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CONSUMER FINANCIAL PROTECTION BUREAU

12 CFR Part 1022

[Docket No. CFPB-2024-0023]

RIN 3170-AA54

Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information (Regulation V)

AGENCY: Consumer Financial Protection Bureau.

ACTION: Final rule.

SUMMARY: The Consumer Financial Protection Bureau (CFPB) is issuing a final rule amending Regulation V, which implements the Fair Credit Reporting Act (FCRA), concerning medical information. The FCRA prohibits creditors from considering medical information in credit eligibility determinations. The CFPB is removing a regulatory exception that had permitted creditors to obtain and use information on medical debts notwithstanding this statutory limitation. The final rule also provides that a consumer reporting agency generally may not furnish to a creditor a consumer report containing information on medical debt that the creditor is prohibited from using.

DATES: This final rule is effective **[INSERT DATE 60 DAYS AFTER DATE OF PUBLICATION IN THE *FEDERAL REGISTER*]**.

FOR FURTHER INFORMATION CONTACT: George Karithanom, Regulatory Implementation & Guidance Program Analyst, Office of Regulations, at 202-435-7700 or *https://reginquiries.consumerfinance.gov/*. If you require this document in an alternative electronic format, please contact *CFPB_Accessibility@cfpb.gov*.

SUPPLEMENTARY INFORMATION:

I. Overview

A. Summary of the Final Rule

Information about a person's medical history and health is sacrosanct and among the most intimate and sensitive categories of data. Recognizing the uniquely sensitive nature of such information, Congress acted to limit the use and sharing of medical information in the financial system by amending the Fair Credit Reporting Act (FCRA) through the Fair and Accurate Credit Transactions Act of 2003 (FACT Act).[1] In doing so, Congress "establish[ed] strong privacy protections for consumers' sensitive medical information,"[2] in line with the overarching privacy protection purpose of the FCRA.[3] As part of these protections, Congress generally limited a creditor's ability to obtain or use a consumer's medical information in connection with any determination of the consumer's eligibility, or continued eligibility, for credit (creditor prohibition), subject to certain exceptions.[4] One of these exceptions required the Federal financial banking agencies and the National Credit Union Administration (Agencies) to prescribe regulations that permit transactions that are determined to be necessary and appropriate to protect legitimate operational, transactional, risk, consumer, and other needs (including administrative verification purposes), consistent with congressional intent to restrict the use of medical information for inappropriate purposes.[5]

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[1] Fair and Accurate Credit Transactions Act of 2003 (FACT Act), Pub. L. 108-159, 117 Stat. 1952, 1999 (2003).

[2] 149 Cong. Rec. H8122-02, H8122 (daily ed. Sept. 10, 2003) (statement of Rep. Kanjorsky).

[3] 15 U.S.C. 1681 e*t seq.*, 1681(a)(4).

[4] 15 U.S.C. 1681b(g)(2).

[5] 15 U.S.C. 1681b(g)(5).

In 2005, the Agencies issued a regulatory exception (financial information exception) to this statutory prohibition, permitting consumers' medical financial information to be obtained and used by creditors in connection with credit eligibility determinations if certain conditions were met.[6] Since the financial information exception was created, a number of concerns have been raised about whether a regulatory exception that permits creditors to consider sensitive medical information about a consumer's debts and certain other types of medical information is necessary and appropriate to protect legitimate operational, transactional, risk, consumer, and other needs, and consistent with the congressional intent to restrict the use of medical information for inappropriate purposes.

First, when the Agencies issued the financial information exception to the statutory prohibition, they did so without providing evidence or reasoning to support their main conclusion that an exception from a congressionally created legal requirement was warranted.

Second, research has shown that medical debt has limited predictive value in predicting future default for credit underwriting purposes. Questions about the reliability of information about medical debt, as compared to information about other types of consumer debt, have been raised based on research performed by the CFPB and others.[7] Medical debt may be less predictive of whether a consumer will pay a future loan, because medical debts can occur and are collected through unique circumstances and practices. For example, consumers often have limited ability to control the timing and types of medical services that are required.

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[6] 70 FR 70664 (Nov. 22, 2005).

[7] *See, e.g.*, Kenneth P. Brevoort & 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. *See also* Mark Rukavina, *Medical Debt and Its Relevance When Assessing Creditworthiness*, 46 Suffolk U. L. Rev. 967 (2013), https://bpb-us-e1.wpmucdn.com/sites.suffolk.edu/dist/3/1172/files/2014/01/Rukavina_Lead.pdf.

Third, market participants, including in the consumer reporting industry and those most financially incentivized to assess the predictive value of medical debt, have reduced their reliance on medical debt in recognition of its limited utility. Consumer reporting agencies have removed certain medical debts from consumer reports.[8] Major credit scoring companies have accorded less weight to, or excluded entirely, medical debt information in their newer scoring models.[9] Similarly, some creditors have adjusted how their underwriting standards treat medical debt information.[10]

Key Changes

Given the developments over the past decade in its understanding of how consumer medical debt differs from other types of consumer debt and its uses in credit underwriting, the CFPB, now with primary regulatory authority over the FCRA, is updating the non-statutory exceptions in Regulation V to ensure the use of medical information is consistent with the

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[8] *See, e.g.*, Bus. Wire, *Equifax, Experian, and TransUnion Support U.S. Consumers With Changes to Medical Collection Debt Reporting* (Mar. 18, 2022), https://www.businesswire.com/news/home/20220318005244/en/Equifax-Experian-and-TransUnion-Support-U.S.-Consumers-With-Changes-to-Medical-Collection-Debt-Reporting.

[9] *See* AnnaMaria Andriotis, *Major Credit-Score Provider to Exclude Medical Debts*, Wall St. J. (Aug. 10, 2022), https://www.wsj.com/articles/major-credit-score-provider-to-exclude-medical-debts-11660102729 (VantageScore CEO quoted as saying that having medical debt is not necessarily reflective of a consumer's ability to pay back a loan); Ethan Dornhelm, *The Impact of Medical Debt on FICO Scores*, FICO Blog (July 13, 2015), https://www.fico.com/blogs/impact-medical-debt-ficor-scores.

[10] *See, e.g.*, Fed. Nat'l Mortg. Ass'n, *Single Family Selling Guide*, B3-2-03 (2021), https://selling-guide.fanniemae.com/#Public.20Records.2C.20Foreclosures.2C.20and.20Collection.20Accounts (noting that "[c]ollection accounts reported as medical collections are not used in the DU [Desk Underwriter] risk assessment"); Fed. Home Loan Mortg. Corp., *The Single-Family Seller/Servicer Guide*, 5201.1 (2022), https://guide.freddiemac.com/app/guide/section/5201.1; U.S. Dep't of Hous. & Urban Dev., *Single Family Housing Policy Handbook*, 4000.1 (2021), https://www.hud.gov/sites/dfiles/OCHCO/documents/4000.1hsgh-112021.pdf. *See also* The White House, *Fact Sheet: The Biden Administration Announces New Actions to Lessen the Burden of Medical Debt and Increase Consumer Protection* (Apr. 11, 2022), 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/ (announcing changes to certain Federal government underwriting standards to remove medical debt from evaluations of whether a consumer will repay a loan, including those for the U.S. Department of Agriculture's rural housing service loans and the Small Business Administration's loan programs and the Federal Housing Finance Authority's review of credit models).

congressional intent to safeguard consumers' privacy and restrict the use of medical information for inappropriate purposes. To do so, the CFPB is finalizing changes to how creditors and consumer reporting agencies treat medical information concerning a consumer's medical debt in §§ 1022.3, 1022.30, and 1022.38, as outlined below and discussed in further detail in part IV, *Discussion of the Final Rule*.

These amendments apply to any person that participates as a creditor in a transaction, except for a person excluded from coverage by section 1029 of the Consumer Financial Protection Act of 2010 (CFPA)[11] (*i.e.*, certain auto dealers). According to existing Regulation V, the term "creditor" has the same meaning as in section 702 of the Equal Credit Opportunity Act (ECOA).[12] The amendments also apply to a consumer reporting agency as defined in section 603(f) of the FCRA.[13]

Removal of the Financial Information Exception

Under this final rule, a creditor will no longer be able to consider medical information related to a consumer's medical debt in connection with any determination of the consumer's eligibility, or continued eligibility, for credit, unless one of the specific exceptions in final § 1022.30(e) applies. Specifically, the CFPB is finalizing its interpretation as set forth in the proposed rule that for information about a consumer's debt to be "medical information" under

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[11] Pub. L. 111-203, 124 Stat. 1955, 2004 (2010).

[12] 12 CFR 1022.30(b)(2)(ii); *see also* 15 U.S.C. 1681a(r)(5). ECOA is codified at 15 U.S.C. 1691 *et seq.*; ECOA section 702 is codified at 15 U.S.C. 1691a(e). The term creditor means any person who regularly extends, renews, or continues credit; any person who regularly arranges for the extension, renewal, or continuation of credit; or any assignee of an original creditor who participates in the decision to extend, renew, or continue credit.

[13] 15 U.S.C. 1681a(f). The term consumer reporting agency means any person which, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties, and which uses any means or facility of interstate commerce for the purpose of preparing or furnishing consumer reports.

FCRA section 603(i), the information must relate to a debt the consumer owes, or at one time owed, directly to a health care provider or to the health care provider's agent or assignee for the provision of the health care underlying the payment obligation.

As discussed in further detail in part IV.B.1, *Medical Information Related to Debts*, the CFPB finalizes its definition of medical debt information in final § 1022.3(j), as medical information that pertains to a debt owed by a consumer to a person whose primary business is providing medical services, products, or devices (also referred to herein as a health care provider), or to the person's agent or assignee, for the provision of such medical services, products, or devices. The definition also provides that medical debt information includes, but is not limited to, medical bills that are not past due or that have been paid.

The CFPB is removing the financial information exception to the creditor prohibition in current § 1022.30(d). This non-statutory exception provides that a creditor may generally obtain and use medical information pertaining to a consumer in connection with any determination of the consumer's eligibility, or continued eligibility, for credit subject to certain exceptions. With respect to information concerning a consumer's medical debts, the CFPB has concluded that it generally is neither "necessary and appropriate to protect legitimate operational, transactional, risk, consumer, and other needs," nor consistent with Congress's intent "to restrict the use of medical information for inappropriate purposes," for creditors to consider such sensitive financial information in underwriting. Because of the CFPB's elimination of the financial information exception, the FCRA will return to its original restrictions on creditors considering, in connection with credit eligibility determinations, certain medical information related to consumers' medical debts.

The final rule is also removing the financial information exception for expenses, assets, and collateral and related examples at current § 1022.30(d). As discussed in more detail in part IV.B.2, *Medical Information Related to Expenses, Assets, and Collateral*, the CFPB has determined that the financial information exception for a creditor to consider medical information relating to a consumer's expenses, assets, and collateral is also not warranted to protect legitimate operational, transactional, risk, or consumer needs and is not consistent with the intent of the creditor prohibition to restrict the use of medical information for inappropriate purposes as required under FCRA section 604(g)(5).

As discussed in more detail in part IV.B.3, *Medical Information Related to Income, Benefits, or the Purpose of the Loan*, the CFPB is retaining certain elements of the financial information exception related to income, benefits, and the purpose of the loan in current § 1022.30(d) by moving relevant provisions to the list of specific exceptions to the creditor prohibition at § 1022.30(e)(1)(x), with technical edits for renumbering, and is finalizing proposed § 1022.30(e)(7) (Example 7) which is an example that illustrates a use of medical information related to long-term disability income.

This final rule is also modifying the text of proposed § 1022.30(e)(1)(x)(A) to add a new provision at final § 1022.30(e)(1)(x)(A)(*1*), as to medical information included in the transaction information of an account for a consumer financial product or service described in 12 CFR 1033.111(b)(1) through (3), and accessed with the consumer's authorization. As discussed in more detail in part VI.A, *Consumer-Authorized Transaction History*, the CFPB has determined that including medical information included in the transaction history of a consumer's account in this exception is necessary and appropriate to protect legitimate operational, transactional, risk, consumer, and other needs, including permitting actions necessary for administrative verification

purposes, consistent with FCRA's intent to restrict the use of medical information for inappropriate purposes.

Limits on a Consumer Reporting Agency's Disclosure of Medical Debt Information

Under the final rule, new § 1022.38 to subpart D addresses how a consumer reporting agency's medical debt information reporting responsibilities are impacted when creditors are prohibited from obtaining or using medical debt information. As discussed in more detail in part IV.C, *Limits on a Consumer Reporting Agency's Disclosure of Medical Debt Information*, final § 1022.38 provides that a consumer reporting agency is permitted to include medical debt information in a consumer report furnished to a creditor for credit eligibility purposes only if the following criteria are met: (1) the consumer reporting agency has reason to believe the creditor intends to use the medical debt information in a manner not prohibited by § 1022.30; and (2) the consumer reporting agency has reason to believe the creditor is not otherwise legally prohibited from obtaining or using the medical debt information, including by a State law that prohibits a creditor from obtaining or using medical debt information. The CFPB has determined that a creditor who is prohibited from obtaining or using medical debt information does not have a permissible purpose for a consumer report containing medical debt information. The CFPB has also determined that limiting the circumstances under which consumer reporting agencies may furnish medical debt information is necessary or appropriate to administer and carry out the purposes and objectives of the FCRA to protect consumers' privacy, and to prevent evasions or to facilitate compliance.

Example to Comply With Applicable Requirements of Local, State, or Federal Laws

The CFPB is finalizing a specific example for obtaining and using medical information as proposed in new § 1022.30(e)(6) (Example 6) concerning the ability-to-repay or pay requirements in Regulation Z with respect to mortgages and credit card accounts, with one

clarification as discussed below. The CFPB has determined that Example 6 does not conflict with the ability-to-repay or pay requirements in Regulation Z and provides sufficient information for how creditors may comply with both the ability-to-repay or pay requirements in Regulation Z and the changes in this final rule with respect to use of medical information. The CFPB has determined it would not be necessary or appropriate to protect legitimate operational, transactional, risk, consumer, and other needs, including permitting actions necessary for administrative verification purposes, nor consistent with Congress's intent to restrict the use of medical information for inappropriate purposes, for a creditor or card issuer under § 1022.30(e)(1)(ii) to use medical information contained in a consumer report in order to comply with the applicable laws because a creditor or card issuer can comply with the applicable laws using the information provided by the consumer, including any medical information received from the consumer on the application in response to a general inquiry about debts or obligations.

The final rule revises Example 6 from the proposal, however, to make clear that this example only relates to the exception under § 1022.30(e)(1)(ii), and a creditor or card issuer may obtain and use medical information for purposes of Regulation Z's ability-to-repay or pay determinations pursuant to other exceptions in § 1022.30(e), as applicable. With respect to the ability-to-repay requirements in Regulation Z § 1026.43(c), final Example 6 also contains additional information on the interplay between the ability-to-repay requirement in Regulation Z § 1026.43(c) and final § 1022.30(e)(1)(ii).

Effective Date

The final rule will take effect sixty days after the date the rule is published in the *Federal Register*.

B. Market Background

Unique Characteristics of Medical Debt in the United States

A significant number of Americans have medical debt.[14] According to one nationally representative survey, in 2022 around 41 percent of adults stated that they had some kind of medical debt, including debt that they were unable to pay, that was on credit cards, that was being paid over time, directly to a provider, or that they owed to family members, or to a bank, collection agency, or other lender.[15]

Several characteristics of medical debt pose special risks to consumers and distinguish it from other types of debt.[16] The need for medical care can be unexpected,[17] and medical debt often results from bills for a one-time or short-term medical expense due to an unforeseen event such as an accident or sudden illness.[18] Consumers are rarely informed of the costs of medical

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[14] For more information about medical debt in the United States, including population disparities, impacts on consumers, and COVID-19 impacts, *see* Consumer Fin. Prot. Bureau, *Medical Debt Burden in the United States* (Feb. 2022), https://files.consumerfinance.gov/f/documents/cfpb_medical-debt-burden-in-the-united-states_report_2022-03.pdf.

[15] Lunna Lopes et al., Kaiser Fam. Found., *Health Care Debt In The U.S.: The Broad Consequences Of Medical And Dental Bills* (June 16, 2022), https://www.kff.org/report-section/kff-health-care-debt-survey-main-findings/ (reporting results of 2022 Kaiser Family Foundation Health Care Debt Survey, which polled 2,375 adults).

[16] *See generally* Consumer Fin. Prot. Bureau, *Bulletin 2022–01: Medical Debt Collection and Consumer Reporting Requirements in Connection with the No Surprises Act*, 87 FR 3025 (Jan. 20, 2022), https://www.govinfo.gov/content/pkg/FR-2022-01-20/pdf/2022-01012.pdf; Consumer Fin. Prot. Bureau, *Consumer credit reports: A study of medical and non-medical collections*, at 15-16, 38-42 (Dec. 2014), https://files.consumerfinance.gov/f/201412_cfpb_reports_consumer-credit-medical-and-non-medical-collections.pdf.

[17] *See* Consumer Fin. Prot. Bureau, *Complaint Bulletin: Medical billing and collection issues described in consumer complaints*, at 7 (Apr. 2022), https://files.consumerfinance.gov/f/documents/cfpb_complaint-bulletin-medical-billing_report_2022-04.pdf (describing consumer complaints received by the CFPB about unexpected medical care).

[18] *See* Lunna Lopes et al., Kaiser Fam. Found., *Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills* (June 16, 2022), https://www.kff.org/report-section/kff-health-care-debt-survey-main-findings/ (reporting survey results that 7 in 10 adults with health care debt say the debt arose from bills for a one-time or short-term medical expense). *But see* Sara R. Collins et al., Commonwealth Fund, *Paying for It: How Health Care Costs and Medical Debt Are Making Americans Sicker and Poorer—Findings from the Commonwealth Fund 2023 Health Care Affordability Survey* (Oct. 2023), https://www.commonwealthfund.org/publications/surveys/2023/oct/paying-for-it-costs-debt-americans-sicker-poorer-2023-affordability-survey (about half of adults with medical debt say it is from treatment received for an ongoing condition).

treatment in advance, and because of price opacity and an often immediate need for medical care, consumers have little or no ability to "shop around."[19] Americans that live in rural communities may also experience limited choices when trying to access health care,[20] which may impact the amount of their medical debt in ways that are not reflective of their other debts.

There are significant concerns with the accuracy of medical bills. For example, 43 percent of all adults and 53 percent of adults with medical debt in a nationally representative survey believed they had received a medical or dental bill that included an error.[21] While the survey found that most of these adults had taken some action to dispute the mistake, 51 percent reported that they either did not dispute the bill or were unable to successfully resolve their dispute. This may be because medical billing and collections can be complicated and confusing since a consumer may have difficulty determining whether the amount is covered by insurance or a hospital's financial assistance program (if applicable) and, if so, whether and to what extent the

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[19] Consumer Fin. Prot. Bureau, *Bulletin 2022–01: Medical Debt Collection and Consumer Reporting Requirements in Connection with the No Surprises Act*, 87 FR 3025 (Jan. 20, 2022), https://www.govinfo.gov/content/pkg/FR-2022-01-20/pdf/2022-01012.pdf. *See also* Consumer Fin. Prot. Bureau, *Complaint Bulletin: Medical billing and collection issues described in consumer complaints*, at 7-8 (Apr. 20, 2022), https://www.consumerfinance.gov/data-research/research-reports/complaint-bulletin-medical-billing-and-collection-issues-described-in-consumer-complaints/ (detailing consumer complaints received by the CFPB).

[20] *See, e.g.*, U.S. Gov't Acct. Off., *Health Care Capsule: Accessing Health Care in Rural America* (May 2023), https://www.gao.gov/assets/gao-23-106651.pdf (generally describing health care access challenges for rural populations).

[21] *See, e.g.*, Karen Pollitz & Kaye Pestaina, Kaiser Fam. Found., *Could Consumer Assistance Be Helpful to People Facing Medical Debt?* (July 14, 2022), https://www.kff.org/policy-watch/could-consumer-assistance-be-helpful-to-people-facing-medical-debt/ (analyzing results of 2022 Kaiser Family Foundation Health Care Debt Survey).

amount was already paid or reduced.[22] Also some health care providers and debt collectors exploit these complications and charge inflated or unearned bills.[23]

Medical Debt and Consumer Reporting

Information about medical debt is used in different ways in the financial system. Consumer reporting agencies play a key role in assembling and evaluating consumer credit and other information on consumers[24]—including information about a consumer's medical debt—and in providing consumer reports to other companies for employment, housing, insurance, and other decisions.[25] Medical debt information on a consumer report can increase the cost and reduce the availability of credit, and can even reduce access to employment and housing.[26]

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[22] *See, e.g.*, Consumer Fin. Prot. Bureau, *Medical Debt Burden in the United States*, at 9-14 (Feb. 2022), https://files.consumerfinance.gov/f/documents/cfpb_medical-debt-burden-in-the-united-states_report_2022-03.pdf (describing issues with medical billing and collections practices); Consumer Fin. Prot. Bureau, *Complaint Bulletin: Medical billing and collection issues described in consumer complaints* (Apr. 2022), https://files.consumerfinance.gov/f/documents/cfpb_complaint-bulletin-medical-billing_report_2022-04.pdf.

[23] Press Release, U.S. Dep't of Just., *Hospital Chain Will Pay Over $260 Million to Resolve False Billing and Kickback Allegations; One Subsidiary Agrees to Plead Guilty* (Sept. 25, 2018), https://www.justice.gov/opa/pr/hospital-chain-will-pay-over-260-million-resolve-false-billing-and-kickback-allegations-one; Press Release, U.S. Atty's Off. for C.D. Cal., *Prime Healthcare Services and its CEO Agree to Pay $65 Million to Settle Medicare Overbilling Allegations at 14 California Hospitals* (Aug. 3, 2018), https://www.justice.gov/usao-cdca/pr/prime-healthcare-services-and-its-ceo-agree-pay-65-million-settle-medicare-overbilling; Press Release, Off. of Pub. Affairs, U.S. Dep't of Just., *Clinical Laboratory and Its Owner Agree to Pay an Additional $5.7 Million to Resolve Outstanding Judgement for Billing Medicare for Inflated Mileage-Based Lab Technician Travel Allowance Fees* (Aug. 1, 2023), https://www.justice.gov/opa/pr/clinical-laboratory-and-its-owner-agree-pay-additional-57-million-resolve-outstanding; Press Release, Off. of Pub. Affairs, U.S. Dep't of Just., *Physician Partners of America to Pay $24.5 Million to Settle Allegations of Unnecessary Testing, Improper Remuneration to Physicians and a False Statement in Connection with COVID-19 Relief Funds* (Apr. 12, 2022), https://www.justice.gov/opa/pr/physician-partners-america-pay-245-million-settle-allegations-unnecessary-testing-improper; Erica Zucco, *Providence will refund medical bills for thousands of patients after agreement with attorney general*, King 5 News (Feb. 1, 2024), https://www.king5.com/article/news/health/providence-forgive-137-million-medical-payments-refund-20m-patients-after-agreement/281-3063dd66-ab54-413a-893a-73463f213a5b; Off. of the Att'y Gen. of Va., *Common Health Care Fraud Schemes*, https://www.oag.state.va.us/contact-us/frequently-asked-questions?id=511 (last visited Dec. 2, 2024).

