

The Honorable Rohit Chopra
Director
Consumer Financial Protection Bureau
1700 G St. NW
Washington, DC 20552

August 12, 2024

Re: Proposed Rule: Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information (Regulation V) (RIN 3170-AA54)

Dear Director Chopra:

I write today regarding the Consumer Financial Protection Bureau's ("CFPB") proposed rule "Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information (Regulation V) (RIN 3170-AA54)" which would ban credit bureaus from including medical debt in collections on most consumer reports.

Qualifications and Assignment

I am the founder and president of AC Cutts and Associates LLC, an economics and policy consulting firm based in Reston, VA. Before starting my company in 2019 I served as the senior vice president and chief economist for Equifax, Atlanta, GA for eight years. Prior to that I was senior director and deputy chief economist at Freddie Mac from 2003-2011 and was a staff economist and director from 1997-2003. I held the position of assistant professor and senior policy researcher at Syracuse University in the Maxwell School of for Citizenship and Public Affairs from 1994-1997. Throughout my career I have performed economic analysis and policy evaluations relating to fair lending, predatory lending, automated underwriting, credit scoring, mortgage loan servicing, subprime lending, financial regulation, small business lending, appraisal bias, home price models, housing markets, broker and agent commissions, and consumer credit reporting.

I earned an M.A. and Ph.D. in Economics from the University of Virginia and a B.S. in Economics and Applied Mathematics at Trinity University in San Antonio. I am a Certified Business Economist[®], a distinction of professional achievement from the National Association for Business Economics. I have served on the board of directors of the American Real Estate and Urban Economics Association and the National Business Economics Association and currently serve on the board and as secretary of the National Business Economics Issues Council.

The Consumer Data Industry Association hired me through counsel to provide my opinion concerning the economic analyses and empirical evidence cited in the Consumer Financial Protection Bureau's Proposed Rule on the Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information (Regulation V). I am being compensated for the time I spent researching and drafting this report. My opinions are my own.

Summary

I am opposed to the implementation of the CFPB's proposed rule that requires information relating to consumer medical debt in collections to be removed from consumer credit reports and disallows this information from consideration in credit underwriting for the following reasons:

1. It is predicated on out-of-date empirical research that does not take into account changes that have already been made in the reporting of medical debt by the three national credit reporting agencies (Experian, TransUnion, and Equifax, together the CRAs) in 2022 and 2023. Specifically, the research cited in the proposed rule is from a 2014 study by economists at the CFPB and a second

study published in 2013 analyzing consumer credit reports that still contained medical collections that were lower than \$500, were less than a year old, and that had already been paid.¹ These changes already made in the reporting of medical collections have had significant effects on how medical debt is included in consumer reports.² It is premature for the CFPB to act now without having fully analyzed whether these voluntary changes have addressed the CFPB's concerns. Further, other methodologically sound analyses by industry participants show that unpaid medical debt is an important factor for creditors to consider when evaluating whether to extend credit to a consumer.

2. The proposed rule is aimed at righting a perceived problem of fairness in the provision and costs of healthcare services, not a problem borne out of law or regulation within credit markets. That is, the proposed rule aims to correct the perceived injustice that without intention or control, people are incurring large debts for health care services. The CFPB aims to remedy this through the banning of the reporting of all medical collections by credit reporting agencies, which would address none of the causes of the problems of high medical debt among both the insured and uninsured.
3. It is predicated on the incorrect assumption that financial markets do not think the information is valuable. The CFPB cites the fact that Freddie Mac and Fannie Mae no longer consider medical collections as part of mortgage underwriting as evidence that this information is not considered useful. These two companies did not make this decision out of empirical foundations but rather because they are under conservatorship and were directed to do so by their regulator who, like the CFPB, has been directed to make these changes by the Biden Administration.³ These companies are not, as the CFPB asserts, "Market participants, including ... those most financially incentivized to assess the predictive value of medical debt, [who] have reduced their reliance on medical debt in recognition of its limited utility."⁴
4. The proposed rule is predicated on allegations of unfair and deceptive practices by debt collectors. Questions of fairness or deceptions in collections practices are not addressed by the rule, while at the same time it interferes with legitimate operations of creditors, who must make distinctions between good risks and bad risks when allocating finite capital.

