is less predictive, and under that theory consumers are less likely to default because of medical debt alone, that is a risky assumption. Indeed, the majority of U.S. consumers live paycheck to paycheck. Therefore, any hidden challenge that a consumer might face in paying their bills can be significant, even if it is not the most important factor of the larger underwriting process. Simple math tells you that there will be more defaults, and as such, consumers will face increased litigation risks and the increased costs and time associated with responding to a lawsuit.

Under the Proposed Rule, hidden yet not extinguished medical debt, risks creating the same dynamics that led to the 2008 Financial Crisis and the creation of the CFPB. In its own press release, the CFPB acknowledged that that Proposed Rule would suppress up to $49 billion in debt obligations that are currently viewable on consumer credit reports. Blocking lenders from viewing

a debtor's full profile will undoubtedly risk allowing consumers to over-leverage themselves creating risk of individual financial failure that can translate nationwide. The CFPB is a product of the 2008 Financial Crisis, which was caused in large part by a mortgage bubble that arose due to the systematic overleveraging of consumers. Ironically, the CFPB's Proposed Rule here will lead to the same consequences. Lenders, having an incomplete financial understanding of their borrowers, will allow consumers to overleverage themselves and qualify these consumers for mortgages which they simply cannot afford. And, because of these unsound mortgage and other loans, lenders will have unwittingly put other depositors money at risk, leading to the same risks and consequences that caused one of the worst financial crises in recent history.

IV. THE PROPOSED RULE WILL CREATE SITUATIONS WHERE IT IS IMPOSSIBLE FOR BUSINESSES TO COMPLY WITH THEIR OBLIGATIONS UNDER OTHER LAW.

A. Federal Laws and Structure.

Numerous federal laws recognize the harm to consumers that arises when they are unwittingly permitted to overleverage themselves. Lax underwriting standards that did not appropriately consider a consumer's true ability to repay their home loans contributed in large part to the mortgage bubble and subsequent financial crisis in 2008. Indeed, when enacting the Dodd-Frank Act, Congress specifically included stricter lending requirements that ensure that lenders for a range of financial products do not extend credit beyond that which a consumer can actually afford. Most notably, the TILA now requires a robust ATR analysis which considers a consumer's entire financial profile including all existing debt obligations.[72] Mortgage originators must now compare how much income a consumer receives each month with how much they must pay out in existing obligations. This comparison is called the DTI. The DTI calculation is meant to be

[72] *See* 15 U.S.C. § 1639c.

comprehensive and all-inclusive. Everything from an $80 monthly payment on a financed stationary bike to an $800 auto loan monthly payment must be included so that the lender does not inadvertently approve or lend to someone above what they can afford.

B. State Ability to Repay Laws.

Many states have also implemented consumer protection and financial laws that incorporate an ability-to-repay component. For example, in California, the Department of Financial Protection and Innovation has established ATR requirements that rely on credit reports for loans provided under the PACE.[73] Similarly, Pennsylvania law requires that in order to grant an applicant a loan for a mortgage, the creditor must conduct an evaluation of an applicant's ability to repay, which expressly includes reviewing the "fixed expenses of the applicant," defined to include "[a]ny debt obligations."[74] And these requirements are not relics of the past. Just earlier this year, at the end of January 2024, a group of bi-partisan South Carolina Senators introduced a state bill that would require an ATR analysis.[75]

The Bureau's Proposed Rule will make compliance with these types of laws impossible as well, interfering with states' ability to protect their own consumers. The Proposed Rule cannot broadly preempt state laws that require a comprehensive view of debt information prior to offering a credit product and the CFPB's attempt to do so represents a significant intrusion into these states' authority to promulgate and enforce rules that serve and protect their constituents.

V. MANY INDUSTRY PARTICIPANTS ARE "DIRECTLY" IMPACTED BY RULE.

A. Everyone Who Relies on a Credit Report for Any Decision About

[73] *See PACE (Property Assessed Clean Energy): What Homeowners Need to Know*, DFPI (Jul. 5, 2023), available at https://dfpi.ca.gov/pace-program-administrators/pace/.
[74] 10 Pa. Code § 46.1–46.2.
[75] *See South Carolina Proposes Legislation to Impose Ability to Repay Analysis for Installment and Payday Loans*, Consumer Financial Services Law Monitor (Jan. 25, 2024), *available at* https://www.consumerfinancialserviceslawmonitor.com/2024/01/south-carolina-proposes-legislation-to-impose-ability-to-repay-analysis-for-installment-and-payday-loans/.