[24] *See* 15 U.S.C. 1681(a)(3).

[25] *See* Consumer Fin. Prot. Bureau, *Medical Debt Burden in the United States*, at 26 n.117 (Feb. 2022), https://files.consumerfinance.gov/f/documents/cfpb_medical-debt-burden-in-the-united-states_report_2022-03.pdf.

[26] *See* Consumer Fin. Prot. Bureau, *Data Point: Consumer Credit and the Removal of Medical Collections from Credit Reports*, at 2 (Apr. 2023), https://files.consumerfinance.gov/f/documents/cfpb_consumer-credit-removal-medical-collections-from-credit-reports_2023-04.pdf.

Generally, information about a medical debt on a consumer report appears as a collection tradeline. After a medical debt has been placed by the creditor in collections status because the debt has been unpaid for a period of time, the medical debt may be furnished as a collections tradeline to consumer reporting agencies by a debt collector, including a debt collector who collects on behalf of the original creditor for a fee, as well as a debt collector who purchases overdue accounts outright from the original creditor (also known as a debt buyer).[27] Such tradelines are referred to as medical collections or medical collections tradelines. Research by the CFPB has found that nearly all medical collections furnishing is performed by debt collectors, rather than by health care providers (as original creditors) themselves.[28] However, a debt collector may have limited access to an original creditor's system of records, which may contribute to higher dispute rates for collections tradelines compared to other components of consumer reports.[29] When debt collectors furnish to consumer reporting agencies, they generally report to one or more of the three largest nationwide consumer reporting agencies (NCRAs). Debt collections tradelines may persist on consumer reports for up to seven years;[30] however, many collections tradelines are removed well in advance of seven years.[31]

Historically, medical debts have been the most common type of debt on consumer reports at both the consumer-report and individual collections tradeline level. The CFPB estimated that

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[27] Payments made to medical balances not yet sent to collections generally are not furnished to consumer reporting agencies.

[28] Consumer Fin. Prot. Bureau, *Market Snapshot: An Update on Third Party Debt Collections Tradelines Reporting*, at 5 (Feb. 2023), https://files.consumerfinance.gov/f/documents/cfpb_market-snapshot-third-party-debt-collections-tradelines-reporting_2023-02.pdf.

[29] *Id.*

[30] 15 U.S.C. 1681c(a)(4).

[31] Consumer Fin. Prot. Bureau, *Consumer credit reports: A study of medical and non-medical collections*, at 27 (Dec. 2014), https://files.consumerfinance.gov/f/201412_cfpb_reports_consumer-credit-medical-and-non-medical-collections.pdf.

medical collections accounted for 57 percent of all collections tradelines in Q1 2022 and 58 percent in Q2 2018.[32] When debt collectors acting as agents or assignees of health care providers furnish information about medical collections, they must notify the consumer reporting agency that they are furnishing medical information.[33] The FCRA generally prohibits consumer reporting agencies from reporting to third parties the name, address, and telephone number of the health care provider for any account identified as from a medical information furnisher that has notified the consumer reporting agency of its status, unless that information is restricted or coded such that persons other than the consumer cannot identify or infer the specific provider or the nature of the medical services provided.[34] Nevertheless, despite the coding of information on the consumer reports, a consumer report user could infer from the coding that certain debts relate to the provision of health care. Like with medical bills, consumers often find errors with medical collections tradeline information on their consumer reports. A CFPB analysis found that almost 6 percent of medical collections in its data were flagged as having been disputed at some point, almost three times higher than the rate of dispute flags on credit cards and seven times the rate of dispute flags on student loans.[35]

A 2022 review of consumer complaints submitted to the CFPB found that many consumers complaining of disputed debt collection attempts reported first learning of the debt

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[32] Consumer Fin. Prot. Bureau, *Market Snapshot: An Update on Third Party Debt Collections Tradelines Reporting*, at 16-17 (Feb. 2023), https://files.consumerfinance.gov/f/documents/cfpb_market-snapshot-third-party-debt-collections-tradelines-reporting_2023-02.pdf.

[33] *See* 15 U.S.C. 1681s-2(a)(9).

[34] 15 U.S.C. 1681c(a)(6); *see* 15 U.S.C. 1681s-2(a)(9) (requiring medical information furnishers to notify consumer reporting agencies of such status).

[35] Consumer Fin. Prot. Bureau, *Paid and Low-Balance Medical Collections on Consumer Credit Reports* (July 27, 2022), https://www.consumerfinance.gov/data-research/research-reports/paid-and-low-balance-medical-collections-on-consumer-credit-reports/.

from viewing their consumer report. Consumers expressed concern with inaccurate information leading to a decrease in their credit score. Some consumers reported paying debt they did not believe they owed in order to have the tradeline removed from their consumer report.[36] A 2024 review of consumer complaints found that consumers complain that debt collectors continue to collect on and report medical bills to credit reporting agencies even after the consumer has shown that they do not owe the amount.[37]

Some of the errors in medical collections tradelines could be due to debt collection furnishing practices. Some medical debt collectors previously used debt collection furnishing to engage in a practice known as "debt parking," or "passive collection." Debt collectors would report a debt to a consumer reporting agency, then wait for the consumer to notice the tradeline when, for example, applying for credit. The consumer may then pay the debt, possibly without raising any dispute as to any errors in order to access needed credit. The CFPB issued final rules on debt collection, which took effect November 30, 2021, that addressed this practice by requiring a debt collector to take certain actions intended to convey information about the debt to the consumer before furnishing information on that debt to a consumer reporting agency.[38] Despite the protections offered by these rules, CFPB investigations indicate that some medical

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[36] Consumer Fin. Prot. Bureau, *Complaint Bulletin: Medical billing and collection issues described in consumer complaints* (Apr. 2022), https://files.consumerfinance.gov/f/documents/cfpb_complaint-bulletin-medical-billing_report_2022-04.pdf.

[37] Consumer Fin. Prot. Bureau, *Fair Debt Collection Practices Act: CFPB Annual Report 2024* (Sept. 2024), https://files.consumerfinance.gov/f/documents/cfpb_fdcpa-2024-annual-report_2024-09.pdf.

[38] *See* 12 CFR 1006.30(a).

debt collectors may still be attempting to collect on medical debts that were not substantiated after consumers disputed the validity of the debts.[39]

Recent reporting changes announced by the NCRAs in 2022 and 2023 have begun to reduce the amount of medical debt reported on consumer reports and benefit some consumers. Specifically, the NCRAs announced that, starting on July 1, 2022, unpaid medical collections will not appear on a consumer's report for up to one year (an increase from 180 days), and paid medical collections will no longer be on consumer reports.[40] In April 2023, the NCRAs also announced that medical collections with initial balances below $500 had been removed from consumer reports.[41]

The CFPB conducted an analysis of the impacts of the NCRAs' medical debt reporting changes through June 2023.[42] The CFPB found that after these changes, 15 million Americans still have $49 billion in medical bills on their consumer reports. Because the medical collections

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[39] *See* Consumer Fin. Prot. Bureau, *CFPB Takes Action Against Phoenix Financial Services for Illegal Medical Debt Collection and Credit Reporting Practices* (June 8, 2023), https://www.consumerfinance.gov/about-us/newsroom/cfpb-takes-action-against-phoenix-financial-services-for-illegal-medical-debt-collection-and-credit-reporting-practices/; Consumer Fin. Prot. Bureau, *CFPB Shuts Down Commonwealth Financial Systems for Illegal Debt Collection Practices* (Dec. 15, 2023), https://www.consumerfinance.gov/about-us/newsroom/cfpb-shuts-down-commonwealth-financial-systems-for-illegal-debt-collection-practices/.

[40] Equifax, *First Changes to Reporting of Medical Collection Debt Roll Out July 1, 2022* (July 1, 2022), https://www.equifax.com/newsroom/all-news/-/story/first-changes-to-reporting-of-medical-collection-debt-roll-out-july-1-2022; Experian, *First Changes to Reporting of Medical Collection Debt Roll Out July 1, 2022* (July 1, 2022), https://www.experianplc.com/newsroom/press-releases/2022/first-changes-to-reporting-of-medical-collection-debt-roll-out-july-1-2022; TransUnion, *First Changes to Reporting of Medical Collection Debt Roll Out July 1, 2022* (July 1, 2022), https://newsroom.transunion.com/first-changes-to-reporting-of-medical-collection-debt-roll-out-july-1-2022/.

[41] PR Newswire, *Equifax, Experian and TransUnion Remove Medical Collections Debt Under $500 From U.S. Credit Reports* (Apr. 11, 2023), https://www.prnewswire.com/news-releases/equifax-experian-and-transunion-remove-medical-collections-debt-under-500-from-us-credit-reports-301793769.html.

[42] Ryan Sandler & Zachary Blizard, Consumer Fin. Prot. Bureau, *Recent Changes in Medical Collections on Consumer Credit Records Data Point*, at 3-4, 17 (Mar. 2024), https://files.consumerfinance.gov/f/documents/cfpb_recent-changes-medical-collections-on-consumer-credit-reports_2024-03.pdf.

tradelines removed by the NCRAs were those with low balances, the total dollar balances of medical collections on consumer reports fell by only 38 percent nationwide.

Several States and at least one Federal agency have also enacted policies that limit the inclusion of medical debt on consumer reports.[43] For example, Colorado[44] and New York[45] each passed laws in 2023 prohibiting medical debts from appearing on consumer reports. California, Connecticut, Minnesota, New Jersey, Illinois, and Virginia followed suit earlier this year.[46] Maine, in 2019, passed a law requiring consumer reporting agencies to remove medical debt upon receiving reasonable evidence that the debt has been settled or paid.[47] In 2022, the U.S. Department of Veterans Affairs (VA) finalized a rule providing that the VA will report medical debt to consumer reporting agencies only if all other debt collection efforts have been exhausted, the individual is not catastrophically disabled or entitled to free medical care from the VA, and the outstanding debt is over $25.[48]

Current Use of Medical Debt in Credit Scoring and Underwriting

Collections tradelines are considered negative information and can lower consumers' credit scores. A 2014 CFPB analysis found that the presence of medical collections tradelines on consumer reports is less predictive of future defaults or serious delinquencies than the presence

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[43] In 2022, the CFPB issued an interpretive rule clarifying that because FCRA's express preemption provisions have a narrow and targeted scope, States retain substantial flexibility to pass laws involving consumer reporting to reflect emerging problems affecting their local economies and citizens, including problems related to medical debt. Consumer Fin. Prot. Bureau, *The Fair Credit Reporting Act's Limited Preemption of State Laws*, 87 FR 41042 (July 11, 2022).

[44] Colo. Rev. Stat. section 5-18-109.

[45] N.Y. Pub. Health Law art. 49-A.

[46] 2024 Calif. SB 1061; 2024 Conn. Act 24-6; 2024 Minn. Ch. 332C; 2024 New Jersey A3681; 2024 Ill. Pub. Act 103-0648; 2024 Va. Acts ch. 751.

[47] *Consumer Data Indus. Ass'n v. Frey*, 26 F.4th 1 (1st Cir. 2022), cert. denied, 143 S. Ct. 777 (2023).

[48] U.S. Dep't of Veterans Affairs, *Threshold for Reporting VA Debts to Consumer Reporting Agencies*, 87 FR 5693 (Feb. 2, 2022).

of nonmedical collections tradelines, and that consumers with paid medical debts have delinquency rates well below those of consumers with the same credit scores whose medical debts were mostly unpaid.[49] Following the CFPB's publication of its research and in recognition of the limited predictive value of medical bills, major credit score providers FICO and VantageScore made changes so that newer versions of their credit scoring models differentiate between medical and nonmedical collections tradelines, give less weight to unpaid medical collections tradelines than to other collections tradelines, and ignore paid medical collections of any kind.[50] In January 2023, VantageScore implemented changes to VantageScore models 3.0 and 4.0 to ignore all medical collections tradelines.[51]

Older FICO scoring models that do not differentiate between medical and nonmedical collections tradelines, however, remain common in the market. For example, while the Government-Sponsored Enterprises (GSEs), the Federal National Mortgage Association (Fannie Mae) and the Federal Home Loan Mortgage Corporation (Freddie Mac), and the Federal Housing Administration generally do not consider medical debt in their credit risk assessments within their respective automated underwriting systems,[52] the GSEs require creditors to provide

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[49] Kenneth P. Brevoort & 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.

[50] *See* Ethan Dornhelm, *The Impact of Medical Debt on FICO Scores*, FICO Blog (July 13, 2015), https://www.fico.com/blogs/impact-medical-debt-ficor-scores; VantageScore, *How will changes in how medical collection accounts get reported impact credit scores?* (July 5, 2022), https://www.vantagescore.com/how-will-changes-in-how-medical-collection-accounts-get-reported-impact-credit-scores/.

[51] *See* AnnaMaria Andriotis, *Major Credit-Score Provider to Exclude Medical Debts*, Wall St. J. (Aug. 10, 2022), https://www.wsj.com/articles/major-credit-score-provider-to-exclude-medical-debts-11660102729 (VantageScore CEO quoted as saying that having medical debt is not necessarily reflective of a consumer's ability to pay back a loan).

[52] *See* Fed. Nat'l Mortg. Ass'n, *Single Family Selling Guide*, B3-2-03 (2021), https://selling-guide.fanniemae.com/#Public.20Records.2C.20Foreclosures.2C.20and.20Collection.20Accounts (noting that

credit scores derived from the older Classic FICO[53] for each borrower on a loan that the GSEs purchase to assess eligibility for certain loan products and make certain pricing decisions.[54] The GSEs and the Federal Housing Finance Agency (FHFA) announced in 2022 that they had validated and approved two of the new credit score models that lessen the weight of or do not consider medical collections, but that transition is not expected to occur until the fourth quarter of 2025.[55]

II. The Proposal and Other Procedural Background

A. Small Business Advisory Review Panel

Pursuant to the Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA),[56] the CFPB issued its Outline of Proposals and Alternatives under Consideration (Outline or SBREFA Outline).[57] The SBREFA Outline addressed a number of consumer reporting topics under the FCRA, including medical debt collections information proposals under consideration. The CFPB convened a SBREFA Panel on October 16, 2023, and held Panel

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"[c]ollection accounts reported as medical collections are not used in the DU risk assessment"); Fed. Home Loan Mortg. Corp., *The Single-Family Seller/Servicer Guide*, 5201.1 (2022), https://guide.freddiemac.com/app/guide/section/5201.1; U.S. Dep't of Hous. & Urban Dev., *Single Family Housing Policy Handbook*, 4000.1 (2021), https://www.hud.gov/sites/dfiles/OCHCO/documents/4000.1hsgh-102021.pdf.

[53] The Classic FICO score is comprised of the following models: Equifax Beacon® 5.0, Experian/Fair Isaac Risk Model V2SM, and TransUnion FICO® Risk Score, Classic 04.

[54] *See, e.g.*, Fed. Nat'l Mortg. Ass'n, *Single Family Selling Guide* (Oct. 5, 2022), https://selling-guide.fanniemae.com/sel/b3-5.1-01/general-requirements-credit-scores.

[55] Fed. Hous. Fin. Agency, *FHFA Announces Key Updates for Implementation of Enterprise Credit Score Requirements* (Feb. 29, 2024), https://www.fhfa.gov/Media/PublicAffairs/Pages/FHFA-Announces-Key-Updates-for-Implementation-of-Enterprise-Credit-Score-Requirements.aspx.

[56] Pub. L. 104-121, 110 Stat. 857 (1996).

[57] Consumer Fin. Prot. Bureau, *Small Business Advisory Review Panel for Consumer Reporting Rulemaking Outline of Proposals and Alternatives Under Consideration* (Sept. 15, 2023), https://files.consumerfinance.gov/f/documents/cfpb_consumer-reporting-rule-sbrefa_outline-of-proposals.pdf.

meetings on October 18 and 19, 2023.[58] Representatives from 16 small businesses were selected as small entity representatives for this SBREFA process. These entities represented small businesses that the CFPB determined would likely be directly affected by one or more of the proposals under consideration. On December 15, 2023, the Panel completed the Final Report of the Small Business Review Panel on the CFPB's Proposals and Alternatives Under Consideration for the Consumer Reporting Rulemaking (Panel Report or SBREFA Report).[59] In addition to the SBREFA Panel and Panel Report, the CFPB also invited feedback on the proposals under consideration from other stakeholders, including small stakeholders who were not small entity representatives.[60] The CFPB considered the feedback related to the medical debt collection information proposals from small entity representatives and other stakeholders, as well as the findings and recommendations of the Panel, in preparing the proposed rule and this final rule.

B. Other Stakeholder Outreach

The CFPB has long been engaged in outreach and research related to medical debt information in the consumer reporting ecosystem. In 2013, the CFPB and the Federal Trade Commission (FTC) jointly hosted a public roundtable for industry and other stakeholders on the integrity of record keeping by debt collectors, debt buyers, and original creditors. Participants acknowledged that record keeping practices may introduce variability or inaccuracy to the

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[58] The Panel was comprised of a representative from the CFPB, the Chief Counsel for Advocacy of the Small Business Administration (Office of Advocacy), and a representative from the Office of Information and Regulatory Affairs (OIRA) in the Office of Management and Budget.

[59] Consumer Fin. Prot. Bureau, *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), https://files.consumerfinance.gov/f/documents/cfpb_sbrefa-final-report_consumer-reporting-rulemaking_2024-01.pdf. The CFPB considers the Panel's findings in its final regulatory flexibility analysis, as set out in part VIII.B below.

[60] *See* SBREFA Outline at 5.

consumer reporting systems.[61] In December 2014, following the CFPB's publication of its research report, *Data Point: Medical Debt and Credit Scores*,[62] the CFPB issued a study of medical and nonmedical collections tradelines on consumer reports that assessed the furnishing practices of debt collectors and debt buyers, the incidence and type of collections tradelines on consumer reports, and differences between medical and nonmedical debt reporting.[63] The CFPB has continued to monitor the incidence of medical debt on consumer reports and released several other market analyses and research reports on medical debt collection and consumer reporting between 2019 and 2024.[64]

In developing this final rule and the proposed rule, the CFPB consulted with staff from various Federal agencies to discuss aspects of its proposal, in accordance with CFPA section 1022(b)(2)(B). Specifically, the CFPB met with staff from the Board of Governors of the Federal Reserve System, the Office of Comptroller of the Currency, the Federal Deposit Insurance Corporation, the National Credit Union Administration (NCUA), the FTC, the Department of

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[61] Fed. Trade Comm'n & Consumer Fin. Prot. Bureau, *Roundtable on Data Integrity in Debt Collection: Life of a Debt* (2013), https://www.ftc.gov/news-events/events/2013/06/life-debt-data-integrity-debt-collection.

[62] *See* Kenneth P. Brevoort & 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.

[63] Consumer Fin. Prot. Bureau, *Consumer credit reports: A study of medical and non-medical collections* (Dec. 2014), https://files.consumerfinance.gov/f/201412_cfpb_reports_consumer-credit-medical-and-non-medical-collections.pdf.

[64] Consumer Fin. Prot. Bureau, *Market Snapshot: Third-Party Debt Collections Tradeline Reporting* (July 2019), https://files.consumerfinance.gov/f/documents/201907_cfpb_third-party-debt-collections_report.pdf; Consumer Fin. Prot. Bureau, *Market Snapshot: An Update on Third-Party Debt Collections Tradeline Reporting* (Feb. 2023), https://files.consumerfinance.gov/f/documents/cfpb_market-snapshot-third-party-debt-collections-tradelines-reporting_2023-02.pdf; Ryan Sandler & Zachary Blizard, Consumer Fin. Prot. Bureau, *Recent Changes in Medical Collections on Consumer Credit Records Data Point*, at 3-4, 17 (Mar. 2024), https://files.consumerfinance.gov/f/documents/cfpb_recent-changes-medical-collections-on-consumer-credit-reports_2024-03.pdf.

Health and Human Services, Department of Housing and Urban Development, the FHFA, the Small Business Administration, the VA, and the Department of Agriculture.

C. Summary of the Proposed Rule

On June 11, 2024, the CFPB issued a notice of proposed rulemaking (NPRM) containing several proposed amendments to Regulation V, which implements the FCRA, concerning medical information.[65] The NPRM was published in the *Federal Register* on June 18, 2024.[66] The CFPB proposed that the final rule, if adopted, would take effect sixty days after the date it is published in the *Federal Register*.

In the proposed rule, the CFPB discussed how Congress recognized that a consumer's medical information is particularly sensitive, warranting heightened privacy protections. The CFPB explained while Congress did permit the Agencies to create exceptions, Congress mandated that the Agencies determine that any exception be "necessary and appropriate to protect legitimate operational, transactional, risk, consumer, and other needs" and consistent with the congressional intent "to restrict the use of medical information for inappropriate purposes."[67] Based on the CFPB's understanding of how consumer medical debt differs from other types of consumer debt and its uses in credit underwriting, the CFPB preliminarily determined that creditors' use of medical debt in underwriting does not meet that statutory standard, as a result, does not warrant an exception to the medical information privacy protections established by Congress.

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[65] Consumer Fin. Prot. Bureau, *Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information (Regulation V)* (June 11, 2024), https://www.consumerfinance.gov/rules-policy/rules-under-development/prohibition-on-creditors-and-consumer-reporting-agencies-concerning-medical-information-regulation-v/.

[66] 89 FR 51682 (June 18, 2024).

[67] 15 U.S.C. 1681b(g)(5).

The CFPB proposed targeted amendments to Regulation V that would: (1) remove the financial information exception which broadly permits creditors to obtain and use medical financial information (including information about medical debt) in connection with credit eligibility determinations, while retaining select elements of the exception related to income, benefits, and loan purpose; and (2) limit the circumstances under which consumer reporting agencies are permitted to furnish medical debt information to creditors in connection with credit eligibility determinations.

Under the proposed rule, a creditor would no longer be able to obtain or use medical information related to debts, expenses, assets, or collateral, in connection with a credit eligibility determination, unless a specific exception otherwise applies to the creditor's consideration of the medical information. And a consumer reporting agency generally would be prohibited from furnishing to a creditor a consumer report containing medical debt information in connection with a credit eligibility determination.

The CFPB also explained in the proposed rule that as a result of these changes, consumers' sensitive medical information would be protected, and consumers would no longer be unfairly penalized in the credit market for having medical debt. Consumers with and without medical debt would have equal access to credit at comparable terms and debt collectors would have less leverage over consumers to pressure consumers into paying medical debts that they may not owe.