I will address each of these further below.

1. Empirical Evidence

I have reviewed the two studies cited by the CFPB in the proposed rule showing that medical debt has limited predictive value for credit underwriting. These two studies are out of date and do not address the new, *marginal impact* of removing remaining medical collections information from use in credit underwriting and pricing models. Instead, they examine older credit bureau data in which small medical collections amounts (less than \$500), debts that may still be in negotiation with insurance companies (those less than a year old), and medical debts in collection that have already been paid were included. The CRAs

¹ Kenneth P. Brevoort and Michelle Kambara, Consumer Fin. Prot. Bureau, Data point: Medical debt and credit scores (May 2014), https://files.consumerfinance.gov/f/201405_cfpb_report_data-point_medical-debt-credit-scores.pdf and Mark Rukavina, Medical Debt and Its Relevance When Assessing Creditworthiness, 46 Suffolk U. L. Rev. 967 (2013), https://bpb-use1.wpmucdn.com/sites.suffolk.edu/dist/3/1172/files/2014/01/Rukavina_Lead.pdf.

² "Medical Debt Was Erased from Credit Records for Most Consumers, Potentially Improving Many Americans' Lives," by Fredric Blavin, Breno Braga, and Michael Karpman, *Urban Wire*, The Urban Institute, November 2, 2023 available at <https://www.urban.org/urban-wire/medical-debt-was-erased-credit-records-most-consumers-potentially-improving-many>

³ "FACT SHEET: The Biden Administration Announces New Actions to Lessen the Burden of Medical Debt and Increase Consumer Protection," The White House, April 11, 2022 available at <https://www.whitehouse.gov/briefing-room/statements-releases/2022/04/11/fact-sheet-the-biden-administration-announces-new-actions-to-lessen-the-burden-of-medical-debt-and-increase-consumer-protection/>

⁴ Consumer Financial Protection Bureau, Proposed Rule "Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information (Regulation V)", RIN 3170-AA54, page 5.

jointly announced that these three types of medical collections would be removed from consumer reports.⁵ In July 2022, the CRAs removed paid medical collections from credit reports and stopped reporting unpaid medical collections until those debts were one year old – previously there was a six-month grace period before the debts were included.⁶ These two changes resulted in a reduction of about one percentage point in the share of adults with medical collections on their records.⁷ In April 2023, medical collections of \$500 or less were removed from credit reports, which reduced the share of adults with medical collections by a further 6.6 percentage points.⁸

The relevant question is the *marginal impact* of eliminating *all* remaining medical collections information from a consumer credit report. Let me first discuss how tests of marginal impact are done in practice.

Data scientists and economic modelers will test the validity of each variable they use in a credit model by looking first at the statistical measures of importance, that is, whether the impact of the variable is statistically different from zero. Standard estimation packages produce this as part of the model output. But variables can have correlations with other variables that create more influence than the individual variable's statistical measure indicates. As a follow up, the modelers will often test the total effect of a variable on the model by, one at a time, removing the variable from the list of inputs, re-estimating the model coefficients, and then measuring the difference in the goodness of fit, or error rate of the “challenger” model against the original or “champion” model. This is sometimes called a champion-challenger test, which can also mean testing other changes in the model structure against what is believed to be the best, or champion, model. While individual statistics on a variable's importance are useful, the champion-challenger test is a best practice for approving a variable for use in a credit model. A common metric for measuring goodness of fit is called a Kolmogorov-Smirnov (K-S) statistic. Put another way, the K-S statistic assesses how well a model separates two categories, often referred to as “goods” and “bads.” In credit risk for instance, we might label people who miss payments as “bads.” While details matter greatly in K-S analysis, all other things being equal, the model with the higher K-S value is better at separating bads from goods.