Creditworthiness is Directly Affected by the Proposed Rule.

Anecdotal and self-reported evidence suggests that medical debt is the largest driver of consumer bankruptcy.[76] In turn, invisibility of bankruptcy risk frustrates the utility of credit reports in general for all purposes.

Complete and accurate data is essential for a functioning credit market. As a threshold matter, most tradelines on credit reports overall are for non-loan accounts like medical, municipal, and utility debt. Review of this full picture of a consumer's obligations impacts whether creditors keep consumer accounts or those accounts are charged-off, sent to collections, or sent to litigation. And inaccurate data about account recoveries reduces account owners' ability to sell debt into the secondary market, which sales help providers to increase their liquidity so they can offer more services in advance of payment. Therefore, without accurate data, account owners, including hospitals, municipalities, and servicers, cannot determine how to best service their accounts.

The CFPB did not study how constricted payments and liquidity would impact providers' ability to render services. However, industry stakeholders, including ACA have studied this (using current economic data) and have found that any reduction in the effectiveness of debt collectors, as anticipated in the Proposed Rule, will lead to an increase in collection costs or a decrease in collectible amounts. These changes will ultimately be passed on to the consumers of these services—the companies providing financing/services in advance of payment. Using an economic model described more fully in A. Rodrigo's Report, ACA has found that the struggles of debt collectors will be passed-on to companies financing medical procedures and, ultimately, medical providers.

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[76] Forbes, The U.S. Spends More On Healthcare Than Other Wealthy Nations But Ranks Last In Outcomes (Oct 24, 2023). Available at: https://www.forbes.com/sites/arthurkellermann/2023/10/24/the-us-spends-more-on-healthcare-than-other-wealthy-nations-but-ranks-last-in-outcomes/

Without efficient debt collection, medical providers would have to raise the cost of financing or cut consumers off from medical services. America has a market-based healthcare system, which comes with competitive pressures. Systematically lost revenue cannot be written off. Indeed, A. Rodrigo highlights that the data reflects net losses in collections by over 5-10% and concentrated in rural areas and general medicine. Given the competitive nature of this industry, much of these losses will be passed on to medical providers and subsequently their patients. Further, this will build into a nationwide, systematic issue. Given that Americans pay co-pays, deductibles, and out-of-pocket expenses in market-based healthcare, this amounts to a large portion of provider's incomes being put at risk by the Proposed Rule.

Servicers and collectors rely on accurate credit report data to determine how best to resolve an account. And in fact, servicers often use evidence of insolvency to the consumers' benefit—resulting in a settlement of lesser value. Invisibility of medical debt prevents this full picture from benefiting consumers, and incomplete information will likely result in more collection lawsuits. Furthermore, hiding this medical financial information from attorneys will only hinder efforts to settle lawsuits, again hurting consumers.

B. The Regulatory Flexibility Act Requires the CFPB to Study Impacts on All Those Directly Impacted by Rule, but the CFPB Did Not Do This Analysis.

The Regulatory Flexibility Act ("RFA"), which triggers when an agency is required to proceed through notice and comment under section 553(b) of the Administrative Procedure Act, requires that agencies conduct sufficient analyses to measure and consider the regulatory impacts of a rule and determine whether there will be "a significant economic impact on a substantial number of small entities." Since Congress did not define "substantial" or "significant," agencies must tailor the level, scope, and complexity of their analysis to the regulated small entity community at issue in each rule. Certifications must include a factual basis for the decision. The

factual basis must include a sufficient record upon which a court may review an agency's actions. The certification and the factual basis must be provided to the SBA's Chief Counsel for Advocacy. Certification decisions are subject to judicial review. As noted, the SBA Office of Advocacy did not feel the CFPB met its legal obligations.

VI. THE ECONOMIC DATA REVEALS THE CATASTROPHIC EFFECTS THAT THE PROPOSED RULE WILL HAVE ON THE CREDIT INDUSTRY AND SMALL BUSINESSES.