Comments

The CFPB received over 74,000 comments on the proposal.[68] Around 2,000 of these comments were unique comment letters. These commenters included: consumers; consumer advocacy groups; consumer reporting, debt collection, and banking trade groups; economic research and taxpayer advocacy groups; governmental entities, including members of Congress; medical, dental and hospital practitioner groups; and patient advocacy groups.

The remaining comments included some duplicate submissions (*i.e.*, letters with the same content from the same commenter submitted through multiple channels, or letters with the same content submitted by multiple people on behalf of the same commenting organization) as well as comments that appeared to be part of several comment submission campaigns. Such comment campaigns typically advocated for or against particular provisions in the proposal and urged additional changes.

The CFPB considered all the comments it received regarding the proposal, made certain modifications, and is adopting the final rule as described in part IV below.

III. Legal Authority

A. CFPA Section 1022(b)

Section 1022(b)(1) of the CFPA authorizes the CFPB to prescribe rules "as may be necessary or appropriate to enable the [CFPB] to administer and carry out the purposes and objectives of the Federal consumer financial laws, and to prevent evasions thereof."[69] The term

[68] *See* https://www.regulations.gov/document/CFPB-2024-0023-0001/comment.

[69] 12 U.S.C. 5512(b)(1).

"Federal consumer financial laws" includes the "enumerated consumer laws," which include the FCRA.[70]

Section 1022(b)(2) of the CFPA prescribes certain standards for rulemaking that the CFPB must follow in issuing rules under Federal consumer financial laws.[71] For a discussion of the CFPB's standards for rulemaking under CFPA section 1022(b)(2), see part VII below.

B. Fair Credit Reporting Act

The FCRA was enacted in 1970 and was one of the world's first data privacy laws. The law was enacted after growing public concern about the lack of regulation concerning the widespread dissemination of sensitive information about Americans. One of Congress's main purposes in passing the FCRA was a respect for the consumer's right to privacy.[72] The law has been amended several times in the ensuing years, including by the FACT Act.[73] For example, Congress, through the FACT Act, amended the FCRA to include additional protections for consumer privacy, such as restricting the use and transfer of sensitive medical information, enhancing the ability of consumers to combat identity theft, increasing the accuracy of consumer reports, and allowing consumers to exercise greater control regarding the type and amount of marketing solicitations they receive.[74]

The FCRA governs the collection, assembly, and use of consumer report information and provides the framework for the consumer reporting system in the United States. The FCRA

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[70] *See* 12 U.S.C. 5481(12), (14).

[71] *See* 12 U.S.C. 5512(b)(2).

[72] FCRA section 602(a)(4) (15 U.S.C. 1681(a)(4)).

[73] Pub. L. 108-159 (Dec. 4, 2003). Congress also enacted specific protections for servicemembers and veterans, including with respect to medical debt and credit monitoring. Economic Growth, Regulatory Relief, and Consumer Protection Act, Pub. L. 115-174, section 302, 132 Stat. 1296, 1333 (2018).

[74] H. Rep. No. 108-396, at 1 (2003) (Conf. Rep.); S. Rep. No. 108-166, at 3 (2003) (Conf. Rep.).

regulates the practices of consumer reporting agencies that collect and compile consumer information into consumer reports for use by creditors, insurance companies, employers, landlords, and other entities in making eligibility decisions affecting consumers. The FCRA also limits the circumstances under which persons, such as creditors, may obtain and use consumer report information from consumer reporting agencies.

The FCRA was enacted to (1) prevent the misuse of sensitive consumer information by limiting recipients to those who have a legitimate need for it; (2) improve the accuracy and integrity of consumer reports; and (3) promote the efficiency of the nation's banking and consumer credit systems.[75] An important purpose of the FCRA is to enable creditors to make appropriate credit decisions based on accurate consumer reporting information that truly reflects whether a consumer will repay a loan, while simultaneously protecting the privacy of consumer data.[76]

FCRA Section 621(e)

Effective July 21, 2011, section 1088 of the CFPA made conforming amendments to the FCRA, transferring rulemaking authority under much of the FCRA, except with respect to sections 615(e) and 628 and with respect to certain motor vehicle dealers, to the CFPB. Section 621(e) of the FCRA authorizes the CFPB to issue regulations as "necessary or appropriate to administer and carry out the purposes and objectives of [the FCRA], and to prevent evasions thereof or to facilitate compliance therewith."[77]

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[75] *Safeco Ins. Co. of Am. v. Burr*, 551 U.S. 47, 52 (2007); *see also* 15 U.S.C. 1681(a)(4) (recognizing "a need to insure that consumer reporting agencies exercise their grave responsibilities with fairness, impartiality, and a respect for the consumer's right to privacy").

[76] S. Rep. No. 91-517, at 1 (1969); *see also Trans Union Corp. v. FTC*, 81 F.3d 228, 234 (D.C. Cir. 1996).

[77] *See* CFPA section 1088(a)(10)(E) (15 U.S.C. 1681s(e)).

FCRA Section 604(g)(2) and (5)

Through the FACT Act, Congress added, in FCRA section 604(g)(2), a broad new limitation on the ability of creditors to obtain or use medical information pertaining to a consumer in connection with any determination of the consumer's eligibility, or continued eligibility, for credit.[78] Congress also limited the circumstances under which consumer reporting agencies could furnish consumer reports containing medical information for credit, employment, or insurance purposes,[79] and generally required consumer reporting agencies providing consumer reports not to furnish contact information for medical information furnishers—who were also required to identify themselves to consumer reporting agencies[80]—without restrictions or coding "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."[81] Congress also broadly defined medical information in FCRA section 603(i) to include "information or data . . . created or derived from a health care provider or the consumer, that relates to . . . the payment for the provision of health care to an individual."[82]

Congress initially granted rulemaking authority to the Agencies to make exceptions to the limitation on creditors obtaining and using medical information that are necessary and appropriate to protect legitimate operational, transactional, risk, consumer, and other needs

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[78] FACT Act sections 411(a), 412(f)(2), 117 Stat. 1999-2000, 2003 (15 U.S.C. 1681b(g)(2)). FCRA section 604(g)(2) provides: "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." 15 U.S.C. 1681b(g)(2).

[79] FACT Act section 411(a), 117 Stat. 2000 (15 U.S.C. 1681b(g)(1)).

[80] FACT Act section 412(a), 117 Stat. 2002 (15 U.S.C. 1681s-2(a)(9)).

[81] FACT Act section 412(b), 117 Stat. 2002 (15 U.S.C. 1681c(a)(6)).

[82] FACT Act section 411(c), 117 Stat. 2001 (15 U.S.C. 1681a(i)).

(including administrative verification purposes), consistent with congressional intent to restrict the use of medical information for inappropriate purposes.[83] Pursuant to this authority, the Agencies promulgated final rules that, among other things, implemented the statute's general prohibition on creditors obtaining or using medical information pertaining to a consumer in connection with any determination of the consumer's eligibility, or continued eligibility, for credit and created exceptions to the prohibition.[84]

The Agencies' final rules contain the financial information exception for creditors obtaining and using medical information in credit eligibility determinations.[85] The financial information exception consists of a three-part test which allows creditors to use medical information in connection with credit eligibility determinations so long as (1) the information is the type of information routinely used in making credit eligibility determinations; (2) the creditor uses the information in a manner and to an extent no less favorably than comparable nonmedical information; and (3) the creditor does not take the consumer's physical, mental, or behavioral health, condition or history, type of treatment, or prognosis into account when making the determination. The Agencies stated that the "three-part test strikes a balance between permitting creditors to obtain and use certain medical information about consumers when necessary and appropriate to satisfy prudent underwriting criteria and to ensure that credit is extended in a safe and sound manner, while restricting the use of medical information for inappropriate purposes."[86] Although the Agencies explained the boundaries of their three-part test, and gave

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[83] FACT Act section 411(a), 117 Stat. 2001 (15 U.S.C. 1681b(g)(5)(A)).

[84] 70 FR 70664 (Nov. 22, 2005). *See also* interim final rules published at 70 FR 33958 (June 10, 2005).

[85] 70 FR 70664, 70667 (Nov. 22, 2005).

[86] 69 FR 23380, 23384 (Apr. 28, 2004).

responses to commenters on various examples, they did not provide evidence or reasoning to support the main conclusion that an exception from a congressionally created legal requirement was warranted, other than a single conclusory sentence in the proposed rule stating that "[a] creditor should not be prohibited from obtaining or using information about a debt, for example, in connection with making a credit decision, just because that debt happens to be for medical products or services."[87]

The Agencies' final rules also identified a limited number of other particular purposes for which a creditor may use medical information in connection with any determination of the consumer's eligibility, or continued eligibility, for credit.[88] For example, a creditor may use medical information in credit eligibility determinations to comply with applicable requirements of local, State, or Federal laws.[89] The Agencies found that this exception, and the other enumerated specific exceptions, are necessary and appropriate to protect legitimate operational, transactional, risk, consumer, and other needs (including administrative verification purposes), and are consistent with the congressional intent to restrict the use of medical information for inappropriate purposes.[90]

Congress (through the CFPA) transferred to the CFPB primary regulatory authority for the FCRA.[91] The CFPB restated the Agencies' regulations as an interim final rule, with request for comment, on December 21, 2011.[92] On April 28, 2016, the CFPB finalized the interim final

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[87] *Id.*

[88] 70 FR 70664, 70668 (Nov. 22, 2005).

[89] This exception is restated at § 1022.30(e)(1)(ii).

[90] 69 FR 23380, 23382 (Apr. 28, 2004).

[91] Title X of the Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub. L. 111-203, section 1088, 124 Stat. 1376, 1955 (2010).

[92] 76 FR 79308 (Dec. 21, 2011).

rule without assessing or otherwise reconsidering the policy decisions and justifications that served as the basis for the regulations.[93]

As a result of the transfer of authority, FCRA section 604(g)(5) now authorizes the CFPB to prescribe regulations to create exceptions from the statutory prohibition on obtaining or using medical information in connection with determinations of credit eligibility. However, the CFPB must determine that such exceptions to the general prohibition in FCRA section 604(g)(2) are necessary and appropriate to protect legitimate operational, transactional, risk, consumer, and other needs (including administrative verification purposes), consistent with the congressional intent to restrict the use of medical information for inappropriate purposes.[94] Because the CFPB has determined that a regulatory exception for certain financial information is not necessary and appropriate to protect legitimate operational, transactional, risk, consumer, and other needs (including administrative verification purposes), the CFPB is removing the exception. This ensures that only exceptions that are necessary and appropriate, consistent with the CFPB's rulemaking authority under FCRA section 604(g)(5), remain in § 1022.30.

FCRA Section 604(a) Permissible Purposes and Related Provisions

The FCRA protects consumer privacy in multiple ways, including by clearly prohibiting certain uses of data and limiting the circumstances under which consumer reporting agencies may disclose consumer information. FCRA section 604, entitled *Permissible purposes of consumer reports*, identifies an exclusive list of permissible purposes for which consumer

[93] 81 FR 25323 (Apr. 28, 2016).

[94] 15 U.S.C. 1681b(g)(5).

reporting agencies may provide consumer reports.[95] The statute states that a consumer reporting agency may provide consumer reports under these circumstances "and no other." In addition, FCRA section 607(a) requires that "[e]very consumer reporting agency shall maintain reasonable procedures designed to . . . limit the furnishing of consumer reports to the purposes listed under section 604."[96]

In addition to imposing permissible purpose limitations on consumer reporting agencies, the FCRA limits the circumstances under which third parties may obtain and use consumer report information from consumer reporting agencies. FCRA section 604(f) provides that a person shall not use or obtain a consumer report unless the consumer report is obtained for a purpose for which the consumer report is authorized to be furnished under FCRA section 604 and the purpose is certified in accordance with FCRA section 607 by a prospective user of the report.[97]

The FCRA's permissible purpose provisions are thus a key component to the statute's protection of consumer privacy. Consumers suffer harm when consumer reporting agencies provide consumer reports to persons who are not authorized to receive the information or when recipients of consumer reports obtain or use such reports for purposes other than permissible purposes. These harms include the invasion of consumers' privacy, as well as reputational, emotional, physical, and economic harms.

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[95] 15 U.S.C. 1681b(a). Other sections of the FCRA identify additional limited circumstances under which consumer reporting agencies are permitted or required to disclose certain information to government agencies. *See* 15 U.S.C. 1681f, 1681u, 1681v; *see also, e.g.*, *FTC v. Manager, Retail Credit Co., Miami Beach Branch Off.*, 515 F.2d 988, 994-95 (D.C. Cir. 1975) (holding that 15 U.S.C. 1681s(a) authorizes the FTC to obtain consumer reports in FCRA enforcement investigations). Further, the Debt Collection Improvement Act of 1996, Pub. L. 104-134, section 31001(m)(1), 110 Stat. 1321-366, allows the head of an executive, judicial, or legislative agency to obtain a consumer report under certain circumstances relating to debt collection. *See* 31 U.S.C. 3711(h).

[96] 15 U.S.C. 1681e(a).

[97] 15 U.S.C. 1681b(f).

Because the CFPB is removing the financial information exception, which broadly permitted creditors to obtain and use medical financial information (including information about medical debt) in connection with credit eligibility determinations, creditors generally will no longer have a permissible purpose for consumer reports containing medical debt information.

IV. Discussion of the Final Rule

A. Overview of the CFPB's Approach

As discussed above, the CFPB proposed to amend Regulation V to remove a regulatory exception from the limitation in the FCRA on creditors obtaining or using information on medical debts for credit eligibility determinations. The CFPB also proposed that a consumer reporting agency generally may not furnish to a creditor a consumer report containing information on medical debt that the creditor is prohibited from using.

Congress restricted a creditor's ability to obtain or use a consumer's medical information in connection with any determination of the consumer's eligibility, or continued eligibility, for credit.[98] When the Agencies issued the current regulatory exception to the statutory prohibition, they did so without providing evidence or reasoning to support their main conclusion that an exception from a congressionally created legal requirement was warranted. Research has shown that medical debt has limited predictive value for credit underwriting purposes. Market participants, including in the consumer reporting industry and those most financially incentivized to assess the predictive value of medical debt, have reduced their reliance on medical debt in recognition of its limited utility.

[98] 15 U.S.C. 1681b(g)(2).

The CFPB proposed this rule to address concerns that the regulatory exception to the medical information privacy protections established by Congress, which allows creditors to use medical debt information for underwriting, is not necessary and appropriate to protect legitimate operational, transactional, risk, consumer, and other needs, nor consistent with the intent to restrict the use of medical information for inappropriate purposes. The CFPB proposed removing the broad regulatory exception—while retaining select elements of the exception related to income, benefits, and loan purpose—and limiting the circumstances under which consumer reporting agencies are permitted to furnish medical debt information to creditors in connection with credit eligibility determinations.

The CFPB is adopting the same general approach in the final rule, with some modifications, as discussed herein.

Comments Received on the CFPB's Proposed Approach Generally

Comments received by the CFPB on the proposal, and responses thereto, are discussed in more detail throughout this notice. The following is a synopsis of comments received on the CFPB's proposed approach generally.

Commenters, including consumer advocate groups and consumers (generally in the form of a comment submission campaign), supported the CFPB's proposal, noting that the rule would align with congressional intent behind the FCRA, as amended by the FACT Act, and agreeing that medical debt information should be treated differently than other debt information. Commenters stated that the proposed rule is within the CFPB's legal authority under FCRA sections 621(e) and 604(g)(5) and will promote the FCRA's objectives as to the accuracy, fairness, and privacy of consumer information—given that medical debt is often inaccurate or error prone, is inconsistently reported, and has limited predictive value for credit underwriting. Commenters also stated that medical debt disproportionately impacts vulnerable populations and

the CFPB's proposal would mitigate medical debt's negative impacts on consumers' health decisions and financial well-being, including by increasing consumers' access to credit.

Other commenters including industry commenters and consumers opposed the CFPB's proposal, asserting that it is arbitrary and capricious, exceeds the CFPB's legal authority, and conflicts with FCRA, as amended by the FACT Act, and other laws. Commenters disagreed with the proposal's evidence that medical debt information has limited predictive value and asserted it is necessary for credit underwriting purposes and should not be treated differently than other debt information. Commenters stated that the CFPB's proposal would undermine the fairness and accuracy of credit reports and have negative impacts on consumers' ability to repair credit scores by making payments on collection tradelines and on creditors' ability to accurately assess creditworthiness—resulting in less-qualified consumers becoming overleveraged and well-qualified consumers experiencing decreased access to credit. Commenters also contended that the CFPB's proposal could result in lost income for medical providers, higher healthcare costs for consumers, and increased debt collection litigation.

B. Removal of the Financial Information Exception to the Creditor Prohibition on Obtaining or Using Medical Information

The creditor prohibition in section 604(g)(2) of the FCRA,[99] incorporated at Regulation V § 1022.30(b), restricts creditors from obtaining or using (*i.e.*, considering) medical information pertaining to a consumer in connection with any determination of the consumer's eligibility, or continued eligibility, for credit. Regulatory exceptions to this prohibition are at current § 1022.30(d) and (e), which are respectively titled "Financial information exception for

[99] FCRA section 604(g)(2) (15 U.S.C. 1681b(g)(2)).

obtaining and using medical information" (financial information exception) and "Specific exceptions for obtaining and using medical information".

The CFPB proposed removing the financial information exception at § 1022.30(d). For the reasons discussed in part IV.B.1, *Medical Information Related to Debts*, and part IV.B.2, *Medical Information Related to Expenses, Assets, and Collateral*, the CFPB is finalizing this change as proposed. The CFPB also proposed retaining certain elements of the financial information exception related to income, benefits, and purpose of the loan by moving relevant provisions to the list of specific exceptions to the creditor prohibition at § 1022.30(e). For reasons discussed in part IV.B.3, *Medical Information Related to Income, Benefits, or the Purpose of the Loan*, the CFPB is finalizing its proposal to retain elements of the financial information exception as to income, benefits, and the purpose of the loan. The CFPB has also revised the proposed text for the revised exception to include medical information contained in the transaction information of an account for a consumer financial product or service described in 12 CFR 1033.111(b)(1) through (3), and accessed with the consumer's authorization, as discussed in part VI.A, *Consumer-Authorized Transaction History*.

Additionally, the CFPB proposed adding a definition for "medical debt information" at § 1022.3(j). The CFPB is finalizing the definition as proposed for the reasons discussed in the relevant portion of the discussion in part IV.B.1, *Medical Information Related to Debts*. The CFPB also proposed and is finalizing conforming amendments to § 1022.30(c) to remove the reference to the financial information exception in § 1022.30(d), because the exception is removed under the final rule. Further, the CFPB proposed and is finalizing the removal of an example at existing § 1022.30(c)(3)(iii), which the CFPB discusses further in part IV.C, *Limits on a Consumer Reporting Agency's Disclosure of Medical Debt Information*.

In the NPRM, the CFPB explained that Congress had put in place strong privacy protections for consumers' medical information in the FCRA, including by enacting the creditor prohibition through FCRA section 604(g)(2).[100] Congress also provided additional protections by stipulating that the CFPB may permit exceptions to the creditor prohibition only when the CFPB has determined the exceptions to be "necessary and appropriate to protect legitimate operational, transactional, risk, consumer, and other needs . . . consistent with the intent of [FCRA section 604(g)(2)] to restrict the use of medical information for inappropriate purposes."[101]

The CFPB further explained that, consistent with the general creditor prohibition in FCRA section 604(g)(2), current § 1022.30(b)(1) states: "A creditor may not obtain or use medical information pertaining to a consumer in connection with any determination of the consumer's eligibility, or continued eligibility, for credit, except as provided in this section." The CFPB also noted that in 2005, before the CFPA transferred primary regulatory authority for the FCRA to the CFPB, the Agencies adopted the exceptions to this prohibition that are now codified in the financial information exception at § 1022.30(d) and the list of specific exception at § 1022.30(e) (listing specific exceptions).

The CFPB also explained that the financial information exception allows a creditor to consider medical information pertaining to a consumer in connection with any determination of the consumer's eligibility, or continued eligibility, for credit if the conditions of the following three-part test are met: (1) the information is the type routinely used in making credit eligibility

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[100] As described above, Congress also limited the circumstances under which consumer reporting agencies can provide consumer reports containing medical information for credit, employment, or insurance purposes, and required consumer reporting agencies to restrict or code contact information for medical information furnishers. 15 U.S.C. 1681b(g)(1), 1681c(a)(6).

[101] 15 U.S.C. 1681b(g)(5).

determinations, such as information relating to debts, expenses, income, benefits, assets, collateral, or the purpose of the loan, including the use of proceeds; (2) the creditor uses the medical information in a manner and to an extent no less favorable than it would use comparable information that is not medical information; and (3) the creditor does not take the consumer's physical, mental, or behavioral health, condition or history, type of treatment, or prognosis into account as part of the credit eligibility determination.[102]

The CFPB observed that the predecessor Agencies had stated that it was their belief that the financial information exception struck a balance between permitting creditors to obtain and use certain medical information about consumers when necessary and appropriate to satisfy prudent underwriting criteria and ensuring that credit is extended in a safe and sound manner, while restricting the use of medical information for inappropriate purposes.[103] However, the CFPB noted that the Agencies had not cited evidence or provided analysis in support of this statement of their conclusion.

Comments received in response to specific aspects of the CFPB's proposal to remove the financial information exception, and the CFPB's reasons for finalizing its proposed removal of the exception with regard to each such aspect, are discussed separately below in this part IV.B, *Removal of the Financial Information Exception to the Creditor Prohibition on Obtaining or Using Medical Information*.

1. Medical Information Related to Debts

In its proposal, the CFPB explained that by proposing to eliminate the financial information exception, the CFPB was generally proposing to prohibit creditors from considering,

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[102] 12 CFR 1022.30(d)(1).

[103] Fair Credit Reporting Medical Information Regulations (2004 NPRM), 69 FR 23380, 23384 (Apr. 28, 2004).

in connection with credit eligibility determinations, certain financial information related to consumers' medical debts.

The financial information exception currently permits a creditor to consider certain medical information related to a consumer's debts in connection with any determination of the consumer's eligibility, or continued eligibility, for credit.[104] Such medical information related to medical debt includes, for example, "[t]he dollar amount, repayment terms, repayment history, and similar information regarding medical debts to calculate, measure, or verify the repayment ability of the consumer, the use of proceeds, or the terms for granting credit"[105] and "[t]he identity of creditors to whom outstanding medical debts are owed in connection with an application for credit, including but not limited to, a transaction involving the consolidation of medical debts"[106] (collectively referred to herein as financial information).