Regarding the statistical relevance of the proposed ban, I have reviewed the 2015 study done by FICO in which they examined the differential effects of medical collections on the predicted model accuracy of FICO® Score 9.⁹ In the analysis, constructed as a champion-challenger test, FICO data scientists found that removing paid medical collections actually improved the model's accuracy but that removing all medical collections significantly diminished the accuracy both statistically and economically.

Further, the FICO researchers found that “...consumers with unpaid medical collections are less risky than those with unpaid non-medical collections, [but] they are still substantially more risky than the population with no derogatory information in their files.” How much riskier are they? Consumers that had medical

⁵ “National Credit Bureaus Support Consumers with Changes to Medical Collection Debt Reporting,” press release by the Consumer Data Industry Association, March 18, 2022. Available at <https://www.cdiaonline.org/news/2022/03/18/equifax-experian-and-transunion-support-u-s-consumers-with-changes-to-medical-collection-debt-reporting/>

⁶ “First Changes to Reporting of Medical Collection Debt Roll Out,” press release from Experian PLC, July 1, 2022. Available at <https://www.experianplc.com/media/latest-news/2022/first-changes-to-reporting-of-medical-collection-debt-roll-out-july-1-2022/>

⁷ “Medical Debt Was Erased from Credit Records for Most Consumers, Potentially Improving Many Americans' Lives,” by Fredric Blavin, Breno Braga, and Michael Karpman, *Urban Wire*, The Urban Institute, November 2, 2023 available at <https://www.urban.org/urban-wire/medical-debt-was-erased-credit-records-most-consumers-potentially-improving-many>

⁸ Ibid.

⁹ “The Impact of Medical Debt Collections on FICO® Scores,” by Ethan Dornhelm, *FICO Blog*, FICO, July 13, 2015. Available at <https://www.fico.com/blogs/impact-medical-debt-collections-ficor-scores>

collections on their reports had a measured “bad rate”¹⁰ that was ten to twelve times higher than the benchmark rate for consumers with no collections derogatory on their report. For consumers with non-medical collections their measured bad rate was twelve to sixteen times higher. The study as described by FICO appeared to be methodologically sound, so, I conclude from this that it is evidence that medical collections are predictive of future borrower performance.

I also reviewed a non-public study conducted by data scientists at one of the three national CRAs. In this study they examined the impact of removing various types of consumer report information from a credit risk model in a champion-challenger set up. They analyzed a set of consumers from the credit bureau archives from 2017, following them through the end of 2019 (2-year performance window) and they followed a second set of consumers from 2019 through the end of 2021. This analysis showed that the impact of removing all medical collections information available at that time from the model reduced the goodness of fit as measured by the K-S statistic by 1-2% and that the marginal impact of removing remaining medical debt in collections after the 2022-2023 changes in reporting is on the order of a 0.4% to 0.8% reduction of the K-S statistic. That is, removing all medical debt in collections from consumer reports negatively affects the accuracy of credit models.¹¹

While these numbers may seem small if you are not a trained empiricist, this is a massive impact on model accuracy. With the millions of consumers served by credit markets each year any difference in the K-S, positive or negative, is both statistically and economically meaningful to what credit is offered to whom and at what price.

The proposal to ban medical collections information from consumer credit reports doesn’t just impact the consumers who have medical collections on their records, but it also affects the accuracy for all other consumers who did not have this type of derogatory information on their account because it changes their relative attractiveness to creditors vis-à-vis the overall population. By way of example, just for context, consider how the change might affect mortgage borrowers. If the impact of removing all medical collections from credit reports changes the expected loss rates and incidence of default, and that translates into a 0.25 basis point increase (just a quarter of 1/100th of a percent) in the guarantee fee charged by Fannie Mae and Freddie Mac (the fee they charge to insure investors against default, which is added to the interest rate), the aggregate cost for consumers who take out a mortgage this year would rise by about \$15 million for the first year of their loans.¹² I am not implying this is the actual cost, only that small differences matter in credit markets.