A. The Proposed Rule Lacks Current Data, Rigorous Analysis and Makes Unfounded Assumptions.

The Proposed Rule is based on outdated data from 2014 and unsupported anecdotal evidence from consumers and consumer advocacy groups. Moreover, contrary to the position it takes in the Proposed Rule, the CFPB's own 2014 study says that the medical debt information included in consumer scoring is predictive of delinquency, even if not as predictive as other consumer collection accounts over the studied period.[77] As reflected in the study, between 2011 and 2013, consumers' scores and delinquency rates tracked closely for consumers with mostly medical or mostly non-medical collections.[78]

Moreover, in the ten years since the CFPB conducted this study, the industry has affirmatively taken steps to address related genuine issues. For example, ACA members have adopted standards for debt collections and interacting with consumers. And while none of these changes addressed the predictiveness of any one class of debt—because any such distinction is not merited—certain reforms were designed to allow more time for insurance reimbursements to catch up to corresponding consumer debt obligations. Specifically, the waiting period during which

[77] *Consumer Credit Reports: A Study of Medical and Non-Medical Collections* 16, CFPB (Dec. 2014), *available at* https://files.consumerfinance.gov/f/201412_cfpb_reports_consumer-credit-medical-and-non-medical-collections.pdf.

[78] *See Data Point: Medical Debt and Credit Scores* 13, CFPB (May 2014), *available at* https://files.consumerfinance.gov/f/201405_cfpb_report_data-point_medical-debt-credit-scores.pdf.

unpaid medical debt collections would not appear on credit reports was voluntarily increased from six months to one year. Again, ACA members made these changes not because medical debt was not predictive, but because the timeline of reporting did not account for insurance reimbursement. Therefore, industry players have changed the timeline so that these debts are not showing up as trade lines.

Generally, the CFPB's statements regarding the accuracy of medical debt reported on consumer reports are unsubstantiated. The CFPB cites to a rate of disputes as indicative of errors, but disputes are just as likely to indicate the overall societal challenges with medical debt generally. Similarly, the CFPB often cites to its "Consumer Complains Database" as a legitimate source of information about credit reporting concerns over medical debt. Yet, the Bureau's Consumer Complaint Database is rife with problems including duplicate and unverified entries. A consumer complaint, without substantiation, is not indicative of a widespread issue. Because this data is not verified, it cannot form the basis for such expansive rulemaking. Instead, the Bureau should utilize such complaint data to identify areas for additional inquiry and research.

In its SBREFA report, the CFPB acknowledged some of the serious problems that stakeholders raised.[79] However, in turn, the Bureau glosses over these concerns in its Proposed Rule. A transcript of the discussion, combined with the SBREFA Report, reveals that nearly all stakeholders agreed that there are problems and unintended consequences associated with ignoring medical debt. In the Proposed Rule, however, the CFPB simply summarily dismiss these views shared by industry professionals with no supporting data or information to back views up. For example the Proposed Rule states that,

> CFPB received feedback from several healthcare providers during the SBREFA process stating that the proposed rule would lead them to deny non-emergency care to consumers who cannot pay upfront or have not paid their previous balances in

[79] *See supra* SBREFA Report.

> full. *However, these views are not shared by the CFPB*. The CFPB views these outcomes as unlikely given that many healthcare providers already require payment before treatment.[80]

(Emphasis added). Here the CFPB does not provide any data showing that they have studied this issue, or provide any analysis of the potential impact, beyond stating the fact that some healthcare providers may already require cash up front. As A. Rodrigo outlines in his attached research, this is a critical issue that could impact a variety of consumers and small businesses. Yet, the CFPB demonstrates that it has no expertise or research supporting its hypothesis.

The many letters filed with the CFPB in response to SBREFA, and to this Proposed Rule from a variety of stakeholders, make clear that there is widespread concern about this how this Proposed Rule will impact small business lenders, medical providers, credit bureaus, and collection agencies.

B. <u>Comparison to Industry Stakeholders' Current Data and Analysis.</u>

In contrast, industry stakeholders, including ACA, have sought analysis from economists to measure the real costs of the Proposed Rule, both direct and indirect, as well as the likely impact to the financial and credit markets.