Thus, under the CFPB's proposal, which the CFPB is finalizing as proposed for the reasons discussed in this part IV.B.1, a creditor would no longer be able to consider such medical information related to a consumer's medical debt, unless one of the specific exceptions in final § 1022.30(e) applies. Specifically, as discussed in further detail below, the CFPB is finalizing its interpretation as set forth in the proposed rule that for information about a consumer's debt to be "medical information" under FCRA section 603(i), the information must relate to a debt the consumer owes, or at one time owed, directly to a health care provider or to the health care provider's agent or assignee for the provision of the health care underlying the payment obligation. The CFPB is also finalizing its definition of medical debt information in final

[104] 12 CFR 1022.30(d)(1)(i).

[105] 12 CFR 1022.30(d)(2)(i)(A).

[106] 12 CFR 1022.30(d)(2)(i)(D).

§ 1022.3(j), as medical information that pertains to a debt owed by a consumer to a person whose primary business is providing medical services, products, or devices (also referred to herein as a health care provider), or to the person's agent or assignee, for the provision of such medical services, products, or devices. The definition also provides that medical debt information includes, but is not limited to, medical bills that are not past due or that have been paid. Further, the CFPB has concluded that it generally is neither "necessary and appropriate to protect legitimate operational, transactional, risk, consumer, and other needs," nor consistent with Congress's intent "to restrict the use of medical information for inappropriate purposes," for creditors to consider sensitive financial information concerning a consumer's medical debt in underwriting.

Preliminary Interpretation—Owes or Owed to a Health Care Provider

FCRA section 603(i)'s definition of "medical information," incorporated in Regulation V at § 1022.3(k), informs the types of medical debt that creditors are generally prohibited from considering, but for which the financial information exception currently applies. Medical information is defined as "[i]nformation or data, whether oral or recorded, in any form or medium, created by or derived from a health care provider or the consumer" that relates to, among other things, "[t]he payment for the provision of health care to an individual."

In its proposal, the CFPB explained that with regard to "[t]he payment for the provision of health care to an individual"—*i.e.*, the subset of "medical information" concerning debt—the CFPB proposed to interpret FCRA section 603(i) to mean that medical information about a consumer's debt must relate to a debt the consumer owes, or at one time owed (for example, in the case of paid medical debt), directly to a health care provider or to the health care provider's

agent or assignee.[107] Specifically, the CFPB stated that the statute provides that medical information is information or data "created by or derived from a health care provider or the consumer" that relates to "the payment for the provision of health care to an individual." And, as a result, the CFPB preliminarily interpreted the statute's use of the phrase "provision of health care," following the requirement that the medical information must be "created by or derived from a health care provider or the consumer," to mean that for information on a debt to be medical information under the FCRA, the information must relate to a debt arising from a payment obligation that the consumer owes (or at one time owed) directly to a health care provider for the provision of the health care underlying the payment obligation.

The CFPB also stated that its preliminary interpretation would include medical debt that had been sold or resold to a debt buyer, who had become the health provider's assignee for the debt, because the payment obligation that was sold was created by a health care provider and at one time was owed to the health care provider. It would also include medical debt that had been assigned to a third-party debt collector, who was acting as an agent on behalf of the health care provider, or debt buyer to whom the debt was owed.[108] Further, it would include medical information in the form of a civil judgment arising from a debt collection action as to a medical debt directly owed to a health care provider or debt buyer, whether provided on a consumer report, by the consumer on a credit application, or if the creditor learned of the civil judgment through other means; a credit score that had weighed medical debt information; and debts arising

[107] The CFPB explained that its use of the word "owed" referred to the characterization of the debt by the health care provider or its agent or assignee.

[108] *Cf.* 15 U.S.C. 1681s-2(a)(9) (providing that the term "medical information furnisher" includes the "agent or assignee" of a medical provider).

from medical care that is elective, or otherwise not medically necessary (*e.g.*, some cosmetic surgeries).

The CFPB further explained that because medical information on a consumer's debt must relate to a debt the consumer owes (or owed) directly to a health care provider under the CFPB's preliminary interpretation, medical debt would not include a debt owed to a third-party lender (including a medical credit card issuer whose products are offered specifically for the payment of medical services or general purpose credit card issuer), from whom a consumer took out a loan to pay medical expenses or bills. The CFPB noted that such loans would be new debt obligations used to pay the medical debt obligation owed to a health care provider. Moreover, the CFPB also preliminarily concluded that debts owed to such third-party lenders are distinguishable from debts that health care providers have sold to debt buyers because medical debts are assigned to such debt buyers, but not to third-party lenders.

The CFPB sought comment on its approach and on whether, in the alternative, information about debts generally incurred to pay for medical bills and expenses should be considered to be "medical information" that is "derived" from a health care provider or consumer. The CFPB also sought comment on the feasibility of furnishing such medical debt information under this latter approach to consumer reporting agencies and reporting to creditors in a way that distinguishes between loan obligations and disbursements that pay for medical expenses and those that do not.

In consideration of its preliminary interpretation of FCRA section 603(i), the CFPB also proposed adding a definition for medical debt information at § 1022.3(j) to facilitate compliance with various aspects of the proposed rule. As explained in the NPRM, the CFPB's intent was for the definition of medical debt information under proposed § 1022.3(j) to align with the scope of

information about medical debt (also referred to herein as medical debt information) that creditors would be prohibited from considering if the financial information exception is removed.

The CFPB's proposed medical debt definition, comments received in response to the proposed definition, and the CFPB's responses are generally discussed later in this part. To the extent commenters raised issues related to and about the CFPB's preliminary interpretation of medical debt information under FCRA section 603(i) in the context of their discussion of other aspects of the CFPB's proposal, including of the proposed definition at § 1022.3(j), such issues are generally addressed immediately below.

Comments—Preliminary Interpretation: Owes or Owed to a Health Care Provider

The CFPB received a number of comments related to and about its preliminary interpretation of medical information under FCRA section 603(i), that medical information about a consumer's debt must relate to a debt the consumer owes, or at one time owed, directly to a health care provider or to the health care provider's agent or assignee. Comments also discussed the corresponding scope of the proposed medical debt information definition at § 1022.3(j) in relation to medical debt owed to third-party lenders, information about civil judgments arising from medical debt collection litigation, and credit scores that weighed medical debt information.[109]

[109] The CFPB also received comments addressing its preliminary interpretation that information about a debt originally owed to a health care provider that has been sold and resold to a debt buyer or assigned to a third-party debt collector is generally medical information. These comments are discussed with comments about the CFPB's proposed medical debt information definition (§ 1022.3(j)) later in this part.

Third-Party Lenders

A number of commenters agreed with the CFPB's position that medical debt directly owed to a health care provider, or to their agent or assignee, should be information about medical debt that is subject to the creditor prohibition. One such commenter, who generally supported the CFPB's proposal, stated that the CFPB's interpretation of FCRA section 603(i) would protect consumers' sensitive medical information and prevent the mischaracterization or improper assignments of debts arising from services directly provided by health care professionals. However, the commenter, and many others that also substantially supported the CFPB's proposal, expressed concern that the CFPB's proposed interpretation and proposed medical debt information definition did not also include information about medical debts incurred by a consumer that had been paid for with third-party lender payment products. Some of these commenters urged the CFPB to revise its preliminary interpretation as to medical debt information under FCRA section 603(i) and/or its proposed definition under § 1022.3(j) to include information about such debts owed to third-party lenders.

Specifically, commenters stated that the CFPB should include other sources of medical debt, such as general purpose credit cards, medical credit cards, medical installment loans, loans owed to friends and family, and loans owed to third-party lenders, within the scope of the rulemaking. While some commenters urged the CFPB to include all types of third-party loan products, many commenters specifically emphasized that medical debt incurred through medical credit cards and general purpose credit cards should be included. Others requested that the CFPB include medical credit cards without mention of general purpose credit cards. Some commenters urged the CFPB to more broadly include third-party medical payment or lending products

specifically meant to pay for medical care, such as medical credit cards (including those used to pay dental expenses) or medical financing plans.

With regard to credit cards, commenters stated that credit cards are a significant source of medical debt, with some commenters flagging that they are prevalently used by specific populations like older Americans or patients with chronic conditions or cancer. These commenters also stated that the same reasons that make information about medical debt unfair and unreliable indicators of a consumer's creditworthiness (*i.e.*, that the debts are often incurred on an involuntary and unexpected basis so that consumers have little ability to compare and negotiate prices) also apply to medical debt paid for with these kinds of third-party lending products. The commenters expressed concern that not including medical debt from these types of products within the scope of the CFPB's final rule would leave consumers with such debt without the protections of the rule. One commenter stated that a broad interpretation of the term medical information and medical debt information definition would provide flexibility to capture future types of medical financing.

With regard to medical payment products, commenters stated that if the CFPB's final rule does not apply to debts owed to issuers of medical payment products, such debts could become a loophole that would result in more medical providers promoting or requiring the use of these products, particularly if there is general shift towards requiring upfront payment for medical services. One commenter cited Arizona's Predatory Debt Collection Protection Act as an example of the importance of ensuring that such types of debt are included in the final definition. The commenter stated that although the Arizona law limits the maximum interest rate on medical debt to 3 percent, the law does not consider credit cards or loans taken out to pay for medical

debt to be subject to the interest rate ceiling. And, as a result, there are medical credit cards charging Arizona residents significantly more than 3 percent interest.

With regard to medical credit cards, some commenters stated that medical credit cards can be more expensive than other forms of payment, may be advertised with low promotional interest rates but later have much higher interest rates, and may be used to pay for expenses that the consumer never incurred. Other commenters stated that consumers may be misled or not fully informed about such cards by their medical providers and in some instances may not even be aware that they are opening up a credit account. Commenters also noted that the use of medical credit cards is increasing, citing factors such as how they are being used to finance a growing array of medical services that may or may not be covered by health insurance, the trend of health insurance practices shifting costs to patients through high deductible and limited network plans, and that medical providers may be motivated to promote medical credit cards' use to reduce administrative billing costs and improve the timeliness of consumer payments. A couple of commenters also noted that some states, like Connecticut and New York, already restrict the medical debt from being on credit reports, including if charged to a medical credit card.

Several commenters stated that expanding the CFPB's preliminary interpretation of medical debt information and proposed definition would be consistent with the FCRA. A couple of commenters stated that the CFPB should consider information about debts generally incurred to pay for medical bills and expenses to be "medical information" that is "derived" from a health care provider or consumer under FCRA section 603(i). Another commenter made a similar argument, specifically as to medical credit cards. One commenter suggesting that the interpretation and proposed definition should include all purchases for medical services, products

and devices, irrespective of the type of financing, stated that these changes would be consistent with the FCRA, because a consumer creates medical information by seeking out and obtaining medical services, products or devices and creates a payment obligation through intermediary payment methods by opening up a credit card or medical payment product where they bear the financial obligation. The commenter cited, as an example, a definition for "medical debt" in legislation under consideration in Congress, which provides that a medical debt is a debt related to, in whole or in part, transactions, accounts, or balances arising from the receipt of medical services, products, or devices.[110] Another commenter urging the CFPB to include medical credit cards within the final rule's scope stated that medical credit cards are lending products, which the CFPB has broad authority over.

Some commenters stated that they agree with the CFPB's interpretation, and its proposed definition for medical debt information aligning with that interpretation, because they said it reflects the most reasonable interpretation of the statute. Consequently, these commenters stated that the CFPB should not revise the CFPB's interpretation of medical information under FCRA section 603(i) and the CFPB's proposed medical debt definition to include medical debts paid for with payment products from third-party lenders and creditors, such as general purpose credit card issuers, specialty credit card issuers, issuers of medical payment products, and home equity lenders. The commenters stated that the distinction was important, with several urging the CFPB to affirmatively exclude medical debt owed to third-party lenders and creditors in the final medical debt information definition. Several of the commenters, who also generally opposed the CFPB's proposal, stated that an expansion of the medical debt information definition would

[110] Medical Debt Relief Act, H.R. 6003, 118th Cong. (2023).

remove more types of debt information from creditors' consideration when underwriting credit and affect creditors' ability to make risk-based lending decisions, leading to overleveraged consumers or causing lenders to tighten their underwriting standards and increase the cost of credit to offset anticipated increases in a consumer's repayment risk.

One commenter stated that the CFPB's preliminary interpretation of FCRA section 603(i) is arbitrary and capricious, because it distinguishes between creditors who are health care providers (and their agents or assignees) and credit card issuers. The commenter stated that such a distinction is arbitrary because whether a consumer pays a healthcare provider by credit card or if the healthcare provider sends a consumer a bill is the result of the consumer's choice of payment and individual health provider billing practices. Yet, under the CFPB's preliminary interpretation and its proposed rule, in the former scenario information about the debt could be on a consumer report and in the latter it could not be, even though the consumer has the same credit risk and the same amount of debt. The commenter stated the proposed approach could give consumers the ability to manipulate their credit scores. The commenter stated that the CFPB did not address this issue in the NPRM, which it says is arbitrary and capricious. The commenter also characterized the CFPB's interpretation as a departure from the position it states was taken by the CFPB's predecessor Agencies and accepted by the CFPB in restating Regulation V after primary regulatory authority for the FCRA was transferred to it. Specifically, the commenter cited the Agencies' interim final rule implementing section 411 of the FACT Act. The commenter pointed to language where the Agencies stated that the creditor prohibition at FCRA section 604(g)(2) applies to all creditors and that the scope of the exceptions to the prohibition adopted pursuant to FCRA section 604(g)(5) is as broad as the prohibition and applies to all

creditors.[111] The commenter started that the CFPB did not address what the commenter characterized as a change in interpretation as to the statutory text.

In the NPRM, the CFPB asked for public comment on the feasibility of furnishing medical debt information to consumer reporting agencies and reporting to creditors in a way that distinguishes between loan obligations and disbursements that pay for medical expenses and those that do not, if the CFPB were to consider information about debts generally incurred to pay for medical bills and expenses to be "medical information" that is "derived" from a health care provider or consumer. One commenter who supported expanding the CFPB's proposed definition of medical debt information (and interpretation of medical information under the FCRA) suggested that for medical expenses charged to general purpose credit cards, a furnisher or lender providing information to the credit reporting agencies would merely need to designate that the debt is medical debt. Other commenters stated that they believed medical expenses on credit cards could be identified by using Merchant Category Codes (MCC). One commenter stated that the CFPB should require credit card issuers to have medical providers identify themselves using the MCCs for medical services and supplies. Another commenter noted, for example, that flexible spending account credit cards use MCCs to automatically substantiate qualified expenses and suggested that a similar technology applied under the CFPB's final rule.

Some commenters suggested that the CFPB require credit card issuers to exclude negative information about debts from merchants who are coded under the MCCs as medical providers. One such commenter stated that, under this approach, the CFPB would be required to establish rules for payment application and allocation of interest for mixed medical and non-

[111] 70 FR 33958, 33963 (June 10, 2005).

medical credit card balances through a separate rulemaking, which it anticipated would not be more complicated than the rules for payment allocation and calculation of interest on balances with different annual percentage rates (APRs) under Regulation Z, to make clear to what portions of a consumer's credit card debt could be provided to consumer reporting agencies and creditors. Another commenter said that the CFPB should additionally develop mechanisms for identifying and tracking when loan disbursements or payments from other general purpose lending products are used to pay for medical expenses. A different commenter suggested that the CFPB require creditors to expand their categorization system to flag medical expenses at the point of transaction or through subsequent verification processes. The commenter stated that a new merchant code could be created to flag healthcare provider payments or existing medical merchant codes would be flagged as part of a broader medical expense category.

In contrast, commenters supporting the current scope of the proposed medical debt information definition stated that it is not feasible to implement an expansion of the medical debt information definition and interpretation of medical information under the FCRA to include products from third-party lenders. Specifically, the commenters stated third-party lenders like credit card issuers or home equity lenders would need to be able to identify medical charges or expenses and recalculate fields such as the consumer's current balance, credit limit, amount past due, and actual payment amount. One commenter also stated that, unlike credit card issuers who may be able to identify which merchant a consumer has shopped with, banks that offer unsecured credit generally do not know how a consumer spends loan proceeds and if any of the loan was used to pay for medical expenses. A couple of commenters stated that even if a third-party lender or creditor were able to identify such charges using merchant category codes or some other

information, it would need to maintain two sets of records, one with medical debt information and one without, which may lead to consumer confusion and other operational risks.

Several commenters asked that if the CFPB does not include debts owed to third-party lenders or creditors such as credit card issuers within the scope of the final rule, that the CFPB continue to evaluate the impacts of such debt, such as for specific populations like family caregivers and persons in their care who may not understand the scope of the CFPB's final rule, and to ascertain the impact of the final rule. Other commenters asked the CFPB to actively regulate and implement consumer protections related to medical lending products.

Civil Judgments

The CFPB also received several comments about its interpretation of FCRA section 603(i) that medical debt information includes civil judgments arising from medical debt collection actions, where the debt is directly owed to a health care provider, or to their agent or assignee. One commenter supported the CFPB's proposed approach, stating that the CFPB's interpretation is important considering that there are credit reporting agencies that specialize in providing consumer reports consisting of public records information, including about civil judgments. This commenter recommended that the CFPB include its interpretation about civil judgments in the final regulatory text or in official commentary. A couple of commenters opposed the CFPB's interpretation about civil judgments. The commenters generally stated that it is not apparent from public record information whether a debt underlying a civil judgment is owed or was once owed directly to a health care provider for the provision of health care, particularly if the legal action was brought by a debt buyer whose name does not reference health care. In such cases, the commenters stated creditors would need to engage in burdensome individualized investigations to determine if a civil judgment is medical debt information. The

commenters suggested that the CFPB revise its interpretation so that information about a civil judgment arising from a medical debt collection action is not considered medical information under the FCRA. In the alternative, one of the commenters suggested that the CFPB revise its interpretation of what constitutes medical information about a debt, so that it includes, other than the name of the judgment creditor, publicly available information that the civil judgment arises from a debt collection action as to a medical debt directly owed to a health care provider or to such person's assignee (as opposed to debt buyer, as referenced in the CFPB's NPRM).

This commenter also stated that the CFPB's discussion of its preliminary interpretation in the NPRM was inconsistent with its proposed definition for medical debt information. According to the commenter, while the proposed definition is clear that the debt at issue must be owed to health care provider or to their agent or assignee, in the NPRM the CFPB stated that medical information in the form of a civil judgment arising from a debt collection action as to a medical debt "directly owed to a health care provider or debt buyer" would be considered information about a debt that is medical information under FCRA section 603(i).[112] The commenter stated that this statement in the preamble of the NPRM could be read as meaning that the CFPB's proposal includes medical debt owed to a debt buyer even if the debt had not been originally owed to a health care provider.

Credit Scores

Several commenters generally opposing the CFPB's proposed rule also disagreed that credit scores that have weighed medical debt information should be medical debt information under the CFPB's preliminary interpretation. One commenter stated that the final rule should

[112] 79 FR 51682, 51690 (June 18, 2024).

provide that a creditor that considers a credit score that could have weighed medical debt information does not violate the creditor prohibition. Another commenter, a financial institution, stated that credit scores are essential for lenders to determine a consumer's creditworthiness. The commenter argued that removing medical debt information from the data used to calculate credit scores would lead to the inflation of those scores, affect lenders' ability to accurately make credit risk assessments, and lead to loan defaults. The commenter stated that CFPB should consider establishing a safe harbor for financial institutions that inadvertently rely on a credit score that weighed medical debt information, because a lender would have difficulty recalculating a credit score due to the proprietary nature of the credit score algorithms used by consumer reporting agencies.

Final Rule—Owes or Owed to a Health Care Provider

For the reasons set forth herein, the CFPB is finalizing its interpretation as set forth in the proposed rule that for information about a consumer's debt to be "medical information" under FCRA section 603(i), the information must relate to a debt the consumer owes, or at one time owed, directly to a health care provider or to the health care provider's agent or assignee for the provision of the health care underlying the payment obligation. The CFPB's interpretation includes medical information in the form of a civil judgment arising from a debt collection action as to a medical debt directly owed to a health care provider or their assignee (*i.e.*, a debt buyer), whether provided on a consumer report, by the consumer on a credit application, or if the creditor learns of the civil judgment through other means; a credit score that had weighed medical debt information; and debts arising from medical care that is elective, or otherwise not medically necessary (*e.g.*, some cosmetic surgeries).

As discussed later in this part with regard to the definition of medical debt information under proposed and final § 1022.3(j), the CFPB also finalizes its approach that its interpretation

includes medical debt that has been sold or resold to a debt buyer—who has become the health provider's assignee for the debt, because the payment obligation that was sold was created by a health care provider and at one time was owed to the health care provider—as well as medical debt that has been assigned to a third-party debt collector, who is acting as an agent on behalf of the health care provider or debt buyer to whom the debt is owed. The CFPB also addresses comments regarding the CFPB's approach as to medical information about debts arising from elective versus non-elective care with the other comments about the CFPB's proposed medical debt information definition.

Third-Party Lenders

FCRA section 603(i) defines "medical information" as "[i]nformation or data, whether oral or recorded, in any form or medium, *created by or derived from a health care provider* or the consumer" that relates to, among other things, "[t]he payment for the *provision of health care* to an individual" (emphasis added). As set forth in its proposal, the CFPB believes that it is consistent with the text of FCRA section 603(i) to interpret the statute's use of these two phrases to mean that for information on a debt to be medical information under the FCRA, the information must relate to a debt arising from a payment obligation that the consumer owes (or at one time owed) directly to a health care provider for the provision of the health care underlying the payment obligation.

The CFPB also finds that the manner in which the final rule implements FCRA section 603(i) is appropriate at this time given operational difficulties for information furnishers, creditors, and consumer reporting agencies in distinguishing between third-party loan obligations and disbursements that pay for medical expenses and those that do not. To implement the rule, entities furnishing information on consumer debts, consumer reporting agencies receiving such

information and providing consumer reports to creditors, and creditors receiving information about the consumer's debt obligations must be able to identify the specific information subject to the rule's requirements. Logically, a debt owed directly to a health care provider for the provision of health care to an individual is generally understood by consumers and the health care providers (and their agents and assignees) that are furnishing information to consumer reporting agencies to be medical debt. And, because of medical information furnisher obligations under FCRA section 623(a)(9), information about such debts that is furnished by health care providers (or their agents or assignees) already is and can be easily labeled as medical information by consumer reporting agencies so that they may comply with their medical debt information disclosure obligations under final § 1022.38.[113] The CFPB also notes that it did not receive any comments disagreeing that information about debts owed directly to a health care provider for the provision of health care to an individual is medical information under the statute, even if some commenters urged the CFPB to expand its interpretation.

In contrast, currently medical information is generally not easily identifiable when a consumer uses a credit card or the proceeds of a loan from a third-party lender to pay, for example, a medical bill. When a consumer owes a debt to a third-party lender, the amount of that debt may consist of a mix of both medical and non-medical debt.

In the context of credit and debit cards, the CFPB does not believe that the problem of identifying medical debt can be resolved with existing MCCs[114] used by credit card issuers to

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[113] *See* 15 U.S.C. 1681c(a)(6), 1681s-2(a)(9).

