August 12, 2024

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)

Dear Director Chopra and CFPB Staff:

I. Background

My name is Jack W. Brown III, and I am a second-generation operator of a consumer collection agency focused on healthcare self-pay and revenue cycle receivables management. I am a past president of ACA International, the trade association for credit and collection professionals. Over the past 23 years, I have helped 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.

There is no denying the fact that the cost of healthcare in the U.S. is expensive. Health insurance premiums for my employees have increased over the last 10 years, rising to 10% of my total payroll expense. Additionally, these plans have continued to increase the patient responsibility portion by raising deductibles and co-pays to make the premiums more palatable. The ACA marketplace is not any better; A bronze plan under the health exchange created pursuant to the Affordable Care Act carries a maximum out of pocket costs (in addition to premiums) of $9,100 per year for an individual and $17,400 for a family.[1] Health savings accounts allow for a maximum annual contribution of $7,300 per year.[2] Accordingly, the systems to allow for consumers to save for and plan for healthcare expenditures has not kept pace with the rate of increase in deductible and out of pocket maximum amounts. The rule being proposed by the CFPB does not do anything to address the high cost of healthcare; and, in fact, stand to make the problem much worse by removing a provider's ability to collect for the life

[1] HealthCare.Gov "Out-of-Pocket Maximum/Limit" (last visited Nov. 4, 2023) https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/.
[2] 26 CFR 601.602 § 2.01.

saving care they deliver after those services have been rendered. The Proposal from the CFPB related to the Fair Credit Reporting Act missed several steps in engaging all stakeholders to address the affordability problem.

During a recent public forum, public commentators discussed some of their concerns with medical debt and have hope that the CFPB proposed rule will alleviate some of those issues. Unfortunately, the rules proposed by the CFPB fail to address the problems that were shared. One of the commenters talked about the high cost of medical care and that unexpected medical care should not create a financial hardship. Under the proposed rule, the CFPB has applied the credit reporting ban to all medical services due a provider for services provided to humans inclusive of elective and cosmetic surgeries. Elective and cosmetic surgeries are expected and are chosen by the patient. The CFPB should limit the application of the rule, at a minimum, to emergency medical treatment only.

Another commenter talked about the adverse impacts that affect consumers when providers pursue the debt through litigation. The commentor quipped that 99% of consumers do not show up and the case results in a default judgment that later ends up with added costs, attorney fees, wage garnishment, and bank levies. The CFPB has advocated litigation as a viable alternative to credit reporting. Surely, a bank levy or wage garnishment has a more detrimental effect than a consumer being denied a loan or paying a risk adjusted rate on the loan.

Finally, many commentators mentioned specialized financial products in the marketplace that consumers are using to pay for medical care. This rule will force more consumers to seek out and obtain credit for services as medical providers will, and already have started, demanding payment prior to services being provided. Currently, a patient can seek care and address their medical situation and then work out the financial component after and obtain extended repayment terms at zero interest allowing the patient to focus on the healthcare needs and workout payment terms with the provider after the care has been delivered. Medical debt stems from much more than a financial transaction. Healthcare providers deliver lifesaving and prolonging care when we need them most.

Each day, my employees have hundreds of interactions with patients regarding their medical bills. Our team works collaboratively with the patient to find the proper resolution of each account we handle. This is a difficult process that requires skill and expertise. The financial component of a healthcare visit is a very 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 Healthcare industry constitutes nearly 20 percent of the nation's total Gross Domestic Production (GDP).[3] In 2020, Hospitals provided more than $42 Billion in uncompensated care.[4] Providers are responding to the challenges faces by patients by

[3] Keehan et. al., *National Health Expenditure Projections, 2022-31*, 42 Health Affairs 886 (June 14, 2023) https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2023.00403.
[4] Am. Hosp. Assoc. "Uncompensated Hospital Care Cost Fact Sheet" (Feb. 2022) https://www.aha.org/system/files/media/file/2020/01/2020-Uncompensated-Care-Fact-Sheet.pdf.

automatically applying self-pay discounts for uninsured patients and providing other solutions to help consumers grapple with the high cost of care.

The Affordable Care Act has gone a long way in expanding health insurance coverage in the United States, however, there are still too many uninsured Americans. Affordable, comprehensive health care coverage is the most important protection agent medical debt. Affordability is the main reason for the not having coverage.

Finally, the proposals to prohibit creditors from reviewing all debts related to a potential borrower conflict with the very reason the CFPB was created under the Dodd-Frank Act. The Dodd-Frank Act was passed in the wake of the 2008 mortgage crisis to ensure that the American taxpayer would not be on the hook to bail out financial institutions that provided mortgages and other loans to consumers who could not afford the loan. It seems the lesson learned during the Great Recession have been forgotten and now the very same agency is inserting its opinion that medical debt is not as predictive as other debt to determine a consumer's ability to repay the loan in contrast to actions already taken to address the concerns regarding medical debt in underwriting decisions.