A. Rodrigo, an accomplished economist who previously worked for the Bureau, has conducted robust economic modeling and data testing utilizing accepted economic standards. In his Report, incorporated by reference to this letter, he considers a range of possible economic consequences stemming from the Proposed Rule. He also explains why the data and assumptions underlying the CFPB's Proposed Rule are problematic. For example, as reflected in the attached report, A. Rodrigo explains:

> The Bureau relies on internal research that fails to predict or shed light on the expected consequences of its proposed rule. Two key pieces of research are frequently cited. The first, "Data Point: Consumer Credit and the Removal of

[80] *See* NPRM.

> Medical Collections from Credit Reports" from April 2023, notes a 25-point increase in credit scores after removing the last medical collection. It also finds that consumers with a deleted medical collection are likelier to have a first-lien mortgage inquiry. This Data Point proves little. It is well-understood that when individuals work to actively clear negative tradelines off their credit report, they are more likely in the market for a mortgage. This Data Point fails to study anything beyond this immediate effect and has no informative conclusions about the broader impact on medical debt collection or consumer credit. The second cited work is a 2014 study titled "Data Point: Medical Debt and Credit Scores," which suggests that medical debts are not as predictive as other types of unpaid debt. While this finding is intriguing, it should not be interpreted as indicating that medical debt tradelines have *no* predictive power in credit scores. The Bureau frequently uses the less predictive claim to justify the removal or suppression of medical debt, which, according to the CFPB's research, would diminish the accuracy of credit reports and the underwriting based on credit reports.

A. Rodrigo further identifies how these two sources of data on which the Bureaus relies do not meet the rigorous standards one would expect to support a Proposed Rule with such far reaching implication. A. Rodrigo notes that the 2023 Model has many serious errors and deficiencies, such as: the "event analysis" methodology is not as rigorous as a difference-in-differences analysis that incorporates a control group; the consumer records used in the study have inherent biases because they are comprised of only consumers who were able to have medical tradelines removed; the analysis overstates the benefits of medical tradeline removal concurrent with other changes and the results are most likely a mixture of effects; the data is outdated and is being used from vastly different time periods with no statistical controls; this research does not capture the unanticipated effects of this rule; and the research does not reflect impacts from the No Surprises Act, enacted on January 1, 2022.

By comparison, the data and economic models used by A. Rodrigo look at the industry effects of this rule. His research and analysis considers the realistic consequences of tradeline removal, including the impact that debt suppression has on the wider credit markets. He relies on data that is recent, sourced directly from affected industry stakeholders, and also reflects the

impacts of both Congressional action in the past ten years, as well as critical voluntary industry initiatives.

VII. OTHER PROBLEMS WITH THE PROPOSED RULE.

A. Arguments Advocated by the Bureau and Consumer Advocacy Groups Lack Relevant Data and Analysis.

1. Fallacy No. 1: Medical Debt Is Not Predictive of Consumer Payment Behavior.

The Bureau asserts that medical debt is not predictive of ability and willingness to pay off debt. Yet, even the CFPB's own ten-year-old study shows otherwise. The study establishes that medical debt is at least somewhat predictive of ability and willingness to pay off debt. Moreover, reliable and current studies show that persons with unpaid medical debts pose materially greater credit risks than those with no derogatory information.

3. Fallacy No. 2: Debt Parking.

In its rationale for the Proposed Rule, the CFPB abhors "debt parking," but fails to mention that Regulation F has already been enacted to stop this practice. Debt parking is "the practice of placing purported debts on consumers' credit reports without first attempting to communicate with the consumer about the debt."[81] Despite CFPB hyperbole, there has been little to no enforcement activity indicating this is a widespread problem. And the practice was addressed already at 12 CFR § 1006.30(a).

2. Fallacy No. 3: Medical Debt Is Foisted Upon Consumers and They Can't Control When That Debt Goes to Collections, Making the Obligation "Unavoidable."

[81] Lesley Fair, *Setting the debt parking brake*, Federal Trade Commission Business Blog (Nov. 30, 2020), *available at* https://www.ftc.gov/business-guidance/blog/2020/11/setting-debt-parking-brake.