[114] *See, e.g.*, Visa, *Visa Merchant Data Standards Manual - Visa Supplemental Requirements* (Apr. 2023), https://usa.visa.com/content/dam/VCOM/download/merchants/visa-merchant-data-standards-manual.pdf; Mastercard, *Quick Reference Booklet—Merchant Edition* (Apr. 16, 2024), https://www.mastercard.us/content/dam/public/mastercardcom/na/global-site/documents/quick-reference-booklet-merchant.pdf.

categorize businesses by the type of services or goods the business provides or existing systems in place for health-related tax-advantaged accounts or arrangements, including health savings accounts (HSAs), flexible spending accounts (FSAs), and health reimbursement accounts (HRAs) pursuant to guidelines set by the Internal Revenue Service (IRS).[115] With respect to MCCs, some commenters suggested that the CFPB simply require credit card issuers to exclude negative information about debts from merchants coded as some sort of health care provider under the MCCs when furnishing information to consumer reporting agencies. However, it is not clear that all credit card transactions at businesses that could reasonably be said to provide health care services, products, or devices would be related to a "payment for the provision of health care" as required for medical information under FCRA section 603(i). For example, as raised by other commenters, in addition to selling prescription medicine, a pharmacy may also sell household or grocery items. Medical credit cards are also currently used to pay for some expenses that are not clearly medical in nature, such as for funeral services.[116]

Similarly, one commenter suggested that technology similar to the inventory information approval system used for FSA cards could be adapted to identify specific medical expenses charged to credit or debit cards. But not all businesses participate in inventory approval systems and/or accept FSA and HSA cards, even if some system was developed to specifically identify

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[115] With these accounts or arrangements, consumers can use their cards to pay for certain medical care expenses that are deemed qualified under guidelines set by the Internal Revenue Service (IRS). *See* Consumer Fin. Prot. Bureau, *What is a flexible spending account (FSA) card or health savings account card (HSA)?*, https://www.consumerfinance.gov/ask-cfpb/what-is-a-flexible-spending-account-fsa-card-health-savings-account-card-hsa-en-417/ (last reviewed Sept. 6, 2024); Ryan J. Rosso, Cong. Rsch. Serv., R45277, *Health Savings Accounts (HSAs)* (2022), https://crsreports.congress.gov/product/pdf/R/R45277. *See also* Ryan J. Rosso, Cong. Rsch. Serv., R46782, *A Comparison of Tax-Advantaged Accounts for Health Care Expenses* 5 (2021) (explaining qualified medical expenses under the Internal Revenue Code, 26 U.S.C. 213(d)), https://crsreports.congress.gov/product/pdf/R/R46782.

[116] *See, e.g.*, CareCredit, *Ways to use your health and wellness credit card*, https://www.carecredit.com/procedures/ (listing categories of procedures a CareCredit medical credit card can be used for) (last visited Nov. 15, 2024).

expenses that would be medical information under FCRA section 603(i), as opposed to identification as medical expenses under other law. Furthermore, this system is complex; the IRS has issued detailed guidance with regard to the substantiation of eligible medical care expenses paid for with such cards, even at certain businesses with non-health care related MCCs if the business meets conditions such as participation in an inventory information approval system.[117]

Some commenters suggested that the CFPB itself develop or require industry to develop and use transaction-level classification codes to identify what would be medical information at the transactional level under FCRA section 603(i). However, such work or any such requirements would require further input and consultation with industry experts and impose more burden on creditors, information furnishers, and consumer reporting agencies than have been contemplated for this rulemaking. As a result, the CFPB declines to impose such a requirement or itself develop such rules at this time.

Identification of medical debt information could also be problematic in the case of third-party loans. For example, a home equity lender would not know whether and how much of the proceeds of the loan were used to pay for a medical expense and thus whether it should furnish the loan to consumer reporting agencies as being for medical purposes. As a result, the CFPB also declines to impose such a requirement or itself develop such rules at this time.

The CFPB appreciates, as raised by many commenters, that many Americans use credit products offered by third-party lenders to pay their medical bills. However, as described in more detail in part VII, *CFPA Section 1022(b) Analysis*, the CFPB has also determined that there is not

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[117] *See, e.g.*, Internal Revenue Serv., *Notice 2007-2* (addressing the use of debit cards for medical expense reimbursements at merchants with non-health care related MCCs), https://www.irs.gov/pub/irs-drop/n-07-02.pdf and *Notice 2006-69 Debit cards used to reimburse participants in self-insured medical reimbursement plans and dependent care assistance programs* (describing inventory information approval system requirements), https://www.irs.gov/pub/irs-drop/n-06-69.pdf (both last visited Dec. 5, 2024).

yet substantial evidence that the inclusion of information related to medical debt owed to third-party lenders on consumer reports, or its use in underwriting, leads to consumer harm.

While including information about medical debts owed to third-party lenders might have additional benefits for consumers, the CFPB has determined that such information is beyond the scope of this rulemaking and for the reasons stated above, the CFPB declines to change its approach at this time.

One commenter stated that the CFPB's approach is arbitrary and capricious, because it would generally provide that information about a debt owed directly to a health care provider, or its agent or assignee, for the payment of the provider's provision of health care is medical information about a debt under the FCRA and the CFPB's proposed rule, whereas a debt owed to a third-party lender would not be, even though the consumer (and their creditworthiness) is the same in either instance. However, as stated above, the CFPB believes that its approach aligns with the definition of medical information under FCRA section 603(i). Further, as noted, the operational difficulties and likely compliance burdens further justify its approach.

The CFPB also disagrees with the commenter's statement that the CFPB's interpretation was an arbitrary and capricious deviation from the predecessor Agencies' interpretation of the FCRA in the 2005 interim final rule implementing section 411 of the FACT Act. The language cited by the commenter from the 2005 interim final rule relates to the Agencies' interpretation of the general applicability of the creditor prohibition and the exceptions to the creditor prohibition. The CFPB agrees with the Agencies' statements in the 2005 interim final rule that the creditor prohibition and any exceptions to the prohibition are applicable to all creditors. Accordingly, the CFPB did not propose to, and the final rule does not, distinguish between creditor types in regulating creditors' ability to *obtain or use* medical information for the purpose of making

credit eligibility determinations. The CFPB's interpretation pertains to the issue of what types of information fall under the definition of medical information under FCRA section 603(i), which is entirely distinct from the issue considered by the Agencies in 2005 of whether all creditors should be subject to the creditor prohibition and any exceptions to the prohibition under FCRA section 604(g)(2) and (g)(5).

With regard to some commenters' requests that the CFPB evaluate the impacts of its final rule and examine or engage in rulemaking as to medical lending products, the CFPB has long been engaged in outreach and research related to medical debt information in the consumer reporting ecosystem, including on issues such as medical lending products.[118] The CFPB will continue to observe the market and may consider issuing other guidance or rules if it later determines that doing so is consistent with its authority under the FCRA.

Civil Judgments

As explained above, the CFPB interprets FCRA section 603(i) to mean that medical information about a consumer's debt must relate to a debt the consumer owes, or at one time owed (for example, in the case of paid medical debt), directly to a health care provider or to the health care provider's agent or assignee. Generally, the CFPB's approach applies regardless of the form of the medical information pertaining to a consumer's debt owed to a health care provider, or their agent or assignee. A civil judgment on a medical debt is information about a medical debt that has been reduced to judgment. Thus, under the CFPB's interpretation, medical information about a consumer's debts includes medical information in the form of a civil

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[118] *See, e.g.*, Consumer Fin. Prot. Bureau, *Medical Credit Cards and Financing Plans* (May 2023), https://files.consumerfinance.gov/f/documents/cfpb_medical-credit-cards-and-financing-plans_2023-05.pdf; Lorelei Salas, Consumer Fin. Prot. Bureau, *Ensuring consumers aren't pushed into medical payment products* (June 18, 2024), https://www.consumerfinance.gov/about-us/blog/ensuring-consumers-arent-pushed-into-medical-payment-products/.

judgment arising from a debt collection action as to a medical debt directly owed to a health care provider or to their assignee (*i.e.*, a debt buyer), whether provided on a consumer report or by the consumer on a credit application. It also includes information about a civil judgment the creditor learned of through other means. The CFPB declines to revise its interpretation to exclude civil judgments as suggested by several commenters.

The CFPB appreciates the comment it received supporting its approach to civil judgments. However, the CFPB declines to explicitly address civil judgments in the regulation or in official commentary as suggested by the commenter. The CFPB believes that its approach to civil judgments is a straightforward application of its interpretation and that it is not necessary to include it in regulatory text or in official commentary.

The CFPB declines to revise its interpretation in the manner suggested by one commenter. The commenter suggested that the CFPB clarify that as to civil judgments, medical information would include publicly available information—other than the name of the judgment creditor—that the judgment was related to a debt collection action arising from a debt directly owed to a health care provider or their assignee, which the commenter stated would avoid having creditors engage in individualized investigations to determine whether a civil judgment is medical information about a medical debt. The CFPB does not believe that the commenter's suggested clarification aligns with the text of the statute. The definition of medical information under FCRA section 603(i) does not imply that only publicly available information can be

medical information. It also does not provide a basis for stating that the name of the entity to whom the consumer owes a debt is not medical information.[119]

The CFPB appreciates, as raised by the commenter and others, that a creditor may need to engage in follow-up inquiries to determine if a civil judgment is medical information about a debt under the CFPB's interpretation of FCRA section 603(i) and under final § 1022.3(j). The CFPB reminds creditors that the example in final § 1022.30(e)(6) explains how creditors may use medical information provided by the consumer in compliance with TILA and Regulation Z, as set forth in § 1022.30(e)(1)(ii), for purposes of compliance with the ability-to-repay rule under § 1026.43(c) for closed-end mortgages, the repayment ability rule under § 1026.34(a)(4) for open-end, high-cost mortgages, and the ability-to-pay rule under § 1026.51(a) for open-end (not home-secured) credit card accounts.

The commenter also suggested that the CFPB's statements in the preamble about its approach to civil judgments were inconsistent, and could be read to mean that the CFPB intends to treat as medical information civil judgments arising from a debt collection action brought by a debt buyer, even if the underlying debt was not originally owed to a health care provider. The CFPB clarifies that under its interpretation of FCRA section 603(i), medical information about a consumer's debts includes medical information in the form of a civil judgment arising from a debt collection action as to a medical debt directly owed to a health care provider or to their assignee (*i.e.*, a debt buyer).

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[119] *Cf.* 15 U.S.C. 1681c(a)(6) (the name of a medical information furnisher—*i.e.*, a health care provider or its agent or assignee—that has notified the consumer reporting agency of its status must be coded or restricted on a consumer report in a manner that would not identify, or provide information sufficient to infer, the specific provider or the nature of the services, products, or devices).

Credit Scores

The CFPB declines to adopt suggestions from some commenters that the CFPB provide that credit scores that weighed information about medical debt should not be subject to the creditor prohibition under the CFPB's final rule or that the CFPB establish a safe harbor for creditors that inadvertently use such scores. The CFPB's approach to credit scores is a logical extension of its interpretation of FCRA section 603(i) as to medical debt information (and, correspondingly, the definition for medical debt information under § 1022.3(j)). As explained above, the removal of the existing financial information exception in § 1022.30(d) as to medical debt information in the final rule means that the creditor prohibition under FCRA section 604(g)(2) and § 1022.30(b) will apply to generally prohibit creditors from obtaining or using such information for credit eligibility determinations. It would be a paradoxical effect if creditors were then permitted to use a credit score that weighed such information in making those same credit eligibility determinations.

The CFPB also does not believe that a safe harbor for a creditor's inadvertent use of a credit score that weighed medical debt information is necessary. Under final § 1022.38, consumer reporting agencies will generally be prohibited from furnishing consumer reports reflecting medical debt information to creditors, and any credit score based on the information in a consumer's file generally would not weigh medical debt information after the effective date of the final rule. Accordingly, no safe harbor is required.[120]

[120] As discussed in part XI, the CFPB intends that, if the consumer reporting agency prohibition on furnishing medical debt information finalized in § 1022.38 (or any provision or application of that section) is stayed or determined to be invalid, the amendments to § 1022.30 are severable and shall continue in effect. Should that occur, consumer reporting agencies would not be prohibited from furnishing medical debt information to creditors for use in underwriting, and accordingly their credit scores could also reflect medical debt information. In such a circumstance, the CFPB could revisit the question of a safe harbor for creditors that inadvertently use such scores.

Proposed Definition—Medical Debt Information (§ 1022.3(j))

In consideration of its preliminary interpretation of FCRA section 603(i), the CFPB also proposed adding a definition for medical debt information at § 1022.3(j) to facilitate compliance with various aspects of the proposed rule. Under proposed § 1022.3(j), medical debt information would have been defined as medical information that pertains to a debt owed by a consumer to a person whose primary business is providing medical services, products, or devices (*i.e.*, a health care provider), or to the person's agent or assignee, for the provision of such medical services, products, or devices. The definition would have also clarified that medical debt information includes, but is not limited to, medical bills that are not past due or that have been paid.

The CFPB explained that it intended for the definition of medical debt information to align with the scope of information about medical debt that creditors would be prohibited from considering if the financial information exception is removed.

The proposed definition would have also clarified that the term includes information about a debt owed to a health care provider's agent or assignee. The CFPB explained that it intended, by including agents and assignees in the medical debt information definition, to include medical debt that has been purchased by a debt buyer or that is being collected by a third-party debt collector. The CFPB sought comment on whether this aspect of the proposed definition should be modified, such as to ensure it accommodated circumstances where the medical debt has been sold and then resold, as well as on its proposed definition for medical debt information generally.

The CFPB also sought comment on whether the proposed definition provided the clarity needed for consumers, creditors, and consumer reporting agencies to implement the proposed rule if finalized.

Comments—Proposed Definition, Medical Debt Information (§ 1022.3(j))

In addition to comments about whether the CFPB's interpretation of FCRA section 603(i) as to medical debt information and the CFPB's proposed definition at § 1022.3(j) should be revised to include information about debts paid for with third-party lender or creditor products, civil judgments, and credit scores (discussed above), the CFPB also received comments about other aspects of the proposed medical debt information definition. Such comments included those about the types of expenses and providers included under the definition (*i.e.*, because they are "medical" or "health care"-related in nature), suggestions for different treatment of debt arising from elective versus non-elective care, and other general comments about the proposed inclusion of information about debts owed to agents and assignees of medical providers. These comments, and others, are described below.

General Comments and Payment Status

The CFPB received one comment explicitly supporting the inclusion of a proposed definition for medical debt information, which the commenter stated would facilitate compliance with and enforcement of the final rule. Another commenter stated that the CFPB's proposed medical debt definition was insufficiently clear as to what constitutes medical debt, but did not provide any explanation or illustrative examples.

A couple of commenters expressed support for the CFPB's proposal to expressly provide that medical debt information includes, but is not limited to, information involving medical bills that have already been paid or that are not yet past due. One such commenter suggested that the CFPB include an example about a past-due medical bill to clarify that medical debt information also includes information about past-due medical debt.

Agents and Assignees

Several commenters agreed with the CFPB's proposal that generally information about a debt owed to a health care provider's agent or assignee should be considered medical debt information, as well as with the CFPB's statements in the preamble that such agents and assignees would include third-party debt collectors and debt buyers. One such commenter stated that the CFPB should explicitly reference debt buyers and debt collectors in either the text of the definition or in official commentary to the final rule to facilitate the CFPB's intent.

Health Care Providers

The CFPB received a few comments about whether certain persons would be considered a "person whose primary business is providing medical services, products, or devices" (*i.e.*, a health care provider) under the proposed medical debt information definition.

One commenter stated that the proposal was not clear as to whether unlicensed or unregulated providers of complementary and alternative medicine would be considered covered health care providers under the definition. The commenter stated its belief that medical debt information under the rule should be limited to information about debts owed to only regulated or licensed persons who provide medical services, products, or devices. The commenter also suggested that, accordingly, the text of the proposed definition be modified to refer to a "health care provider" in place of a "person" and to explicitly state that the term refers to a provider of services or a provider of medical or health services as defined under the statute governing the Medicare program, at 42 U.S.C. 1395x(u) and 1395x(s), respectively.

Another commenter asked the CFPB to clarify whether a person who, in addition to "providing medical services, products, and devices," also provides a significant amount of non-

medical services, products, and devices would be considered to be a health care provider under the CFPB's proposed medical debt information definition.

One commenter generally supporting the CFPB's proposal expressed concern that the medical debt information definition may not include debts owed to hospitals or health care facilities. The commenter explained that consumers often receive bills not just from providers who provide a health care service like radiological services, but also a bill from the facility in the form of a facility fee. The commenter stated that limiting the definition of medical debt information debts owed to a person, or a person's agent or assignee, may exclude such facility fees charged by hospitals or health care facilities. To avoid this outcome, the commenter suggested that the CFPB include hospitals and health care facilities in the medical debt information definition.

With regard to hospitals, one commenter generally supporting the proposed rule stated its view that hospital bills are particularly prone to error, and as a result also expressed concern that existing § 1022.30(c)(3)(i)'s example refers to information about a hospital bill that a creditor "receives" (which the commenter also said was ambiguous). This commenter also suggested that the CFPB require creditors to include a disclaimer on credit applications to inform consumers that it is not necessary to include medical debt information and if the consumer chooses to disclose such information, it will be used by the creditor to determine the consumer's creditworthiness.

Medical Services, Products, and Devices

The CFPB also received comments about whether specific types of services, products, or devices should be considered "medical services, products, or devices" under the proposed medical debt information definition. Several commenters stated that the CFPB's proposed

definition was unclear in this regard and as a result may lead to confusion and add to the compliance and operational burden for regulated entities and small businesses.

Several commenters stated that information about debt arising from dental care should be included in the scope of the medical debt information definition. One of the commenters emphasized that dental debt can present a burden for consumers, citing reports that many Americans report that dental bills are the cause of some of their medical debt and that there may be a disproportionate impact on Black and Latino communities who have a higher incidence of periodontal disease. The commenter also noted that many dental costs may not be covered by health insurance. Another commenter stated that the CFPB should explicitly note in the final rule and provide official staff commentary stating that medical debt information includes information about dental debt. The commenter suggested that the CFPB revise its proposed medical debt information definition to change references to "medical services, products, or devices" to "health care services, products, or devices" to capture information about dental debt. Other commenters questioned generally if dental debt was within the scope of the CFPB's proposed definition.

Several commenters raised questions about whether debt related to other specific types of services, products, or devices were included in the CFPB's proposed medical debt information definition. For example, the commenters asked for clarity about whether veterinarian services, eye care or vision services, counseling, therapy, over-the-counter medication, bandages, dermatological services, cosmetic procedures, pharmacy expenses, primary and specialty care, lab and diagnostic expenses, other outpatient care, and massages were covered under the definition.

Elective Medical Care

Some commenters suggested that the CFPB's final rule should distinguish between information about medical debt that arises from elective care versus non-elective (or emergency) care. Generally, these commenters stated that elective medical procedures are typically planned and discretionary, unlike non-elective medical debt which arise from unexpected or unavoidable circumstances. Specifically, the commenters stated that elective medical care reflect a consumer's conscious financial decision and thus should be included in creditors' determination of a consumers' ability to repay a future loan. The commenters suggested that by categorizing medical debt in this way, the CFPB would be able to protect consumers from the adverse effects of medical debt and also allow lenders to have access to necessary information for making informed credit decisions. One commenter similarly suggested that the CFPB's final medical debt information definition not include information about debt arising from elective procedures, unless the elective procedure was needed as the result of an injury or illness. Another commenter suggested that the CFPB distinguish between non-elective care and other types of health care-related debt, including daily goods and services. A few commenters suggested that the CFPB's rule should not apply to elective and cosmetic surgery and should be limited to emergency medical treatment only.

One commenter stated that the CFPB's approach may lead to unequal treatment. The commenter, who generally argued that the CFPB's proposal would cause distortions in the credit market, stated that consumers with recurring medical expenses would benefit less from the rule, because they continually will have new medical debts.

One commenter, who also generally supported the CFPB's proposed rule and urged the CFPB to include debt paid for with third-party medical payment products in the final medical

debt definition, suggested that CFPB restrict reporting of debt paid for with third-party medical payment products unless the medical provider and the consumer each attest to the elective or non-elective nature of the medical service, to allow the medical and financial industries to report debt related to only elective medical care to a consumer reporting agency, but did not make a similar suggestion for medical debts owed directly to a health care provider.

Final Rule—Definition, Medical Debt Information (§ 1022.3(j))

For the reasons stated herein, the CFPB finalizes its definition as proposed for medical debt information at § 1022.3(j). Under final § 1022.3(j), medical debt information is defined as medical information that pertains to a debt owed by a consumer to a person whose primary business is providing medical services, products, or devices (also referred to herein as a health care provider), or to the person's agent or assignee, for the provision of such medical services, products, or devices. The definition also provides that medical debt information includes, but is not limited to, medical bills that are not past due or that have been paid.

Generally, under the final definition, for information about a debt to be medical debt information, it must meet two requirements. First, the debt must be directly owed to a person whose primary business is providing medical services, products, or devices, or their agent or assignee. Second, the debt must be for the provision of the medical services, products, or devices by the health care provider.

The final definition is adapted from FCRA section 623(a)(9), which defines the term "medical information furnisher" as a person whose primary business is providing medical services, products, or devices, or the person's agent or assignee, who furnishes information to a consumer reporting agency on a consumer. The CFPB believes that aligning the definition of "medical debt information" with the FCRA definition for "medical information furnisher" will provide a familiar standard under the FCRA that will facilitate compliance with the proposed

rule. For consumer reporting agencies specifically, the CFPB anticipates that the self-identification of medical information furnishers under FCRA section 623(a)(9) will assist consumer reporting agencies in identifying and excluding medical debt information from consumer reports provided to creditors, as required under final § 1022.38.

The CFPB intends for the final medical debt information definition to align with the CFPB's interpretation of FCRA section 603(i) as to medical information and thus correspond with the scope of the medical information about a consumer's medical debts that a creditor generally may not obtain or use under final § 1022.30, as revised to remove the financial information exception at § 1022.30(d). The medical debt information definition also establishes what medical information a consumer reporting agency must consider in complying with final §1022.38.

General Comments and Payment Status

The CFPB agrees with the commenter stating that including a medical debt definition in the final rule will facilitate compliance and enforcement of the final rule. The CFPB also appreciates the comments supporting the proposed definition's clarification that medical debt information includes information about medical bills that are not past due or that have been paid. The CFPB disagrees, however, with one commenter's suggestion that the CFPB include a specific example in the text of the regulation as to a past-due medical bill. The CFPB believes that it is clear from the definition and use of the term "debt" that medical information about a past-due medical bill is medical debt information under the rule.