I urge the CFPB, as a first step, to refrain from implementing the Proposal until there is comprehensive research studying the impact of recent changes announced by the Consumer Reporting Agencies (CRAs) to require a one year waiting period before a medical debt can be credit reported; raising the minimum account balance to $500; and the deletion of paid in full medical accounts from the consumer's report. These changes, in addition to the heightened notice requirements under Regulation F[5], and the implementation of the No Surprise Billing Act have marked a major shift in the marketplace and those changes have not, been considered in the underlying reasoning that the CFPB has pursued this rule.

II. The Proposal Would Have Deleterious Effects on Consumers, Markets, Small Businesses, and the Entire Credit and Debt Collection Industry

The Proposal will have significant negative impacts and will violate existing law:

- Even for medical providers and collection agencies that do not credit report, we have data which highlights that the "message behind the message" that you do not have to pay medical debt, has already harmed providers and their collection agency partners. This will lead to a variety of consequences including the need for more cash-upfront payments and an increase in medical providers turning directly to litigation to seek to recover payment. The economic analysis showing this, and anecdotal support will be provided in comments.

- The Affordable Care Act requires that nonprofit hospitals establish "charity care" for patients unable to cover their expenses. IRS Regulation 501(r) already addresses extraordinary collection activities. For providers in many states, ACA

[5] 85 FR 76887, Nov. 30, 2020.

International members have seen the threshold at 200% or 300% of the Federal Poverty Level as the starting point before any copays or deductibles need to be paid to a non-profit provider. Since there are already many programs and laws in place to help consumers that truly cannot afford medical debt, the CFPB's efforts are more likely to encourage people that can pay their debt not to address it. This may not benefit them since hospitals or medical providers can take legal action, or in the case of non-emergency care, not provide care.

- Medical providers and their third-party collection agency partners will need to consider changes to their collection practices for unpaid medical care including litigation, denial of care, or pulling out of a market all together. If the CFPB removes the incentive to maintain good credit, consumers will have no reason to pay their medical bills, which will force stakeholders to turn to other remedies sooner and more often. This will lead to more costs for consumers as a whole to absorb the highs costs associated with litigation, increased costs for small businesses, and a loss of privacy for consumers when their medical debts become part of the public legal record.

- By the CFPB's own admission, medical debt information is less predictive, not "not predictive". Thus, underwriters will have less information to make credit determinations if the CFPB moves forward with its goal to remove all medical debt from credit reports, and credit will be extended in situations when consumers do not have the ability to repay. As such, the host of negative consequences that the CFPB itself has outlined in its ability to repay test in mortgage, and other rules when creditors do not have accurate information will come into play. Similar to the factors of the 2008 financial crisis, which led to the creation of the CFPB, lenders will be operating with blind spots and overlooking debt and legal obligations for consumers who are seeking credit.

- The data analysis supporting the Proposal has serious methodological defects and did not consider data that reflects the current state of the industry or the critical economic impacts of medical debt reporting.

- The Proposal will create overly burdensome costs to small businesses, which will likely result in the reduction of consumer choice, increased upfront costs and costs overall, and less access for patients to lifesaving care services. This proposal will increase the cost and availability of credit for ACA members, as well as their medical provider clients, since this fundamentally changes the law and will make it harder to collect payment for medical bills. Stymieing collections and changing the credit reporting process, will hurt both clients and their third-party collection agencies' bottom lines.

- The Proposal fails to consider, and has done no research, on less expensive alternatives that avoid the significant constitutional problems and reduce monetary impacts on small businesses, and consumers, and governments, such as implementing a waiting period before a medical debt can be reported; allow for

deletion of paid medical debt; review marketplace responses to the issue including the vantage score model that reduces the weight of a medical debt on the consumer's score.

III. By Attempting to Regulate in the Field of Healthcare and Associated Medical Transactions, the CFPB Exceeds its Statutory Authority

To find a solution to the affordability of healthcare, all parties need to be a part of the solution including providers, payors (insurance companies), and patient advocates. The CFPB has no authority of the healthcare nor the insurance industry and therefore is contorting the provisions of the Fair Credit Reporting Act to achieve a desired outcome without having any care of the impact this will have on our healthcare system.

The CFPB does not have the authority, expertise, or proper tools to regulate the healthcare and insurance industries and cannot do so through Regulation V. When Congress passed the FCRA, it did so with a narrow and explicit prerogative: to promote fair and accurate credit reporting.[6] It did not intend for the Act to be used to regulate the non-financial products and services simply because they are purchased on credit.