Medical needs are inevitable, and the law requires health insurance with known-in-advance deductibles. Accident, auto breakdown, house breakdown, etc. expenses are equally unpredicted—is that a basis to exclude those fix-it purchases from credit reports?

In 2020, the HFMA and ACA International jointly published the 2nd edition of Best Practices for Resolution of Medical Accounts with input from consumer groups and providers. These Best Practices further enhanced controls over credit reporting, and intentionally 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 payer if needed. This timeframe is now closer to 360 days as a result of the private market changes made by the credit reporting agencies. This timeframe was determined by the CRAs as the date within which timely filing periods generally expire and therefore would not be an insurance responsibility.

Additionally, during this time frame, ACA members who observe industry best practices are working their active accounts receivables for a period of 90-120 days (this may be through an EBO or in house process) where they will send a minimum of three statements to the patient and make contact attempts to try to resolve the balance. If after that 120 -150 day period, the bill is still outstanding, most will place the account with the bad debt vendor in a primary placement environment. In a primary placement environment, the debt collector will send a validation notice and make communication attempts to help resolve the balance. Generally speaking, credit reporting still does not occur in the primary placement environment. During both of these processes, the early out and bad debt vendors will advocate on behalf of the patient and the provider in an attempt to get the insurance company to properly pay and adjust the account. After 180-210 days, the accounts are generally placed in a secondary placement environment where the debt

collector again sends a validation notice and makes communication attempts with the consumer. This is the phase were credit reporting may be introduced depending on the procedures of the provider. In both primary and secondary environments, there is generally a statement sent 30-45 days after the validation notice and there are expectations for a minimum of three to four contact attempts per month. Thus, in practice, there is a substantial amount of time and attempted patient communications before an outstanding medical debt is placed on a consumer's credit report.

For the minority of people who do not open mail or answer telephone calls, finally seeing a financial obligation on their credit report may alert a consumer they must take action on an issue with their insurance company, or to avoid future litigation. Removing early an inexpensive consequence for nonpayment of financial obligations means more consumers will be surprised when the first time they take action on a debt is after they are served with a lawsuit. At that point, they must immediately spend additional resources to respond. They also may miss important insurance deadlines and be forced to pay out of pocket for medical care that could have been covered by insurance or charity care. Credit reporting provides for the most efficient mechanism to achieve resolution of the account and at much reduced cost as compared to the costs of litigation or delay. Further, the stress and embarrassment of having to respond to a lawsuit as opposed to not getting approved for a new car loan more than likely prefers the denial of credit option especially considering the account will be deleted once paid or otherwise resolved.

Finally, the Bureau's apparent suggestion that healthcare providers should turn to litigation first, as a replacement for the far less damaging credit reporting, is head scratching. Litigation costs patients and providers more and does not solve the underlying issues present in the American healthcare system. The CFPB's calculation here shows a fundamental misunderstanding of the realities associated with ensuring payment.

3. Fallacy No. 4: Medical Debt Is Riddled with Inaccuracies.

The CFPB's assertion that medical debt is typically riddled with inaccuracies is limited to a flawed review of the CFPB's own consumer complaint database. The CFPB's complaint database has been widely criticized for its inaccuracy since its inception. In fact, the Bureau's own Ombudsman has voiced concerns regarding duplicate complaints housed in the database—and members of Congress have highlighted that information in certain instances has been repeated thousands of times.[82] Many so called "complaints" are in fact mere inquiries about a consumer debt and in the context of medical debt, many of the "complaints" are actually health insurance related questions. The CFPB has unfortunately misdirected many consumers who have questions about their health insurance coverage to their complaint database, rather than the correct place to have them resolved, through their public campaigning on this issue and political rhetoric targeting the debt collection industry. Again, if the CFPB has identified widespread malfeasance in this area, its enforcement activity does not demonstrate that. Relying on the highly speculative complaint database alone is very problematic.