¹⁰ The FICO researchers did not indicate in their study how they defined the “bad rate,” but it is often measured as the incidence of a delinquency on any credit account of 60 or more or 90 or more days past due.

¹¹ While the analysis of both time periods showed that medical collections have a substantial impact on the ability of a credit score to predict future performance, the 2019 to 2021 analysis showed a much larger impact. In 2020 and 2021 there were unprecedented government interventions in the consumer economy; not just direct and indirect payments, but also things like foreclosure moratoria and mortgage forbearance that allowed consumers to increase savings and use funds that might otherwise have been used on rent or mortgage payments to cover other debts. As a result, consumer behavior during this time period likely is not representative of more normal economic conditions. However, the reason why medical collections were seen to be more predictive of future defaults during this period is because consumers that still had these collections on their records after the generous economic interventions likely meant they were in much worse financial condition than those without those collections all else equal.

¹² In 2023 Freddie Mac and Fannie Mae together purchased about \$616 billion in mortgages. Guarantee fees (g-fees) are charged on the unpaid principal balance of loans, with the fees determined at the time of purchase based on characteristics of the loan. The g-fee is included in the interest rate paid by the borrower. The calculation assumes that the same volume of loans would be purchased after the change went into effect but at the 0.25 bps higher g-fee.

It was a glaring omission and lack of responsible policy making for the CFPB to fail to conduct a full cost-benefit analysis of this proposed rule.¹³ It is critically important that the CFPB measure the statistical relevance and the economic cost of this rule on consumers, lenders, and small businesses, including medical providers. This point was powerfully and exhaustively made by Nigrinis (2024).

In effect, by removing all medical collections from the information set, credit models will be less accurate and will lead to both more false-positive (providing credit where the model would not otherwise) and more false-negative errors (denying credit where the model would not otherwise). Some people who today have a high risk of defaulting on a new debt obligation due to existing medical debt in collections will be approved for credit and other consumers who are at lower risk of defaulting and who not have medical debt in collections will be denied credit. While it may be socially unjust that consumers with medical debt are burdened by their circumstances, it is not accurate to claim that empirical evidence shows that, especially in the current credit environment, medical debt is not predictive of future borrower performance and that it is not necessary and appropriate for creditors to obtain or consider medical debt information as part of the credit decision process. The opposite is closer to the truth. It is not fair for the CFPB to try to mitigate the perceived unfairness against those with medical debt by imposing a system that unjustly denies credit-worthy consumers without medical debt the credit they deserve.

2. Market Failure in the Provision of Healthcare Services

Healthcare in the United States is becoming more and more concentrated in every aspect – whether we look at insurance markets, drug manufacturing, pharmacies, hospitals, or doctors, there are fewer providers now than there were 10 or 20 years ago, and this market concentration is raising costs on consumers. Healthcare and how we pay for it in the U.S. is complex and not under the Bureau’s purview to fix. Nonetheless, it is relevant to this proposed rule because who incurs medical debt is thought to be profoundly unfair by the CFPB as expressed in this proposal.

A 2022 study by researchers at the Urban Institute looked at which consumers are more likely to incur high amounts of medical debt.¹⁴ Not surprisingly, they found that consumers based in the Southern US, especially those living in states that had not opted to expand Medicaid coverage like Texas and Georgia, had the highest concentrations of medical debt. Further, counties in those states with the highest debt levels are typically more rural, have less access to healthcare services, have higher rates of disability, and have lower shares of insured adults. Large medical debt burdens can impact both the insured and uninsured, and consumers often have little say in the care they receive in emergency or other situations requiring hospitalization and even less negotiating power with the hospital billing department or the insurance company. To fix these problems would require state and federal legislators or regulators of healthcare and insurance markets to act, not CRAs regulated by the CFPB.