Agents and Assignees

The CFPB appreciates the comments it received supporting its interpretation that agents and assignees of a health care provider under the proposed medical debt information definition

includes third-party debt collectors and debt buyers. The CFPB is finalizing this approach for the proposed definition (which the CFPB intends to align with the scope of medical debt information under its interpretation of FCRA section 603(i)). The CFPB declines to implement a suggestion from one commenter that it explicitly reference debt buyer and third-party debt collectors in the text of the regulation. The CFPB believes the medical debt information definition is sufficiently clear and finalizes § 1022.3(j) as proposed.

Health Care Providers

Under the CFPB's proposed and final definition at § 1022.3(j), for information about a consumer's debt to be medical debt information, the debt must be owed by the consumer to "a person whose primary business is providing medical services, products, or devices." For the purposes of this document, the CFPB refers to such a person as a health care provider. As noted above, this aspect of the final medical debt information definition at § 1022.3(j) is adapted from the definition of "medical information furnisher" in FCRA section 623(a)(9) and the CFPB anticipates it will provide a familiar standard that will facilitate compliance with the final rule.

Some commenters asked for clarification as to whether specific types of providers, such as providers of complementary and alternative medicine or pharmacies, would be health providers under the rule. The CFPB notes neither the definition of medical information in FCRA section 603(i) nor the definition of medical information furnisher in FCRA section 623(a)(9) states that only providers of certain kinds of health care are "medical." The CFPB likewise declines to do so for the final rule. Generally, the CFPB anticipates that whether a provider is a health care provider for the purposes of the final rule will depend on the specific facts and circumstances for each provider. The CFPB also anticipates that such determinations may be guided by whether such providers, as well as their agents and assignees, notify consumer

reporting agencies of their status as medical information furnishers under FCRA section 623(a)(9).

As to the comment seeking clarification about whether hospitals and health care facilities and facility fees they may charge would be covered under the CFPB's rule, the CFPB believes the definition is sufficiently clear and as a result declines to revise the definition to reference hospitals and health care facilities as suggested by the commenter. However, while generally a determination as to whether a person is a health care provider under the final rule may depend on individual facts and circumstances, the CFPB believes that hospitals and health care facilities are plainly "person[s] whose primary business is providing medical services, products, or devices." Further, the CFPB also believes that facility fees that may be charged in association with a consumer's health care are clearly part of the "provision of such medical services, products, or devices" to a consumer and that information about a medical debt arising from such fees are medical debt information under the final rule, even if the specific medical professional providing care at, for example, a hospital sends a separate bill for the care provided.

In response to one commenter expressing concerns about hospitals and requesting the CFPB require disclaimers on credit applications, the CFPB does not believe that any examples in § 1022.30 should be revised to refer to something other than a hospital bill where currently used. The examples are meant to be illustrative and hospital bills are often a source of medical information, even if they contain errors. Further, the CFPB declines to require creditors to include a disclaimer informing consumers that they do not need to provide medical debt information on credit applications. Such a disclaimer would not be an accurate reflection of the proposed or final rule.

Medical Services, Products, and Devices

The CFPB disagrees with commenters stating that the proposed definition for medical debt information, which the CFPB is finalizing as proposed, is unclear. As noted earlier, neither the definition of medical information in FCRA section 603(i) nor the definition of medical information furnisher in FCRA section 623(a)(9) states that only certain types of health care or providers of such health care are "medical." It also does not state that only certain types of services, products, or devices are "medical." The CFPB accordingly declines to specify in the text of the definition or in official commentary, as urged by a commenter, that certain types of medical services, products, or devices are covered under the CFPB's medical debt information definition or under the CFPB's interpretation of FCRA section 603(i). As with health care providers, the CFPB anticipates that industry's interpretation of the similar definition for medical information furnisher under FCRA section 623(a)(9) will provide a familiar standard that will facilitate compliance with the final rule.

Generally, as long as both requirements of the definition are satisfied (*i.e.*, that the debt is directly owed to a health care provider, or their agent or assignee, and it is for the provision of medical services, products, or devices), information about the debt at issue is considered medical debt information under the final rule. Thus, for example, the CFPB would anticipate that debt owed to an optometry or ophthalmology practice (or its agent or assignee) arising from its provision of eye care would be covered under the CFPB's final rule, as well as a debt owed to a dental practice (or its agent or assignee) arising from its provision of dental care. Similarly, the CFPB would also anticipate that a debt owed to a health care provider or a supplier of durable medical equipment (or their agent or assignee) arising from the purchase of a wheelchair, or a debt owed to a supplier of orthotic and prosthetic devices (or its agent or assignee) arising from

the purchase of a prosthetic limb, would generally also be covered under the final rule. However, a debt to a grocery store arising from bandages purchased there would not meet the requirements, because the primary business of the grocery store is not the provision of medical services, products, or devices.

Elective Medical Care

Some commenters urged the CFPB to distinguish and provide different treatment under the final rule for different types of medical debt, including as to debt arising from elective care versus non-elective care or emergency care. The CFPB understands that many elective procedures are treatment for serious illnesses and health conditions that are often unanticipated. In such circumstances, consumers still have limited ability to shop around or control the timing of costs. And, many of the factors regarding errors in medical billing and collections still apply to limit the value of information about such types of medical debt. Further, CFPB research discussed elsewhere in this preamble indicates generally that the use of medical debt information (including information about debts related to both elective and non-elective medical care) in credit eligibility determinations does not reduce the delinquency risk faced by creditors, and commenters have not cited any research establishing that debt related to elective medical care is more predictive of delinquency risk than debt related to non-elective medical care. As a result, after further consideration, the CFPB declines to provide different treatment for debt arising from elective care than from other types of medical debt under the final rule.

The CFPB also disagrees with the commenter stating that a failure to distinguish between medical debt arising from elective care versus non-elective care would benefit consumers unequally because some consumers have recurring medical expenses that may lead to new debt. Under the final rule, treatment by creditors and consumer reporting agencies of medical debt will

be the same, without regard to whether the debt is recurring. To the extent the commenter was expressing the general concern, also expressed by other commenters, that the rule would impact creditors' ability to accurately assess consumers' delinquency risk because they would have less information about consumers' medical debts, the CFPB disagrees as discussed in part VII, *CFPA Section 1022(b) Analysis*.

Determination that Medical Debt Information Is Not Necessary and Appropriate for Credit Eligibility Determinations

Under FCRA section 604(g)(5), the CFPB (like the predecessor Agencies before it) has authority to permit an exception to the creditor prohibition that it determines to be necessary and appropriate, consistent with the intent of the creditor prohibition to restrict the use of medical information for inappropriate purposes.[121]

When the predecessor Agencies established the existing financial information exception at § 1022.30(d), it appears that the Agencies addressed specific comments on the parameters of their proposal for the financial information exception (which they substantially finalized as proposed) but did not provide evidence or analysis to support their determination.[122]

In the period since the predecessor Agencies enacted their rule, creditors have been able to obtain and use financial information relating to a consumer's medical debts as a result of the financial information exception. However, and as the CFPB explained in its proposal, there has been a significant body of research and marketplace changes that have shed more light on the nature of medical debt and financial information available to creditors about medical debt. The

[121] 15 U.S.C. 1681b(g)(5).

[122] 70 FR 33958, 33966-67 (June 10, 2005)*; see also* part III.B, *Fair Credit Reporting Act*.

CFPB stated that these developments provide a more nuanced picture that raises questions about creditors' use of medical debt information in credit underwriting.

In consideration of its stated points, the CFPB preliminarily determined that it is not "necessary and appropriate to protect legitimate operational, transactional, risk, consumer, and other needs" for creditors to consider sensitive financial information concerning consumers' medical debt, nor is it consistent with the intent of the creditor prohibition to restrict the use of medical information for inappropriate purposes, as required for an exception under FCRA section 604(g)(5).[123] The CFPB sought comment on its preliminary determination.

In support of this preliminary conclusion, the CFPB cited a number of points. Comments addressing these points, and others, are discussed below, with references where they are also discussed in part VII, *CFPA Section 1022(b) Analysis*, as part of the CFPB's discussion of the potential benefits, costs, and impacts of the rule.

First, the CFPB noted that recent research has demonstrated that unlike other types of debt, medical debt often results from an event such as an accident or sudden illness.[124] In these circumstances, the CFPB explained that consumers have no control over whether to incur a debt; they may have limited or no ability to shop around and may not be able to control the amount or timing of their costs.

Many commenters, who generally supported the CFPB's proposal, agreed with these findings by the CFPB. Some such commenters emphasized that patients in need of urgent or

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[123] 15 U.S.C. 1681b(g)(5).

[124] Lunna Lopes et al., Kaiser Fam. Found., *Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills* (June 16, 2022), https://www.kff.org/health-costs/report/kff-health-care-debt-survey/ (results of national survey show that 7 in 10 adults with health care debt say that the bills that led to their debt were for a one-time or short-term medical expense).

emergency medical care are not in a position to negotiate the costs of their care and have little choice about which health providers to receive care from based on who will accept their insurance (if the consumer has any). A few commenters also stated there is also generally a lack of price transparency for care, despite Federal law requiring it, because providers may not comply with the law or the prices are missing, unreliable, or difficult to obtain in advance or because of the health providers' practice (also known as chargemaster pricing) of charging high rates that are discounted for insurers but not for uninsured or out-of-network patients.

In contrast, and as described in more detail in part VII, *CFPA Section 1022(b) Analysis*, commenters opposing the CFPB's proposed rule alleged that the CFPB had overstated the extent to which medical debt results from circumstances over which consumers have no control. The commenters also stated that there is no statutory basis for excluding a creditor's consideration of such debt because it is unexpected. They further questioned this aspect of the CFPB's rationale, noting that the CFPB's proposal is not limited to just unexpected medical debt and also covered elective services. These commenters and others stated their opinion that, even assuming a medical debt is unexpected, there are many consumer debts that are the result of unplanned events that are not the fault of the consumer and all such information is still pertinent for credit underwriting regardless of their underlying cause. Another commenter stated that even if medical debt is not a good indicator of a consumer's repayment risk because in many cases it is unavoidable or the result of an emergency, it does not alter the consumer's ability to repay even if relevant to a consumer's willingness to repay. One commenter stated that medical debt should not be treated differently from other kinds of consumer debt because it is taken on involuntarily, because consumers are aware that illness is inevitable and should be saving for such expenses.

As explained above and in part VII, *CFPA Section 1022(b) Analysis*, available data implies that a substantial fraction of medical debt results from unplanned expenditures. The CFPB did not state in its proposal or mean to imply that all medical debt is the result of sudden events. However, as stated in the NPRM, the fact that much medical debt is unexpected means that, as to much medical debt, consumers had limited ability to understand and control costs or their timing, distinguishing such debt from other types of consumer debt. For example, as noted by a commenter, even when a hospital must make prices known to consumers under Federal law,[125] reporting indicates that consumers may still have difficulty ascertaining the cost of their care.[126] And, while consumers may also encounter a need to take on debt as a result of unexpected, non-medical events, the CFPB notes that medical debt is also unique in ways that limit its informational value, such as because of the prevalence of errors in such information and inconsistent reporting, as further addressed below and elsewhere in this preamble.

In response to commenters noting that the rule covers both non-elective care that stems from emergency health needs as well as elective care that is planned, the CFPB notes that, as discussed above with regard to comments about the proposed medical debt information definition, elective care is inclusive of necessary health care for unanticipated health conditions. Further, many of the same issues limiting the informational value of information about non-elective care applies to medical debt information about elective care.

With regard to the comment about how medical debt information, even if related to an unexpected or sudden health event, is relevant to a creditor's assessments of a consumer's ability

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[125] *See* 45 CFR part 180 (Centers for Medicare & Medicaid Services Hospital Price Transparency rule).

[126] *See* U.S. PIRG Educ. Fund, *Post the Price: Hospital Price Transparency Could Save Patients Thousands* (May 2024), https://publicinterestnetwork.org/wp-content/uploads/2024/05/Re-uploaded-Revised-After-Release_-Cleveland-Price-Transparency-Report-.pdf.

to repay, the CFPB refers to its discussion in part VII.E.5, as to the availability of information on consumer reports used in underwriting and the ability-to-repay or pay requirements under the Truth in Lending Act and Regulation Z.

In the proposal, the CFPB also noted that, second, in the period of time since the predecessor Agencies enacted their rule, more evidence has come to light showing that information about medical debt is prone to error. The CFPB stated that third-party surveys and complaints received by the CFPB have shown that medical bills commonly contain errors and are frequently disputed by consumers.[127] Further, the CFPB noted that the complexity of medical billing, the third-party reimbursement process, and debt collection practices can lead to consumer confusion on payment due dates and amounts owed for medical bills, as well as questions about the accuracy of their bills.[128]

Comments about inaccuracy and errors in medical debt information and with medical billing are addressed in part VII, *CFPA Section 1022(b) Analysis*. However, to summarize at a high level, the CFPB received a large number of comments agreeing with the CFPB's point, with many commenters providing or citing to consumer anecdotes or publicly available consumer complaints about consumers encountering errors in their medical bills, notices of collection for medical debt, or on their consumer reports. In addition to the issues raised by the CFPB,

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[127] *See, e.g.*, Karen Pollitz & Kaye Pestaina, Kaiser Fam. Found., *Could Consumer Assistance Be Helpful to People Facing Medical Debt?* (July 14, 2022), https://www.kff.org/policy-watch/could-consumer-assistance-be-helpful-to-people-facing-medical-debt/ (reporting survey results that 43 percent of all adults and 53 percent of adults with health care debt say they thought they received a medical or dental bill with an error).

[128] *See, e.g.*, Consumer Fin. Prot. Bureau, *Medical Debt Burden in the United States*, at 9-14 (Feb. 2022), https://files.consumerfinance.gov/f/documents/cfpb_medical-debt-burden-in-the-united-states_report_2022-03.pdf (describing issues with medical billing and collections practices); Gideon Weissman et al., Frontier Grp. & U.S. Pub. Int. Rsch. Grp. Educ. Fund, *Medical Debt Malpractice: Consumer Complaints About Medical Debt Collectors, and How the CFPB Can Help* (Spring 2017), https://publicinterestnetwork.org/wp-content/uploads/2017/04/Medical-Debt-Malpractic-vUS-1.pdf (63 percent of medical debt collection complaints submitted to the CFPB asserted that the debt had never been owed in the first place, had already been paid or discharged in bankruptcy, or was not verified as the consumer's debt).

commenters also stated that third-party debt collectors and debt buyers often lack access to original creditors' systems of records about medical debt, which can lead to errors on collection notices sent to consumers or in medical debt information reported to consumer reporting agencies. Several commenters also flagged that many consumers have difficulty understanding medical bills, navigating insurance appeals, or successfully using the dispute process for errors related to medical debt information on their consumer reports, suggesting that the rate of error may be higher than is known.

Some commenters generally opposing the CFPB's proposal did not disagree with the CFPB that information about medical debt often contains errors, but either implied that even erroneous medical debt information is needed for accurate credit assessments or stated that the solution for errors in medical debt information is to improve the accuracy of medical debt information that is reported to consumer reporting agencies or reform the health care system. One commenter stated that billing errors should be resolved between health care providers and consumers rather than by removing medical debt information from consumer reports. Other commenters opposing the proposal stated that the CFPB's assessment that information about medical debt is prone to error is based upon biased and/or flawed studies and information.

As explained in detail in part VII, *CFPA Section 1022(b) Analysis*, the CFPB understands that many medical collections included on consumer reports reflect incorrect billing, including debts that were already paid by either the consumer or by their insurance company, or debts that are not owed by the consumer. Further, the CFPB understands that the prevalence of such errors could be due to factors such as that, unlike other consumer debts like banking/financial debts, nearly all credit reporting of medical debt is managed by third-party debt collection agencies,

who may have limited access to the original creditors' systems of records.[129] The CFPB disagrees with commenters implying that erroneous medical debt information can assist in making accurate evaluations of a consumer's ability to repay future debt. The CFPB has also assessed potential alternatives for improving the accuracy of medical debt information reported to consumer reporting agencies and determined that such measures would not be sufficient to achieve the objective of protecting consumer privacy with respect to sensitive medical information.

In support of its preliminary determination, the CFPB also explained that, third, its work shows that medical debt information has relatively limited predictive value. Generally, the CFPB cited its research from 2014, which the CFPB explained found that medical debt collections tradelines (also referred to as medical collections) are less predictive of future consumer credit performance than nonmedical collections.[130] The CFPB cited research included in part XI, *Technical Appendix*, of the NPRM (which is also addressed in part XII, *Technical Appendix*, of this final rule), which the CFPB said suggests that not only can creditors responsibly underwrite credit without information about consumers' medical debts, but also that such information may lead to a market failure because it may be an inaccurate signal of whether a consumer will pay a future debt. The CFPB also stated that under the assumption that two-year serious delinquency is a good proxy for the overall risk of a credit account, the *Technical Appendix* implies that information about consumers' medical debts distorts underwriting decisions, impairs creditors'

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[129] Consumer Fin. Prot. Bureau, *Market Snapshot: An Update on Third Party Debt Collections Tradelines Reporting*, at 5 (Feb. 2023), https://files.consumerfinance.gov/f/documents/cfpb_market-snapshot-third-party-debt-collections-tradelines-reporting_2023-02.pdf.

[130] Kenneth P. Brevoort & 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.

ability to make safe and low-risk credit approvals, and thus reduces credit approval volumes within creditors' risk-tolerances.

The CFPB also noted that two major credit score providers had adjusted their newer models to reduce or eliminate the weight of medical debt collections,[131] which it said further confirmed the limited value of medical debt information for ensuring that credit decisions are based on whether a consumer will repay a loan. The CFPB observed that, however, some widely used models still weigh medical and nonmedical collections equally.[132] The CFPB stated that this means that consumers with medical debt may still be negatively affected if creditors use older scoring models that overweigh medical debt.

Comments about the CFPB's findings and research about the limited predictive value of medical debt information are discussed in part VII, *CFPA Section 1022(b) Analysis*. Generally, however, the CFPB received comments both agreeing and disagreeing with the CFPB's findings about the value of medical debt information for predicting a consumer's ability to repay a future debt. Commenters disagreeing with the CFPB's conclusions emphasized that the CFPB's research states that medical debt is less predictive and is not "not" predictive of a consumer's risk of delinquency. These commenters also stated that because, in their view, medical debt information is predictive, creditors need such information to make accurate assessments of a consumers' creditworthiness and capacity to take on debt. One commenter also stated that the

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[131] *See* VantageScore, *Major Credit Score News: VantageScore Removes Medical Debt Collection Records From Latest Scoring Models [Update]* (Aug. 10, 2022), https://www.vantagescore.com/major-credit-score-news-vantagescore-removes-medical-debt-collection-records-from-latest-scoring-models/ (VantageScore to remove medical collection data from VantageScore 3.0 and 4.0 models by January 2023); Ethan Dornhelm, *The Impact of Medical Debt Collections on FICO Scores*, FICO Blog (July 13, 2015), https://www.fico.com/blogs/impact-medical-debt-collections-ficor-scores (describing changes to FICO Score 9 with regard to medical collections).

[132] Consumer Fin. Prot. Bureau, *Medical Debt Burden in the United States*, at 27-28 (Feb. 2022), https://files.consumerfinance.gov/f/documents/cfpb_medical-debt-burden-in-the-united-states_report_2022-03.pdf.

CFPB had failed to consider whether voluntarily incurred medical debt differs from involuntarily incurred medical debt in terms of predictiveness. Commenters disputing the CFPB's finding that medical debt information has limited predictive value also stated that even though one major credit score provider, VantageScore, has removed medical debt as a factor in its newer credit score models, another major credit score provider, FICO, has found that consumers with unpaid medical debt tradelines are more risky than consumers without any derogatory information in their credit files.

Commenters opposing the rule also stated that several public statements by CFPB officials that medical debt information is not predictive contradict the CFPB's research findings that medical collections information is relatively less predictive than nonmedical collections information. Commenters also stated that the proposal conflicts with the CFPB's positions in other contexts, such as with regard to a CFPB blog post about credit reporting and the buy now pay later industry encouraging more information furnishing of both positive and negative information.[133]

As explained further by the CFPB in part VII, *CFPA Section 1022(b) Analysis*, the CFPB maintains that its research shows that medical debt information overall has only limited predictive value and the CFPB expects that medical collections can be removed from underwriting models without significantly reducing their ability to predict serious delinquency if underwriting models continue to include other variables that are sufficiently predictive of delinquency risk. The CFPB reminds creditors and consumer reporting agencies to look to the requirements of the final rule to determine their compliance obligations and not statements

[133] Martin Kleinbard & Laura Udis, *Buy Now, Pay Later and Credit Reporting*, Consumer Fin. Prot. Bureau (June 15, 2022), https://www.consumerfinance.gov/about-us/blog/by-now-pay-later-and-credit-reporting/.

generally characterizing the rule for the public. The CFPB also disagrees with commenters that the CFPB's proposed approach is contradictory; any general statements about credit reporting or consideration of consumer information for credit eligibility were made under contexts specific to those statements and were not made in consideration of the findings, evidence, and policies for this final rule.

In support of its preliminary determination, the CFPB also noted that, fourth, the inconsistent nature of medical collection furnishing and medical debt collection practices likely limits the value of such information for credit underwriting. The CFPB expressed that the vast majority of such medical debt reporting is done by third-party debt collectors,[134] who use consumer reporting as a way to coerce consumers to pay medical debt, even in some cases for medical debt that the consumer may not owe or that has already been paid.[135] However, the CFPB also explained that not all medical debt is reported; not all medical debt collectors report medical debts to consumer reporting agencies and health care providers themselves rarely do so.[136] The CFPB suggested that these issues imply that even consumers with similar amounts of

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[134] Consumer Fin. Prot. Bureau, *Market Snapshot: An Update on Third-Party Debt Collections Tradelines Reporting*, at 16 (Feb. 2023), https://files.consumerfinance.gov/f/documents/cfpb_market-snapshot-third-party-debt-collections-tradelines-reporting_2023-02.pdf (as of Q1 2022, 57 percent of all tradelines were medical collections and were the most common collections type); Consumer Fin. Prot. Bureau, *Market Snapshot: Third-Party Debt Collections Tradeline Reporting*, at 12-13 (July 2019), https://files.consumerfinance.gov/f/documents/201907_cfpb_third-party-debt-collections_report.pdf (finding that 58 percent of collections tradelines in credit records from 2004 to 2018 were for medical debt); Consumer Fin. Prot. Bureau, *Consumer credit reports: A study of medical and non-medical collections*, at 5 (Dec. 2014), https://files.consumerfinance.gov/f/201412_cfpb_reports_consumer-credit-medical-and-non-medical-collections.pdf (medical collections account for 52.1 percent of all collections tradelines).

[135] *See* Consumer Fin. Prot. Bureau, *Market Snapshot: An Update on Third-Party Debt Collections Tradelines Reporting*, at 12 n.9 (Feb. 2023), https://files.consumerfinance.gov/f/documents/cfpb_market-snapshot-third-party-debt-collections-tradelines-reporting_2023-02.pdf (describing how medical tradelines often do not persist on consumer reports, how medical collections accounts are rarely marked as paid, and noting "pay-to-delete" practices used by debt collectors and debt buyers to pressure consumers into paying or settling debt).