VIII. THE CFPB'S PUBLIC MESSAGING ABOUT MEDICAL DEBT CONFLICTS WITH THE PROPOSED RULE.

As also discussed above, a number of the CFPB's public-facing comments about the Proposed Rule conflict with the plain language of the Proposed Rule, and are therefore likely to mislead consumers. For example, in the Prepared Remarks of CFPB Director Rohit Chopra on the Proposed Ban of Medical Bills on Credit Reports, Director Chopra stated: "Today, the CFPB is proposing a rule that would ban medical bills from most credit reports. This rule would stop debt collectors from using the credit report as a cudgel to coerce consumers into paying bills they may

[82] *See The Semi-Annual Report of the Bureau of Consumer Financial Protection*, Financial Services Committee (June 13, 2024), *available at* https://financialservices.house.gov/calendar/eventsingle.aspx?EventID=409289.

not even owe, and make sure the credit reporting system doesn't unjustly punish people for getting sick."[83] The reference to "ban medical bills from most credit reports" is misleading, and consumers are likely to believe that their medical debt has been extinguished, which is false. Accordingly, consumers will be confused when their consumer reports still reflect their medical debts, even if such information is suppressed when the consumer credit report is published to a potential creditor for the purpose of determining credit eligibility.

Similarly the Bureau's article titled "CFPB Proposes to Ban Medical Bills from Credit Reports" is misleading.[84] The title alone is misleading, but the body of the article, published on CFPB website, similarly misinforms consumers about the impact of the Proposed Rule. It states:

> The Consumer Financial Protection Bureau (CFPB) today proposed a rule that would remove medical bills from most credit reports, increase privacy protections, help to increase credit scores and loan approvals, and prevent debt collectors from using the credit reporting system to coerce people to pay. The Proposed Rule would stop credit reporting companies from sharing medical debts with lenders and prohibit lenders from making lending decisions based on medical information.[85]

The article goes on to state, "The CFPB is seeking to end the senseless practice of weaponizing the credit reporting system to coerce patients into paying medical bills that they do not owe," quoting Director Chopra.[86] Finally, it asserts that "Medical bills on credit reports too often are inaccurate and have little to no predictive value when it comes to repaying other loans."[87] Not only is this irresponsible messaging from a government official, but the article improperly characterizes

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[83] Rohit Chopra, *Prepared Remarks of CFPB Director Rohit Chopra on the Proposed Ban of Medical Bills on Credit Reports*, CFPB (June 11, 2024), *available at* https://www.consumerfinance.gov/about-us/newsroom/prepared-remarks-of-cfpb-director-rohit-chopra-on-the-proposed-ban-of-medical-bills-on-credit-reports/#:~:text=Today%2C%20the%20CFPB%20is%20proposing,punish%20people%20for%20getting%20sick.

[84] *CFPB Proposes to Ban Medical Bills from Credit Reports*, CFPB (June 11, 2024), https://www.consumerfinance.gov/about-us/newsroom/cfpb-proposes-to-ban-medical-bills-from-credit-reports/.

[85] *Id.*

[86] *Id.*

[87] *Id.*

the accurate reporting of debt as weaponization and falsely states that medical debt has no predictive value on consumer reports, even when the CFPB's own study provides otherwise.

The "FACT SHEET: Vice President Harris Announces Proposed Rule to Prohibit Medical Bills from Being Included on Credit Reports and Calls on States and Localities to Take Further Actions to Reduce Medical Debt" published by the Bureau similarly has an inaccurate and misleading title.[88] But his publication goes even further, asserting that: "Under the CFPB proposed rule, there would be zero Americans with medical debt listed on their credit reports, down from 46 million in 2020."[89] This is wholly inaccurate and misleading.

The CFPB's Letter to California State Legislature on Barring Medical Bills on Credit Reports states, without support, that "Medical debt is categorically different from many types of consumer tradelines that typically appear on credit reports… CFPB research has found that medical debt is less predictive of future consumer credit performance than other tradelines."[90] Characterizing medical debt as categorically different is a misleading overstatement. Also, "less predictive" is a relative term and implicitly acknowledges that medical debt is still somewhat predictive. Its use is also misleading as it risks leading individuals believing that the degree of predictiveness of medical debt is negligible. But the CFPB did not stop there. Relying only on their own data garnered from a small, skewed sample of CFPB complaints, the letter stated that: "In addition to being less predictive of credit risk, unpaid medical bills are frequently rife with unreliable data."[91] This statement is unsupported by a broader review of relevant and current data.