¹³ Nigrinis, Andrew Rodrigo, “Economic Analysis of the Consumer Financial Protection Bureau’s Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information (Regulation V),” Comment letter submitted to the CFPB, July 8, 2024. Available at <https://policymakers.acainternational.org/wp-content/uploads/2024/07/AndrewNigrinisEconomicAnalysis-CFPB-FCRA-NPRM-July2024.pdf>

¹⁴ “Which County Characteristics Predict Medical Debt?” by Fredric Blavin, Breno Braga, and Anuj Gangopadhyaya, 2022. Washington, DC: Urban Institute. Available at <https://www.urban.org/sites/default/files/2022-06/Which%20County%20Characteristics%20Predict%20Medical%20Debt.pdf> and “The Changing Medical Debt Landscape in the United States,” data visualization application by the Urban Institute, July 10, 2024. Available at <https://apps.urban.org/features/medical-debt-over-time/#check-out-more>

For example, a September 2023 study examined hospital closures' impacts on local economies, health care pricing, consumer medical debt, collections practices, and patient health and found profoundly negative impacts on all.¹⁵

3. Value to Financial Markets

Lenders vary in the amount of risk that they are willing to take and at what price that risk is profitable to them. They all have their own credit risk models, loss provisions, cost of capital, and regulatory constraints. Some utilize credit scores provided by third parties while others use just the information from consumer credit reports to most accurately measure expected default risks, losses given default, and net profitability for their target market. A credit scoring or automated underwriting model can only be used in a credit decision process if the model is empirically derived, as well as demonstrably and statistically sound. The lender is already under a legal requirement to provide to the consumer the reason why they were denied credit or how the pricing of the loan was determined. This means that information that is not contributing meaningfully to the credit model's accuracy creates a reputation risk and legal liability on the lender to explain to a consumer that they were denied credit on the basis of something that is irrelevant. The fact that some lenders and scoring system vendors have been using medical collections in underwriting means they have found it to be a reliable indicator of credit risk—otherwise they would not take on the potential reputation or regulatory liability.

Until recently, medical collections were utilized in mortgage underwriting until the Biden Administration directed all federally backed loan programs to stop using this information, including those backed by the FHA, USDA, VA, and SBA.¹⁶ Freddie Mac and Fannie Mae which are private companies held in conservatorship by the Federal Housing Finance Agency and majority owned by the U.S. Treasury Department were also included in this order. It is not accurate to say that the change implemented by Fannie Mae and Freddie Mac represents market forces recognizing that medical debt is not predictive. Rather, it shows that political forces have turned against consideration of medical debt.

The United States benefits from the most efficient consumer credit markets in the world. This is only possible because of the extensive coverage of consumer liabilities and repayment histories through the national CRAs. While the data are not always perfect, the regulatory framework that allows for consumers to set the record straight, the burdens on reporters to be timely, accurate, and complete in their reporting, and the responsibilities placed on the CRAs to ensure that consumer reports are accurate and fair means that lenders can confidently make loan approvals knowing the creditworthiness of the consumer.

This may be the first time the CFPB has said that less data, not more, will lead to fairer markets. As a general matter, laws and regulations require creditors to consider all relevant information when making a credit decision. Ability to repay (ATR) was considered such an important element of prudent lending practices that the U.S. Congress put it into law under the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010. The CFPB has the responsibility to create rules regarding ATR for mortgage lending in the Dodd-Frank Act, and the Bureau's own rules require, among other things, that a lender consider all of a borrower's outstanding liabilities at the time of loan origination. Outstanding medical debts in collections, if substantial, could be an impediment to repaying a mortgage loan, causing a consumer grave additional harm should they

¹⁵ "The Impact of Hospital Closures on Medical Debt in Collections: Analysis Using Consumer Credit Bureau Data" by Jennifer Andre, Fredric Blavin, Breno Braga, and Anuj Gangopadhyaya, IZA Discussion Paper Series, Bonn: IZA-Institute of Labor Economics, September 2023. Available at [dp16448.pdf \(iza.org\)](https://www.iza.org/publications/dp16448)

¹⁶ "FACT SHEET: The Biden Administration Announces New Actions to Lessen the Burden of Medical Debt and Increase Consumer Protection," The White House, April 11, 2022 available at <https://www.whitehouse.gov/briefing-room/statements-releases/2022/04/11/fact-sheet-the-biden-administration-announces-new-actions-to-lessen-the-burden-of-medical-debt-and-increase-consumer-protection/>

buy a home with a mortgage that they cannot afford to carry that ultimately results in foreclosure and eviction.