[136] Consumer Fin. Prot. Bureau, *Medical Debt Burden in the United States*, at 26 (Feb. 2022), https://files.consumerfinance.gov/f/documents/cfpb_medical-debt-burden-in-the-united-states_report_2022-03.pdf.

medical debt may face markedly different outcomes in the credit market based on whether their medical debt is furnished or not.

The CFPB did not receive any comments disputing that medical debt information is inconsistently reported. One commenter, however, stated that the CFPB's proposal would not resolve this issue and medical debt information is nonetheless an important data point for creditors. In response to this commenter, the CFPB notes that as explained in part VII.E.5, *Availability of information on consumer reports used in underwriting*, evidence shows that some medical collections reflect inaccurate billing practices, and their inconsistent inclusion on consumer reports adds only a noisy signal of consumers' ability to pay.

In the proposal, the CFPB also stated that, fifth, many industry participants have reduced or stopped their reliance on information about medical debt, casting doubt on its value. The three NCRAs have stopped reporting medical collections that are under $500, less than a year old, or paid.[137] And, the CFPB observed, large credit scoring companies are moving to models that completely or partially exclude medical collections.[138] The CFPB also noted that it had learned from several small entity representatives during the SBREFA process that some creditors have stopped considering medical collections in their underwriting.[139]

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[137] Bus. Wire, *Equifax, Experian, and TransUnion Support U.S. Consumers With Changes to Medical Collection Debt Reporting* (Mar. 18, 2022), https://www.businesswire.com/news/home/20220318005244/en/Equifax-Experian-and-TransUnion-Support-U.S.-Consumers-With-Changes-to-Medical-Collection-Debt-Reporting.

[138] One such credit score provider, VantageScore, has completely stopped factoring medical collections in the latest versions of its models due to lack of their predictiveness as compared with other accounts in collections. *See* AnnaMaria Andriotis, *Major Credit-Score Provider to Exclude Medical Debts*, Wall St. J. (Aug. 10, 2022), https://www.wsj.com/articles/major-credit-score-provider-to-exclude-medical-debts-11660102729.

[139] *See* Comment from Arlington Cmty. Fed. Credit Union, *Re: FCRA Proposals and Alternatives Under Consideration*, at 2-3 (Nov. 6, 2023), SBREFA Report app. A; Comment from First Sec. Bank & Tr., *Re: CFPB's Outline of Proposals and Alternatives Under Consideration, Small Business Advisory Review Panel for Consumer Reporting Rulemaking*, at 7 (Nov. 6, 2023), SBREFA Report app. A (bank does not consider medical collections unless aware the consumer has made periodic payment arrangements with a collection agency or medical establishment).

Some commenters disagreed with the CFPB that these developments imply that the market likewise finds that medical debt information has limited value for credit underwriting. The commenters generally stated that the market actions indicate that the CFPB's proposal is duplicative and unnecessary. Some other commenters emphasized, however, that the NCRAs' actions were not about the predictiveness of information, but rather were meant to provide more time for health insurance reimbursements. Other commenters stated that the NCRAs' changes have left large medical debts on consumer reports, which the commenters said should be considered in credit underwriting. Commenters supporting the CFPB's proposal, however, stated the market changes have been insufficient and many Americans still have medical debt information on their consumer reports, emphasized that the national consumer reporting agencies' actions are voluntary and could be stopped, and observed that there are still older credit scores and metrics in use that do not have the same adjustments that reduce the amount of medical debt information on consumer reports.

The CFPB disagrees with the commenters implying the market participant actions described in the proposal are not significant indicators it should take under consideration for the final rule. For example, the NCRAs' actions to remove medical debt collections with balances of less than $500 and paid medical collections on consumer reports, credit score providers FICO's and VantageScore's actions to reduce or remove consideration of medical debt collection information from their newer models, and changes by individual lenders represent a clear trend in the credit reporting and credit markets to reduce the weight of medical debt information for credit evaluation purposes. However, as noted by commenters, the NCRAs' actions are voluntary and could be reversed, and medical debt information still remains on consumer reports. Given the CFPB's finding, as noted above, that medical debt information has limited predictive value

and its expectation that medical collections can be removed from underwriting models without significantly reducing their ability to predict serious delinquency if underwriting models continue to include other variables that are sufficiently predictive of delinquency risk, the CFPB concludes that it is no longer appropriate and necessary for creditors to consider medical debt information under a regulatory exception to the statutory creditor prohibition.

Sixth, the CFPB also explained in the proposal that some States and some Federal agencies have also acted to limit creditors' access to, or ability to consider, certain medical debt information. As an example, the CFPB noted that several States had prohibited, or had been considering prohibiting, the inclusion of consumer medical debt on consumer reports at the time of the NPRM.[140] The CFPB stated that although such efforts were in their early stages, the CFPB was not aware of evidence that such actions had affected creditors' underwriting standards or that creditors have materially curtailed access to credit or tightened credit terms in those States. The CFPB also explained that some Federal government agencies had also been reviewing and modifying their underwriting practices to reduce or eliminate medical debt collections from consideration when evaluating whether a consumer will repay a loan.[141] The CFPB stated that these changes by the States and by the Federal government indicate a growing awareness that medical debt information may have limited value for credit underwriting purposes. The CFPB also stated that consumer reporting agencies and creditors will already need to comply with these new laws and best practices and, given operational and business realities, may need to do so on a

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[140] *See* Colo. Rev. Stat. section 5-18-109; N.Y. Pub. Health Law art. 49-A; 2024 Conn. Act 24-6; 2024 Va. Acts ch. 751. Since the NPRM was issued, several other states have passed similar laws. *See* 2024 Cal. SB 1061; 2024 Minn. Ch. 332C; 2024 New Jersey A3681; 2024 Ill. Pub. Act 103-0648.

[141] *See* The White House, *Fact Sheet: The Biden Administration Announces New Actions to Lessen the Burden of Medical Debt and Increase Consumer Protection* (Apr. 11, 2022), 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/.

broad basis. The CFPB concluded that removing the financial information exception in Regulation V would create a uniform nationwide baseline consistent with these advancements.

Commenters opposing the rule disagreed with the CFPB that State and Federal actions related to medical debt also argue in favor of the CFPB's preliminary determination. Some such commenters said that the CFPB should not finalize its proposed rule because some States have already enacted reforms as to medical debt information and credit reporting. One commenter stated that the proposed rule, if finalized, could create confusion for small entities in States with such protections and the CFPB should clarify which law controls. One commenter supporting the proposed rule stated that the rule enhances some States' consumer protection efforts as to medical debt, such as those in New York, or provide protection for residents of states without such measures.

Other commenters stated that changes on the Federal level on medical debt remove the need for any intervention by the CFPB, citing the passage of the No Surprises Act, changes to Regulation F (which implements the Fair Debt Collection Practices Act), and inquiries into medical credit cards and other medical payment products, among others. One commenter also stated that health insurance under the Affordable Care Act is more accessible than before and there currently are high rates of insurance coverage. One commenter stated that the CFPB's reference to actions by Freddie Mac and Fannie Mae to no longer consider medical collections in mortgage underwriting does not prove the CFPB's preliminary determination; the two entities, who are under conservatorship, were directed to make such changes by the Federal government and the changes were not based on research and analysis.

The CFPB reaffirms its point in the proposal that the changes that have been made by the States and by the Federal government indicate that there is a growing awareness that medical

debt information may have limited value for credit underwriting purposes. The CFPB agrees with commenters that the CFPB's proposal would facilitate such efforts. Further, contrary to some commenters' assertions, the CFPB believes that the actions to date, which are not uniform in their scope or execution, suggest that consumers would benefit from having a Federal, baseline standard for the creditors' treatment of medical debt information.

Although not mentioned by the CFPB as part of the reasoning behind its preliminary determination, a few commenters stated the CFPB also claimed that the proposal will solve the issue of debt parking, which the commenters stated is not a real concern. In response, the CFPB notes that debt parking was not a focus of its proposal and was not cited as a one of the reasons underlying its preliminary determination. Likewise, debt parking is not one of the justifications for the final rule.

In addition to disputing the specific points raised by the CFPB in support of its preliminary determination, some commenters also disagreed with the CFPB's preliminary determination that the financial information exception as to medical debt information is not consistent with the intent of the creditor prohibition to protect consumers' sensitive medical information. These commenters stated that current privacy protections are sufficient and that the CFPB had not considered or presented evidence of inappropriate practices by lenders under the current rule that warrant the change in policy. Commenters also stated that the FCRA does not delegate the power to change privacy protections to the CFPB; that the proposal might increase privacy risks, because it may require handling of medical information across more entities; and that consumers would have less privacy because of a likely increase in debt collection litigation as a result of the rule.

With regard to these commenters' concerns about privacy, the CFPB observes that by enacting FCRA section 604(g)(2), Congress made a determination that all medical information—including medical debt information, as a type of medical information—is sensitive data warranting specific privacy protections in the form of the creditor prohibition. By removing the financial information exception, the CFPB is acting within its authority to remove an exception put in place by the predecessor Agencies and is facilitating Congress's intent to provide privacy protections in the manner it determined was appropriate to protect consumers' medical information.

Some commenters also generally stated that the CFPB had not met the requirements of FCRA section 604(g)(5). One commenter stated that Congress had not granted the CFPB authority to further limit the use of medical information at all. And, instead, FCRA section 604(g)(5) authorizes the CFPB to allow more medical information to be considered. Another commenter stated that the CFPB had effectively ignored the statutorily required balancing process by largely ignoring legitimate needs for the information and concluding that use of medical debt information for purposes of assessing credit risk is virtually always an inappropriate purpose. One commenter supporting the rule, however, stated that the CFPB had clearly acted within its authority under FCRA section 604(g)(5) and had used reasoned decision-making in removing a regulatory exception, via notice and comment rulemaking. The commenter also stated that the CFPB's multiple research studies demonstrate that the CFPB's decision was well reasoned.

The CFPB disagrees that it has not met the requirements to amend or remove an exception under FCRA section 604(g)(5). FCRA section 604(g)(5) provides the CFPB with the authority to "prescribe regulations that permit transactions" under the creditor prohibition in

FCRA section 604(g)(2) or, in other words, establish exceptions to the prohibition.[142] The CFPB is exercising that authority here by amending its existing regulation, 12 CFR 1022.30, that creates exceptions to the statutory creditor prohibition. In particular, the CFPB is amending the financial information exception by rescinding the financial information exception in most of its existing applications but retaining a version of the exception in § 1022.30(e)(1)(x), with revisions discussed later in this preamble. Logically, in addition to establishing regulations to permit creditors' consideration of more medical information, the CFPB likewise has authority to amend or rescind, partially or fully, previously promulgated exceptions to the creditor prohibition, if it determines that such an exception is not necessary and appropriate, consistent with the intent of the creditor prohibition to restrict the use of medical information for inappropriate purposes. When determining whether to amend or remove a regulatory exception, the CFPB carefully considers the underlying rationales as well as the policy and economic consequences of doing so, while taking into account the baseline obligations created by Congress. As explained above, the CFPB has carefully reviewed the evidence about medical debt information and its value for credit underwriting, which was not available at the time the predecessor Agencies promulgated the financial information exception, in consideration of the privacy purpose of the creditor prohibition. Its final determination is based upon this review.

For the reasons above, the CFPB is finalizing its determination that it generally is not "necessary and appropriate to protect legitimate operational, transactional, risk, consumer, and other needs" for creditors to consider sensitive financial information concerning a consumer's medical debt for underwriting purposes. The CFPB also finds that creditors' consideration of

[142] As explained below in part VI.B, commenters are also incorrect to assert that the CFPB lacks authority to prohibit creditors from obtaining or using financial aspects of medical information because FCRA section 604(g)(2) has a parenthetical cross-referencing FCRA section 605(a)(6).

such information under the existing financial information exception is not consistent with the intent of the creditor prohibition to restrict the use of medical information for inappropriate purposes, as required for an exception under FCRA section 604(g)(5).[143]

2. Medical Information Related to Expenses, Assets, and Collateral

Proposal

The financial information exception currently permits a creditor to obtain and use medical information relating to expenses, assets, and collateral, including the value, condition, and lien status of a medical device that may be collateral to secure a loan. As the CFPB explained in the NPRM, medical expenses and medical debts are closely related, in that unpaid medical expenses often become medical debts. Because of the similarities between medical expenses and medical debts, the CFPB proposed to treat these categories of medical information the same. The CFPB also explained that medical information related to a consumer's assets and collateral generally refers to medical equipment serving as an asset or as collateral for a loan, which a creditor could potentially seize or anticipate could be liquidated to pay off a loan. The CFPB understood that such medical equipment is often necessary and potentially lifesaving. Because of the similarities between medical expenses and medical debts and the importance of medical assets and collateral to a consumer's well-being, the CFPB preliminarily determined in its proposal that it is not "necessary and appropriate to protect legitimate operational, transactional, risk, consumer, and other needs" for creditors to consider medical information relating to a consumer's expenses or assets and collateral.

[143] 15 U.S.C. 1681b(g)(5).

The CFPB sought comment on its proposed approach to removing the financial information exception for expenses, assets, and collateral, and expressed particular interest in receiving feedback from creditors and their representatives regarding whether they take medical devices as collateral or into consideration as assets that may be used by consumers to pay a future debt obligation.

Comments

The CFPB received many comments related to its proposed approach to removing the financial information exception for expenses, assets, and collateral, most of which expressed support for the CFPB's proposal.

Commenters expressed that as a consumer's medical debt has not been found to have predictive value as to a consumer's ability to repay a loan, the fact that a consumer has medical expenses or durable medical equipment is likewise unlikely to have predictive value.

One commenter shared their opinion that all debt is relevant to creditworthiness, so medical equipment should not be shielded from repossession for failure to pay. However, the same individual commenter ultimately expressed support for the rule as proposed, explaining that the rule as proposed is the best solution given the complex nature of health care and medical billing practices.

Many commenters expressed support for the removal of the financial information exception for collateral, characterizing their support for the rule as support for prohibiting debt collectors from taking medical devices as loan collateral, and protecting consumers from having their medical equipment such as wheelchairs or prosthetic limbs repossessed. Many commenters further indicated that the possibility that medical equipment could be used as collateral and consequently repossessed for a consumer's inability to pay was unreasonable.

A comment from a coalition of several major national orthotic and prosthetic organizations in support of the proposal expressed concern that the rule is unclear as to whether a health care provider or supplier of medical devices would fall under the definition of "creditor" for the purposes of determining whether they are entities that may not repossess a medical device under the rule. The same commenter also expressed that they were unaware of repossession of orthotics and prosthetics as a practice and elaborated that because many types of medical devices, including some orthotics and prosthesis, cannot be reused by other patients, holding such devices as collateral serves only to punish the patient. The CFPB did receive one comment from an attorney saying that she had personally seen medical devices being repossessed, but the CFPB did not hear evidence from other commenters of this being a widespread issue.

Many commenters expressed that medical devices should be prohibited from serving as collateral for a loan. Commenters expressed that repossession of medical devices is a dangerous practice that limits or altogether prohibits individuals' mobility, productivity, and overall well-being. Commenters elaborated that this makes it even more difficult or perhaps impossible for consumers to ever pay their debts. Other commenters also explained the disparate impact using medical devices as collateral has on certain communities, particularly veterans and disabled individuals who may be more likely to rely on medical devices.

Final Rule

The CFPB understands that medical information related to a consumer's assets and collateral generally refers to medical equipment serving as an asset or as collateral for a loan, which a creditor may potentially seize or anticipate could be liquidated to pay off a loan. The CFPB also understands that such medical equipment is often necessary and potentially lifesaving. The CFPB has also not observed the repossession of medical devices as a typical practice in the market, despite the personal experience from one commenter, suggesting that

there is likely to be low or non-existent costs or other burdens associated with the rule as it pertains to repossession of medical devices. Thus, given the importance of medical assets and collateral to a consumer's well-being and the apparent limited existence of this practice currently, the CFPB has determined that it is not "necessary and appropriate to protect legitimate operational, transactional, risk, consumer, and other needs," or consistent with the intent of the creditor prohibition to restrict the use of medical information for inappropriate purposes, for creditors to consider medical information relating to a consumer's assets and collateral. For the reasons stated above, the CFPB finalizes as proposed, removing the financial information exception for expenses, assets, and collateral and related examples at previously existing § 1022.30(d). The CFPB anticipates that under the final rule, creditors will not be able to obtain medical information for purposes of creating a security interest in medical devices, and consequently, typically will not use medical devices as collateral.[144]

In response to the commenter expressing concern about whether health care providers and suppliers of medical devices fall under the definition of "creditor" for the purposes of the rule, this rule does not purport to modify the definition of "creditor," which is defined in 12 CFR 1022.30(b)(2)(ii). Determining whether a health care provider or supplier of medical devices is a creditor is a fact-specific inquiry that depends on the facts and circumstances. In assessing their obligations under the rule, health care providers and suppliers of medical devices should look to the definition of "creditor" in 12 CFR 1022.30(b)(2)(ii), which provides that the term has the same meaning as in section 702 of the ECOA. And, separately, the CFPB reminds health care

[144] *See, e.g.*, U.C.C. 9-203(b)(3).

providers and suppliers to look to final § 1022.30 to determine their obligations as to obtaining or using medical information for credit eligibility determinations.

3. Medical Information Related to Income, Benefits, or the Purpose of the Loan

Proposal

The financial information exception currently permits creditors to consider medical information related to income, benefits, and the purpose of the loan, including the use of the loan proceeds under certain conditions. The CFPB proposed to remove the financial information exception while retaining these elements of the exception that permit a creditor to consider medical information relating to income, benefits, and the purpose of the loan. In its proposal, the CFPB explained its preliminary determination that the elements of the exception relating to income, benefits, and the purpose of the loan are necessary and appropriate to protect legitimate operational, transactional, risk, consumer, and other needs, including permitting actions necessary for administrative verification purposes, consistent with FCRA's intent to restrict the use of medical information for inappropriate purposes. The CFPB explained that consumers whose primary source of income is disability benefits might not be able to obtain credit at all if creditors could not consider their income.[145] And since creditors may be unwilling to underwrite if they lack information about the purpose of a loan, consumers might not be able to obtain needed credit unless creditors have access to that information.

[145] The CFPB notes that ECOA and Regulation B prohibit creditors from discriminating in any aspect of a credit transaction against an applicant because all or part of the applicant's income derives from a public assistance program, which includes but is not limited to Social Security disability income. 15 U.S.C. 1691(a)(2); 12 CFR 1002.2(z), 1002.4(a); *see also* Regulation B comment 2(z)-3.

Comments

The CFPB received a number of comments related to its approach to retaining elements of the financial information exception that permit a creditor to consider medical information relating to income, benefits, and the purpose of the loan. Most comments were from consumers expressing approval of the CFPB's proposal.

One commenter, a professional association for physicians and medical students, stated that this aspect of the financial information exception was appropriate because it ensures that creditors can consider necessary financial information, such as income from disability or workers' compensation, without compromising the privacy and sensitivity of the consumer's medical information. The commenter elaborated that the proposed rule balances the need for accurate credit assessments with the protection of consumer privacy. Another commenter, citing a report by a nonpartisan research and policy institute, explained that a large percentage of Supplemental Security Income (SSI) beneficiaries rely on SSI benefits as their only source of income, and the CFPB's proposal ensures that these consumers can access credit and qualify for a loan.

One commenter expressed concern about the potential for misuse of information obtained under proposed § 1022.30(e)(1)(x). The commenter suggested that once a creditor becomes aware of information obtained under the exception, it may be difficult to measure bias or ensure the information is used in a permitted manner. Another commenter, a State insurance commissioner, expressed support for the CFPB's proposal, but similarly expressed concern about the lack of visibility into a credit reporting agency's use of this type of medical information.

One commenter expressed concern that § 1022.30(e) includes examples illustrating the exception as applied to medical information related to benefits and income but does not include

examples illustrating the exception as applied to medical information related to the purpose of the loan.

Final Rule

Except as discussed in as discussed in part VI.A, *Consumer-Authorized Transaction History* below, the CFPB finalizes § 1022.30(e)(1)(x) as substantially proposed, with technical edits for renumbering. Final § 1022.30(e)(1)(x)(A)(*2*), previously proposed § 1022.30(e)(1)(x)(A), generally provides an exception for the use of medical information relating to income, benefits, or the purpose of the loan, including the use of proceeds. Section 1022.30(e)(1)(x)(A)(*2*) also provides examples of the types of financial information related to income and benefits relied upon as a source of repayment. Final § 1022.30(e)(1)(x)(B) and (C) provide that a creditor must use the medical information described in § 1022.30(e)(1)(x)(A) in a manner and to an extent that is no less favorable than comparable, nonmedical information and that the creditor cannot take the consumer's physical, mental, or behavioral health, condition or history, type of treatment, or prognosis into account.

Regarding comments expressing concerns about transparency and the potential for misuse of information obtained under the rule, final § 1022.30(e)(1)(x) restates the previously codified exception with a narrower scope. The CFPB is not aware of any concerns related to the consideration of medical information related to income, benefits, or purpose of the loan, and declines to make any further revisions.

The CFPB also finalizes as proposed Example 7 in § 1022.30(e)(7), which illustrates a use of medical information related to long-term disability income. Regarding the comment about the need for examples illustrating when medical information may relate to the purpose of the loan, the commenter did not suggest language, and the CFPB declines to revise § 1022.30(e) to

include examples illustrating the exception as applied to medical information related to the purpose of the loan.

C. Limits on a Consumer Reporting Agency's Disclosure of Medical Debt Information

Proposal

The CFPB proposed to add new § 1022.38 to subpart D to address how a consumer reporting agency's medical debt information reporting responsibilities would be impacted by the proposal to remove the financial information exception for obtaining and using medical information in connection with any determination of the consumer's eligibility for credit. Proposed § 1022.38 would have permitted a consumer reporting agency to include medical debt information in a consumer report furnished to a creditor for credit eligibility purposes only if the following criteria are met: (1) the consumer reporting agency has reason to believe the creditor intends to use the medical debt information in a manner not prohibited by § 1022.30; and (2) the consumer reporting agency is not otherwise prohibited from furnishing to the creditor a consumer report containing the medical debt information, including by a State law that prohibits furnishing to the creditor a consumer report containing medical debt information.

The CFPB also proposed a related amendment to remove the example in § 1022.30(c)(3)(iii), which describes a creditor receiving medical information on a consumer report furnished by a consumer reporting agency. While there may be some instances where a consumer reporting agency may furnish to a creditor a consumer report containing medical information, the proposed amendments would limit those instances and render the example less instructive and potentially confusing. Therefore, the CFPB proposed to remove the example.