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[88] *See The White House, FACT SHEET: Vice President Harris Announces Proposal to Prohibit Medical Bills from Being Included on Credit Reports and Calls on States and Localities to Take Further Actions to Reduce Medical Debt.*
[89] *Id.*
[90] Rohit Chopra, *CFPB Letter to California State Legislature on Barring Medical Bills on Credit Reports*, Consumer Financial Protection Bureau (Mar. 25, 2024), *available at* https://www.consumerfinance.gov/about-us/newsroom/cfpb-letter-to-california-state-legislature-on-barring-medical-bills-on-credit-reports/.
[91] *Id.*

The CFPB's Medical Debt page claims, in a primary subheading, that "The CFPB is working to stop unfair medical debt collection…"[92] Read in conjunction with the statements discussed above, this heading implies that all medical debt collection is improper and that the practice of medical debt collection is inherently unfair. Another article on the Bureau's website states, "CFPB Kicks Off Rulemaking to Remove Medical Bills from Credit Reports."[93] The article goes on to say, "The Consumer Financial Protection Bureau (CFPB) today announced it is beginning a rulemaking process to remove medical bills from Americans' credit reports."[94] Again, the Proposed Rule simply does not provide for the removal of medical debt from any consumer's credit report and is thus misleading and likely to result in consumer harm and confusion.

The Bureau's social media presence similarly highlights these inaccurate statements. For example, the CFPB's X (formerly twitter) account includes posts that read: (1) "Last week, the CFPB took an important step toward banning medical bills from credit reports," and (2) "The CFPB has proposed a rule that would remove medical bills from most credit reports, increase privacy protections, help increase credit scores and loan approvals, and stop debt collectors from using the credit reporting system to coerce people to pay." Director Chopra's account makes similar misstatements: (1) "This Sunday, I'll be joining @AliVelshi to talk about the scourge of medical debt on consumer credit reports and what the @CFPB is doing about it." Not only does such language evidence animosity and passion on the issue, "scourge" is emotional language that reflects the disingenuous messaging elsewhere.[95]

[92] *Medical Debt*, Consumer Financial Protection Bureau, *available at* https://www.consumerfinance.gov/rules-policy/medical-debt/.
[93] CFPB Kicks Off Rulemaking to Remove Medical Bills from Credit Reports, CFPB (Sept. 21, 2023), *available at* https://www.consumerfinance.gov/about-us/newsroom/cfpb-kicks-off-rulemaking-to-remove-medical-bills-from-credit-reports/.
[94] *Id.*
[95] *See generally*, consumerfinance.gov (@CFPB), Rohit Chopra (@chopracfpb).

IX. TO THE EXTENT THERE IS ANY PROBLEM WITH REPORTING MEDICAL DEBT, THE CFPB DID NOT STUDY LESS EXPENSIVE ALTERNATIVES.

Addressing genuine inaccuracies on consumer credit reports is a laudable goal. And the CFPB can meaningfully achieve this goal, to the extent it exists related to reporting medical debt, through the existing regulatory framework and in a way that is more efficient, less costly, and does not cause a multitude of serious, negative, and unintended consequences.

For example, the CFPB could better enforce the FCRA consumer dispute provisions to ensure accuracy of medical debt reporting. Section 1681s-2(b) of the FCRA provides robust protections for consumers who identify inaccurate or incomplete data on their consumer credit reports. While that section provides a private right of action for consumers, the CFPB has broad authority to enforce this section, as well as other portions of the FCRA governing furnishers, CRAs, end users, and the data that is reported, exchanged, and published between them. The Bureau already has the means to investigate and penalize inaccurate credit reporting, including reporting about inaccurate medical debt. It should focus on utilizing its existing authority to help consumers without promulgating unnecessary and burdensome rules that only worsen the regulatory morass.

Under Regulation F, if a debt collector furnishes information to CRAs, the debt collector also has additional compliance obligations under the FCRA if a consumer disputes a debt. Despite rhetoric from the CFPB not acknowledging this, the law already prohibits a debt collector from communicating to any person credit information, which the debt collector knows or should know to be false, including the failure to communicate that a debt is disputed. Therefore, if a debt collector reports the debt to a CRA, either method of dispute requires the debt collector to mark the account as disputed on the consumer's credit report when initially reporting the debt.