Because the CFPB recognizes that unpaid medical debt may increase the credit risk of any given borrower, it chose not to amend the ATR rules as part of this rulemaking. The CFPB writes in the proposed rule “Currently, many creditors use medical debt information from consumer reporting agencies that would no longer be available under the proposed rule. The proposed rule would not change any existing law or guidance regarding the information that creditors must request from applicants. Creditors may use (or continue to use) certain information, including information relating to medical debt, that consumers provide in credit applications to satisfy ability to repay requirements.”¹⁷ Although the language in the proposed rule is “may use,” creditors are required to consider, that is, *must use*, all known liabilities whether disclosed by the applicant directly or through CRA-provided consumer reports under existing law and regulations. This places the burden of reporting medical debt on the consumer, who would be falsely representing their application if the information is material and omitted, yet the CFPB is intending to protect consumers from this disclosure by banning it from the consumer reports furnished by the national CRAs. Further, under the CFPB’s proposed rule, creditors would have no way of verifying whether medical debt liabilities disclosed by a consumer (or lack thereof) were in fact accurate.

Erasing the evidence of medical debt in collections from consumer credit reports does not remove the obligation to pay or make the patient healthy, but it does weaken the lender’s ability to accurately assess a consumer’s financial situation when underwriting a loan. The proposed rule runs counter to the intent of the Dodd-Frank Act.

4. Fairness and Deceptive Practices

The CFPB writes in the proposed rule that, “Because consumer reports can operate as a gatekeeper to significant life and economic decisions, medical debt can be used as leverage by debt collectors to coerce consumers to pay medical bills they may not owe. In such circumstances, consumers are forced to choose between challenging inaccurate medical bills, often while recovering from a serious illness, or paying the inaccurate bill due to a frequently short review period.”¹⁸

This justification confuses potentially unfair debt collection practices with the value of reporting legitimate debts to CRAs. Because the CRAs have already removed medical collections that are less than a year old, the time pressure on consumers to pay before insurance claims have been settled or the debts otherwise negotiated is no longer relevant. If the debt collectors are engaging in unfair, deceptive, or abusive acts against consumers with medical debts, then it would seem that the CFPB would be able to prosecute them under the Unfair, Deceptive, or Abusive Acts or Practices (UDAAP) rule which is also under the Bureau’s enforcement powers. Plus, the rule ignores the fact that there is a robust dispute process that consumers can avail themselves of if they believe that information is on their reports in error.

The *point* of gatekeeping in financial markets is to ensure that loans are extended only to consumers who, at the time of the loan’s origination, have a high expectation of being able to repay the debt in a timely manner. Lenders do not have unlimited resources to accommodate all who seek a loan. Credit reports are a reliable way to identify those that have the capacity to carry additional debts from those that are likely to fail, but only if they contain information on all the major liabilities a consumer owns.

¹⁷ Consumer Financial Protection Bureau, Proposed Rule “Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information (Regulation V)”, RIN 3170-AA54, page 124.

¹⁸ *Ibid.*, 5.

Conclusion

There is an undercurrent throughout the proposed rule that because of bad luck, and only bad luck, some people have unfairly accumulated large medical debt burdens and that the empirically sound way to remedy this is to blindfold lenders so that they will make less accurate lending decisions. I oppose the implementation of the proposed rule on the basis that it does nothing to relieve the actual burden of medical debt and it undermines the ability of financial institutions to make empirically derived, demonstrably and statistically sound, credit decisions using the best information available.

Respectfully submitted,

A handwritten signature in cursive script, appearing to read "Amy Crews Cutts".

Amy Crews Cutts, PhD CBE®

Reston, VA