Financial services and products play a very limited role in the healthcare and medical services industries and the CFPB has a correspondingly limited authority to regulate or make policies in those fields. In fact, the CFPB has already acknowledged that it lacks authority to regulate within the medical industry by specifically *excluding* medical debt from its definition of "large market" participants in the consumer debt collection market.[7] 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."[8]

Similarly, and as further detailed below, in many of its public statements, the CFPB takes aim at complex insurance coverage related to healthcare. It is true insurance coverage is a nuanced and complicated process. That is why there are certain Congressional Committees and agencies such as the U.S. Departments of Health and Human Services ("HHS"),[9] Labor ("DOL"),[10] and the Treasury,[11] that are tasked with creating laws and regulations surrounding insurance.[12] In fact, Congress recently passed the No Surprises Act to address some of these issues.[13] Unfortunately, the "research" and data that the CFPB cites for its interest in this issue

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[6] *See e.g.*, 3 Fair Credit Reporting Bill, 115 Cong. Rec. S2410-11 (daily ed. Jan. 31, 1969) ("Credit reporting agencies are absolutely essential in today's credit economy. . .my objective in introducing the fair credit reporting bill is to correct certain abuses which have occurred within the industry and to insure that the credit information system is responsive to the needs of consumers as well as creditors.").
[7] 12 C.F.R. § 1090.105.
[8] 77 FR 9597.
[9] 42 U.S.C. § 3501 *et. seq*.
[10] 29 U.S.C. § 551 *et seq*.
[11] 31 U.S.C. § 301 *et. seq*.
[12] *See e.g.*, 26 U.S.C. §§ 9801–9834 (regulating group health plans and assigning enforcement and regulation to the IRS); 42 U.S.C. § 300gg (regulating insurance requirements including limiting cost-sharing and assigning enforcement and regulation to HHS); 42 U.S.C. 1320f (directing HHS to establish a Drug Price Negotiation Program).
[13] Pub.L. 116–260, the Consolidated Appropriations Act of 2021.

was collected years before this sweeping law that already addresses many of the issues the CFPB raises about the healthcare system.

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 purpose of the FCRA, which is narrow and entirely unrelated to healthcare policy or insurance issues. The FCRA's stated purpose is to support the needs of commerce by providing fair and accurate credit information. Manipulation of what consumer information can appear on a credit report based on external policy considerations is directly contrary to that purpose and exceed 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 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.

The FCRA does not authorize the CFPB to prevent the reporting of accurate information about credit and doing so defies the FCRA's stated purpose.

The very first line of the FCRA is a congressional finding that "the banking system is dependent upon fair and accurate credit reporting."[14] "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 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 contemplates 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 the risk associated in lending to a particular individual. Ability to pay, amount of 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 prevents 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. . . and proper utilization of such information."[15]. 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.

[14] 15 USC §1681(a)(1).
[15] 15 USC §1681(b)

The CFPB twists language in the statute and incorrectly states that Congress, "has raised concerns with the presence of medical debt information on credit reports."[16] In fact, the CFPB incorrectly added the term "debt" and "debt collection" to a statutory provision that states, "medical information." Here the CFPB is literally rewriting the statute to try to concoct a twisted argument about medical debt credit reporting, which is clearly not backed by the legislative history or Congressional intent.

Fair and Accurate Credit Reporting

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 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 has. 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, or 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 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 per month, 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 Proposal, 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 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 is due to having inaccurate and incomplete information.

Rulemaking authority about medical payment and cost 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 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. As mentioned above, the recently passed No

[16] Rulemaking Outline at 18.

Surprises Act aims to reduce burdens by helping consumers understand healthcare costs in advance of care to minimize unforeseen medical bills. The No Surprises Act delegated interpretive and rulemaking authority to the HHS, DOL, and the Treasury.[17]

Congress, through its work in 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) it in no place in the legislation discusses debt collection, so did not identify that market as part of the problem;[18] and (3) it identified certain agencies to address these issues and specifically did not include the CFPB. Unless and until Congress acts, nothing changes their directives on these issues.

The Affordable Care Act,[19] which contains comprehensive legislations aimed to reduce the cost of healthcare, streamline insurance claims, and increase access to quality medical care delegates rulemaking authority primarily to the Department of Health and Human Services, but also to several other federal agencies, yet does not delegate any regulatory authority to the CFPB.[20] 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.[21] 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.

Thank you for the opportunity to allow me to participate in this process and share my experiences on these issues.

Best Regards,

Jack Brown III

Jack W. Brown III, President
Gulf Coast Revenue Cycle Management

[17] *See* 87 FR 52618 (final rules implementing the No Surprises Act issued by the Internal Revenue Service, the Employee Benefits Security Administration, and the Health and Human Services Department).
[18] *See generally*, Pub.L. 116–260, the Consolidated Appropriations Act of 2021. The text of the Act focuses on front-end billing and not collections.
[19] Pub. L. 111-148 (2010)
[20] *See generally*, *Id*.
[21] *See* Pub. L. 111-148 § 9007.