The CFPB could also work with HHS to provide educational materials about charity care options and financial assistance. It could also consider providing guidance to medical debt collectors that the inclusion of a medical provider's financial assistance policy in any debt collection communications would be covered under the safe harbor provisions of Regulation F.

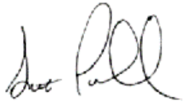
Lastly, it could wait and see how effective the No Surprises Act is when it is fully implemented and its effects can be measured. If components of it are not working, the appropriate agencies of jurisdiction can then address issues that have been studied and measured.

X. CONCLUSION AND REQUEST TO WITHDRAW NPRM.

For the reasons outlined here and in the attached research from A. Rodrigo, the CFPB must rescind the Proposed Rule. The CFPB has not sufficiently addressed the concerns raised by multiple stakeholders, including the SBA Office of Advocacy, during the SBREFA process. It also does not have sufficient data or research to support the very basis of the Proposed Rule that medical debt is not predictive, and many other claims it makes related to the usefulness of information about medical debt for lenders. Beyond this, the CFPB does not have the legal authority to rewrite the FCRA or to make the changes outlined in its Proposed Rule to current law and regulations. The recent *Loper Bright* decision and the Major Questions Doctrine clearly prohibit the politically driven overreach that the CFPB and White House are attempting in the height of the election season. Most concerning however, are the many negative consequences that will result as outlined in this letter, and the attached research, if the CFPB moves forward. Consumers around the country will face increased costs for both medical care and credit, less reliable healthcare options, more litigation, and a variety of other negative outcomes that will result from the CFPB's uninformed policymaking. These problems are of great national economic significance and must be revaluated before the CFPB moves forward.

The invitation remains open, as it has for the past three years, for the Director to meet with ACA leadership to learn more about our industry and the concerns we have raised here.

Respectfully Submitted,



Scott Purcell

Chief Executive Officer

On behalf of ACA International

Polling Responses to ACA HFMA Webinar on July 10, 2024: Healthcare Credit Reporting Rule - - What You Need to Know

Poll 1

What is Your Expected Decrease in Liquidation Rates on Bad Debt Due to Elimination of Credit Reporting of Medical Debts Once the New Rule Takes Effect?		
Response Options	**Number of Responses**	**Percentages of Answers**
0-5%	13	8.0%
5-10%	38	23.3%
10-15%	59	36.2%
15-20%	27	16.6%
>20%	26	16.0%
TOTAL	163	

Poll 2

What is your belief about the "Slippery Slope" concept that this might be one more reason patients choose not to have health insurance? Select one.		
Response Options	**Number of Responses**	**Percentages of Answers**
There is a remote chance this would have an impact on how patients view the need for insurance.	12	7.2%
There is a low chance this would impact a patient's view of the need for insurance.	30	18.0%
There is a moderate chance this would impact a patient's view of the need for insurance.	79	47.3%
There is a high chance this would impact a patient's view of the need for insurance.	46	27.5%
TOTAL	167	

Poll 3

What Options Do You See Your Own Provider Organization Taking to Mitigate Losses from Eliminating Credit Reporting—Including Overall Behavior Changes Even if You Don't Credit		
Response Options	**Number of Responses**	**Percentages of Answers**
Require full or partial payment in advance from patients for non-emergency procedures.	118	72.0%
Start or increase the use of legal strategies for collections in-house or in partnership with third-party agencies.	63	38.4%
Raise prices.	25	15.2%
Send accounts to collection agencies earlier than we currently do.	37	22.6%
Send accounts to the early out process earlier than we currently do.	40	24.4%
Total Respondents	164	

Poll 4

What Actions Do You Plan on Taking to Answer the CFPB's Request for Information and Provide Insight on the Impacts of the Proposed Rule? Select all that apply.		
Response Options	**Number of Responses**	**Percentages of Answers**
Our organization will submit a comment letter directly to the CFPB.	27	18.8%
We will advise our members of Congress directly on the expected harm this rule will cause and our need to take mitigation steps.	50	34.7%
We will work with our state hospital association to submit an anonymous comment.	76	52.8%
We do not plan to provide insights to the CFPB nor our state hospital association regarding the impact of this rule.	18	12.5%
We will use the QR code in this presentation to seek more information to explore filing a comment with the CFPB.	40	27.8%
Total Respondents	144	