The CFPB considered alternatives to its proposed approach to § 1022.38 but preliminarily determined that its rulemaking goals were best achieved through the proposed approach. For example, as discussed in the SBREFA Outline and the proposed rule, the CFPB

considered mandating a delay in the furnishing and reporting of medical debt for a particular period of time, and not reporting or furnishing medical debt below a particular dollar amount.[146] The CFPB also considered requiring consumer reporting agencies and medical information furnishers, upon receiving a dispute, to conduct an independent investigation to certify that a disputed medical debt is accurate and not subject to pending insurance disputes.[147] The CFPB requested comment on all aspects of proposed § 1022.38, including the alternatives discussed.

Comments

Proposed § 1022.38 Generally

A number of commenters expressed general support for proposed § 1022.38 and identified benefits of the proposal. For example, some commenters stated that proposed § 1022.38 would stop debt collectors from using the credit reporting system as a payment coercion tactic and forcing consumers to pay debts that they may not owe. Commenters also explained that proposed § 1022.38 would protect consumers' health privacy. See part VII, *CFPA Section 1022(b) Analysis*, for a more fulsome discussion of benefits.

In addition, the CFPB received comments that appeared to be part of several comment submission campaigns in support of the proposed rule. Such comments typically advocated for finalizing the proposed rule.

Other commenters expressed general opposition to proposed § 1022.38 and identified various categories of harms, including to consumers (*e.g.*, increased healthcare costs, reduced access to medical care), medical providers (*e.g.*, loss of income from non-payment, increased reliance on litigation), debt collectors (*e.g.*, decrease in collectible accounts, increased collection

[146] SBREFA Outline at 19; 89 FR 51682, 51695 (June 18, 2024).

[147] *Id.* at 51696.

costs), creditors (*e.g.*, unable to assess the true credit risk of potential borrowers, increased reliance on litigation), insurance providers (*e.g.*, consumers would be disincentivized from purchasing health insurance), and consumer reporting agencies (*e.g.*, removal of medical debt from consumer reports would be complex and costly). One commenter noted that household surveys, court records, and information collected from providers will be increasingly important sources of data for tracking the prevalence of medical debt, as less of this debt appears on consumer reports. Another commenter noted that the transition to newer credit score models that exclude medical debt is not expected until the fourth quarter of 2025. See part VII, *CFPA Section 1022(b) Analysis*, for a more fulsome discussion of potential harms.

The CFPB also received comments that appeared to be part of several comment submission campaigns opposing the proposed rule. Such comments typically identified potential harms and requested that the CFPB reconsider the proposed rule.

Some commenters appear to have misunderstood the proposal as limiting the circumstances in which a consumer reporting agency can receive information about a consumer's medical information.

A number of commenters stated that proposed § 1022.38 is unnecessary because the recent market changes leave only unpaid medical debts greater than $500 on consumer reports, and the proposal fails to recognize the marketplace's ongoing self-corrections and innovation. At least one commenter pointed to the CFPB's Data Point as demonstrating that debts above $500 are associated with higher delinquency rates and should continue to be reported and considered in underwriting. Some commenters requested that the CFPB at least allow more time to evaluate whether the NCRAs' reporting changes from 2022 and 2023 will address the CFPB's concerns about medical debt.

Some commenters questioned the CFPB's authority to promulgate § 1022.38. For example, commenters stated that FCRA section 604(g)(1)(C) affirmatively authorizes a consumer reporting agency to furnish a consumer report that contains such medical debt information if the information is coded to hide the identity of the provider or nature of services. Commenters therefore concluded that Congress's intent to permit consumer reporting agencies to furnish medical debt information is clear and the CFPB cannot supersede such a statutory authorization. At least one commenter stated that because FCRA section 604(g)(1)(C) affirmatively permits a consumer reporting agency to provide medical information related to transactions, accounts or balances relating to debts arising from the receipt of medical services, products, or devices, the FCRA section 621(e) general rulemaking authority, which 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, is insufficient to support proposed § 1022.38. A commenter noted that Congress has attempted, but failed, to pass legislation to give CFPB the explicit authority to eliminate medical debt from consumer reports. In addition, commenters pointed to the congressional finding in the FCRA that the banking system is dependent upon fair and accurate credit reporting and stated that a consumer report that does not reflect significant debts owed by a consumer is, by definition, inaccurate. One commenter noted that Congress chose to promote the accuracy of information on consumer reports by expressly requiring furnishers to have reasonable procedures to ensure they provide complete and accurate information, and by enabling consumers to dispute the accuracy of specific items on their consumer reports, not by suppressing information.

In addition, commenters stated that FCRA section 605(a) specifically identifies types of records that may not be included on a consumer report (unless an exception applies). They

further stated that in 2018, Congress amended the list of items specifically excluded from consumer reports to include, under certain circumstances, information related to a veteran's medical debt. From this, the commenters concluded that Congress clearly articulated in the FCRA information that may not be included in a consumer report and considered the impact of medical debt reporting but chose not to exclude all categories of medical debt from consumer reports. Another commenter noted that on multiple occasions, Congress has amended the FCRA to regulate when, how, and to what extent medical information may be included in consumer reports and concluded that if Congress wanted to ban medical debt from consumer reports, it would have done so.

Commenters also stated that the specific grants of rulemaking authority in FCRA section 604(g) do not provide the CFPB with authority to restrict account information included in consumer reports or to otherwise regulate how medical debt is reported.

To be clear, the proposed rule did not purport to, and the final rule does not, prohibit furnishers from furnishing accurate medical debts to consumer reporting agencies. Section 1022.38 addresses how consumer reporting agencies' responsibilities, with respect to medical debt information, are impacted when creditors are prohibited from obtaining or using the medical debt information.

As discussed above, the CFPB acknowledges the value of the voluntary consumer reporting changes by the three NCRAs that stopped the reporting of some, but not all, medical debt on a consumer report. However, the CFPB has determined that these types of changes do not do enough to protect the privacy of consumers' medical data during the credit underwriting process, nor do they resolve concerns about accuracy. Although these market changes have reduced the total number of medical collections tradelines reflected on consumer reports, their

voluntary nature means there is some uncertainty about whether the changes could be reversed in the future, and, as discussed in part I.B, *Market Background, Medical Debt and Consumer Reporting*, 15 million Americans still have $49 billion in medical bills on their consumer reports even after the NCRAs' voluntary changes. A number of commenters share the CFPB's position that because the changes are voluntary and do not cover all amounts of medical debt, the permanence and broader effect of removing the financial information exception in this rulemaking is important. And, the fact that the CFPB has no evidence that the voluntary NCRA reporting changes have disrupted the market provides another basis for finalizing this rule, which builds upon those voluntary changes to provide expanded and permanent protections for consumers.

Contrary to some commenters' assertions, FCRA section 604(g)(1)(C) does not affirmatively authorize a consumer reporting agency to furnish a consumer report containing medical information. FCRA section 604(g)(1)(C) is a prohibition. FCRA section 604(g)(1)(C) states "*Limitation on consumer reporting agencies*. A consumer reporting agency shall not furnish . . . in connection with a credit . . . transaction . . . ." FCRA section 604(g)(1)(C) prohibits a consumer reporting agency from furnishing, in connection with a credit transaction, a consumer report that contains medical debt information that is not anonymized (assuming the consumer has not consented to the furnishing of a report under FCRA section 604(g)(1)(B)). Such protections are necessary when creditors are lawfully permitted to obtain and use medical information, such as when an appropriate agency has used its delegated authority to create an exception to the general prohibition on creditors obtaining and using medical information as set forth in FCRA section 604(g)(2) and (5)(A). The protection in FCRA section 604(g)(1)(C) ensures that the medical information obtained or used by creditors would be anonymized to

protect consumers' privacy. The fact that FCRA section 604(g)(1)(C) carves certain anonymized information out of the general prohibition in FCRA section 604(g)(1) does not immunize such anonymized information from restrictions contained in other provisions, such as FCRA section 604(a)'s permissible purpose restrictions or regulations issued under FCRA section 621(e).

In addition, the fact that FCRA section 605(a) identifies some types of records that may not be included on a consumer report does not mean that the CFPB lacks authority to determine that other types of records also may not be included on a consumer report. To the contrary, when Congress gave the CFPB rule writing authority under the FCRA, it excepted only two specific provisions of the FCRA—sections 615(e) and 628.[148] By implication, with respect to every other provision of the FCRA, Congress intended the CFPB to be able to prescribe regulations as may be necessary or appropriate to administer and carry out the purposes and objectives of the FCRA, and to prevent evasions thereof or to facilitate compliance therewith.

Relatedly, the fact that Congress enacted a specific, narrow solution to address particular concerns with veterans' medical debt does not mean that Congress intended to preclude the CFPB from addressing a different type of problem, albeit also related to medical debt. This rulemaking is directly related to the prohibition on creditors obtaining or using medical information in connection with any determination of the consumer's eligibility for credit, also enacted by Congress. This rulemaking merely removes an unwarranted regulatory exception to that prohibition, and the result of the removal of the exception, in light of other provisions in the FCRA, is that medical debt information is now an additional type of record that cannot be included in a consumer report under certain circumstances.

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[148] 15 U.S.C. 1681s(e)(1).

Finally, as discussed in the *Final Rule* section below, the CFPB is not relying on the specific grants of rulemaking authority in FCRA section 604(g) as authority for § 1022.38.

Proposed § 1022.38(a)

The scope of proposed § 1022.38 would have applied to any consumer reporting agency as defined in section 603(f) of the FCRA, 15 U.S.C. 1681a(f). At least one commenter noted that where Congress restricted veterans' medical debt on consumer reports, the provision was limited to the NCRAs as defined under section 603(p) of the FCRA.[149]

The CFPB is finalizing § 1022.38(a) as proposed. Section 1022.38(a) references the definition of consumer reporting agency in FCRA section 603(f) and reflects the coverage of existing Regulation V. Limiting the scope of § 1022.38 to the NCRAs would not make sense because the permissible purpose provision in FCRA section 604(a)(3)(A), which supports the intervention, applies to consumer reporting agencies as that term is defined in FCRA section 603(f). Further, applying § 1022.38 to all consumer reporting agencies would facilitate compliance with the creditor prohibition in § 1022.30(b) when creditors use consumer reports from consumer reporting agencies that are not NCRAs.

Proposed § 1022.38(b)(1)

Proposed § 1022.38 would have permitted a consumer reporting agency to include medical debt information in a consumer report furnished to a creditor for credit eligibility purposes only if certain criteria are met. One criterion, in proposed § 1022.38(b)(1), was that the consumer reporting agency has reason to believe the creditor is not prohibited from using the medical debt information under § 1022.30.

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[149] *See* 15 U.S.C. 1681c(a)(7) through (8).

Some commenters stated that the reason to believe standard in proposed § 1022.38(b)(1) is too loose or vague of a standard to adequately protect consumers, noting that the same language in FCRA section 604(a) has been interpreted by courts to absolve consumer reporting agencies of liability if the user merely avers a permissible use. Commenters identified various solutions, including requiring consumer reporting agencies to have strict procedures to prevent including medical debt in a report unless the user is permitted to use medical information under § 1022.30; replacing the reason to believe standard with a reasonable belief or actual knowledge standard; removing proposed § 1022.38(b)(1); or adding an objective criterion to the reason to believe standard.

Another commenter stated that the proposal to restrict the sharing of medical debt information is not necessary because, if the CFPB prohibits creditors from considering medical debt in making credit decisions, then consumer reporting agencies will neither collect nor share that information with creditors.

The CFPB is finalizing § 1022.38(b)(1) as proposed. The reason to believe standard in § 1022.38(b)(1) is derived from the permissible purpose requirement in FCRA section 604(a)(3)(A). FCRA section 604(a)(3)(A) states that one of the circumstances under which a consumer reporting agency may furnish a consumer report is to a person which it has reason to believe intends to use the information in connection with a credit transaction involving the consumer on which the information is to be furnished and involving the extension of credit to the consumer. With respect to the comment about this provision being unnecessary in light of the prohibition on creditors' consideration of medical debt information in credit decisions, this intervention will facilitate compliance with § 1022.30 by ensuring that consumer reporting agencies do not share information with creditors that creditors are prohibited from obtaining or

using. If, in response to the prohibition on creditors obtaining or using medical debt information in § 1022.30, consumer reporting agencies would not collect or share consumers' medical debt information as the commenter asserts, then there should be no compliance burden or industry concerns associated with this provision.

Proposed § 1022.38(b)(2)

The second criterion, in proposed § 1022.38(b)(2), was that the consumer reporting agency is not otherwise prohibited from furnishing to the creditor a consumer report containing the medical debt information, including by a State law that prohibits furnishing to the creditor a consumer report containing medical debt information. The purpose of proposed § 1022.38(b)(2) was to make clear that proposed § 1022.38 does not override any other prohibition regarding the furnishing of consumer reports.

At least one commenter stated that the CFPB failed to comply with Federal regulations governing incorporation by reference. And relatedly, the commenter noted that incorporating 50 different State laws into Federal law undermines the FCRA's goal of uniform credit-reporting standards.

Some commenters asserted that State laws that regulate what information may or may not be included on a consumer report are preempted by the FCRA and that the proposal violates the Tenth Amendment because CFPB does not have the authority to enforce State laws (or determine whether or not they are preempted by the FCRA). The commenters stated that proposed § 1022.38(b)(2) would have the effect of making a violation of State law into a violation of this rule.

Other commenters expressed support for proposed § 1022.38(b)(2). These commenters stated that Regulation V should not be interpreted to allow consumer reporting agencies to

violate State laws governing medical information, and appreciated the CFPB's acknowledgment that states can implement additional consumer protections.

The CFPB is finalizing § 1022.38(b)(2) with amendments. The criterion set out in final § 1022.38(b)(2) requires the consumer reporting agency to have reason to believe the creditor is not otherwise legally prohibited from obtaining or using the medical debt information, including by a State law that prohibits a creditor from obtaining or using medical debt information. The CFPB is not, in final § 1022.38(b)(2), incorporating by reference State laws, deeming a violation of State law to be a violation of the FCRA, or otherwise affecting the enforcement of State laws, as some commenters asserted the proposed language would have done. As revised, final § 1022.38(b)(2) merely ensures that, independent of the prohibition in § 1022.30, a consumer reporting agency would generally still be prohibited from furnishing a consumer report containing medical debt information to a creditor who is legally prohibited from obtaining or using the medical debt information. FCRA section 604(a)(3)(A) permits a consumer reporting agency to furnish a consumer report to a person which it has reason to believe intends to use the information in connection with a credit transaction involving the consumer. Under the final rule, a consumer reporting agency would not have reason to believe that a creditor who is legally prohibited from obtaining or using medical debt information intends to use that information in connection with a credit transaction. Laws within the scope of § 1022.38(b)(2) include applicable State laws that prohibit a creditor from obtaining or using medical debt information.[150]

[150] *See* 87 FR 41042 (July 11, 2022) (describing the FCRA's limited preemptive scope). Whether the FCRA or any other Federal law preempts any particular State law is beyond the scope of this rulemaking.

Requests to Add Provisions

Some commenters requested that the CFPB add additional provisions to § 1022.38. For example, one commenter requested a safe harbor for credit unions that are unintentionally in possession of information that they are no longer permitted to obtain or use. The commenter was concerned about the security and operational risk that would be experienced by a credit union if a consumer reporting agency furnishes medical debt information to a credit union that the credit union is not permitted to obtain or use. Alternatively, the commenter recommended that the CFPB not finalize the proposed rule.

A number of commenters suggested that the CFPB expand the rule to also prohibit the inclusion of medical debt on consumer reports used for employment or tenant screening. Other commenters suggested that the CFPB expand the rule to prohibit the inclusion of medical debt on consumer reports *altogether*. One commenter requested that the CFPB prohibit consumer reporting agencies from reporting medical debt incurred by individuals under the age of 18. The commenter also requested that the CFPB prohibit data furnishers from reporting to consumer reporting agencies medical debts of minors, particularly those under state wardship.

A commenter suggested that the CFPB amend the rule to require consumer reporting agencies to screen medical information for compliance with already existing non-discrimination language-access protections. The commenter stated that such an amendment would incentivize the industry to safeguard health consumers.

A commenter recommended that the CFPB require consumer reporting agencies to establish a robust appeal process for consumers to address complaints and grievances should consumer reporting agencies erroneously or purposefully include their medical debt information in consumer reports provided to potential creditors.

One commenter requested that the CFPB monitor heath care providers' billing, pricing, and collection practices, to make sure consumers are not paying more or denied care under the new rules.

For the reasons discussed herein, the CFPB is not revising proposed § 1022.38 in response to these requests. The commenter's concern prompting a request for a safe harbor is addressed by the statutory rule of construction in § 1022.30(c)(1). Section 1022.30(c)(1) provides that a creditor does not obtain medical information in violation of the prohibition if it receives medical information pertaining to a consumer in connection with any determination of the consumer's eligibility, or continued eligibility, for credit without specifically requesting medical information. The CFPB's proposed removal of the example in § 1022.30(c)(3)(iii), which describes a creditor receiving medical information on a consumer report furnished by a consumer reporting agency, may have created confusion. The CFPB proposed to remove this example because the proposed amendments would have limited the circumstances under which a consumer reporting agency could permissibly furnish a consumer report containing medical debt information, rendering the example less instructive and potentially confusing. Even though the CFPB is finalizing the removal of § 1022.30(c)(3)(iii), it would still be the case that if a creditor receives, on a consumer report, unsolicited medical debt information, the creditor would not have obtained medical information in violation of the prohibition as provided by the statutory rule of construction in existing § 1022.30(c)(1).

The CFPB declines to expand the rule to cover medical debt on consumer reports used for employment or tenant screening, or for all uses. The requests to cover other uses or to prohibit the reporting of medical debt information based on a consumer's age fall outside the scope of this rule. The request to prohibit data furnishers from reporting to consumer reporting

agencies medical debts of minors also falls outside the scope of this rule. This final rule merely removes an exception, promulgated under FCRA section 604(g)(2) and (5), that permitted creditors to obtain and use a consumer's medical information in connection with a determination of eligibility, or continued eligibility, for credit. Under the final rule, a creditor will no longer be able to obtain or use medical information related to a consumer's medical debt in connection with any determination of the consumer's eligibility, or continued eligibility, for credit, unless one of the specific exceptions in final § 1022.30(e) applies. Relatedly, final § 1022.38 addresses how a consumer reporting agency's medical debt information reporting responsibilities are impacted when creditors are prohibited from obtaining or using medical debt information. Therefore, final § 1022.38 governs only consumer reporting agencies' actions and covers only medical debt information contained in a consumer report furnished to a creditor for credit eligibility purposes.

The commenter's request to require consumer reporting agencies to screen medical information for compliance with already existing non-discrimination language-access protections is also outside the scope of this targeted rulemaking.

The CFPB appreciates the suggestion to require consumer reporting agencies to establish a robust appeals process for consumers to address complaints and grievances. The CFPB is not implementing such a process as part of this rulemaking but will monitor consumer reporting agencies' compliance with § 1022.38.

The CFPB acknowledges the suggestion to monitor health care providers' billing, pricing, and collection practices, to make sure consumers are not paying more or denied care once the rule is implemented. The CFPB currently engages in the monitoring of markets within its authority and will continue to do so.

Alternatives

The CFPB considered alternatives to proposed § 1022.38, including mandating a delay in the furnishing and reporting of medical debt for a particular period of time, and not reporting or furnishing medical debt below a particular dollar amount; and requiring consumer reporting agencies and medical information furnishers, upon receiving a dispute, to conduct an independent investigation to certify that a disputed medical debt is accurate and not subject to pending insurance disputes. The CFPB solicited comment on these identified alternatives.

Some of the alternatives considered by the CFPB would have been similar to the voluntary reporting changes made by the NCRAs in 2022 and 2023, but would have had an expanded scope (*i.e.*, apply to all consumer reporting agencies) and permanent duration (*i.e.*, be issued as an amendment to Regulation V). Some commenters noted the similarities and stated that the NCRA reporting changes are sufficient to address the concerns raised by the CFPB.

At least one commenter stated that the proposal fails to consider less expensive alternatives such as implementing a waiting period before medical debt can be reported.

Several commenters offered various suggestions regarding reporting accuracy and dispute procedures in response to the CFPB's request for comment on alternatives to the proposal. For example, commenters suggested that the CFPB allow only legitimate and verified debts to be reported to consumer reporting agencies (*i.e.*, establish guidelines for medical billing companies, healthcare providers, and collection agencies for reporting medical debt); use enforcement actions on businesses that provide inaccurate information; improve the accuracy and transparency of the medical billing process; and improve the consumer dispute resolution process.

Commenters also suggested a number of other alternatives to the proposal. For example, at least one commenter suggested that the CFPB permit positive credit reporting of medical debt

information. Another commenter expressed a somewhat opposing position, stating that the CFPB should have considered allowing for the deletion of only paid medical debt from consumer reports.

A commenter suggested that the CFPB permit only the account owner, such as hospitals or medical debt purchasers, to report medical debt to consumer reporting agencies, rather than collection agencies, to reduce consumer distress and improve the accuracy of balance audits. Other commenters suggested that the CFPB prohibit furnishers from reporting a medical debt as long as the consumer makes minimum payments toward the debt.

A commenter suggested the CFPB could instead strengthen Regulation F to improve communication protocols to ensure that they are clear, compassionate, and supportive to consumers.

Commenters suggested that the CFPB differentiate between patients who are unwilling to pay for the services provided and those who are genuinely unable to do so. For example, a commenter suggested that the CFPB could require a doctor or medical practice to have the patient or guarantor fill out a form and if they meet certain metrics, the debt should not be reported. Another commenter suggested the CFPB allow consumer reporting agencies to report medical debt incurred by commercially insured health plan beneficiaries for cost-sharing obligations on insurer or health plan adjudicated amounts of between $100-1,000.

One commenter suggested that, in lieu of finalizing the proposed rule, the CFPB should promote financial literacy among consumers regarding medical debt and provide better resources for consumers to understand their medical bills.

One commenter suggested that the CFPB allow medical debt to remain on consumer reports, but give it much less weight than other debts.

The CFPB is not adopting any alternatives to the proposal. As discussed in the proposed rule and the SBREFA outline, and noted above, the CFPB did consider mandating a delay in the furnishing and reporting of medical debt for a particular period of time, which would have been similar to one of the NCRA's recent reporting changes.[151] However, the CFPB has determined that these types of changes by themselves do not do enough to protect the privacy of consumers' medical data during the credit underwriting process, as mandated by the FCRA.

The CFPB also notes that consumer reporting agencies are already subject to accuracy and dispute resolution requirements and the CFPB has played an active role in this space. For example, FCRA section 607(b) requires consumer reporting agencies to follow reasonable procedures to assure maximum possible accuracy of the information concerning the consumer. In addition, the CFPB has published multiple advisory opinions on FCRA issues, including on accuracy requirements,[152] and the CFPB is continuing to consider a possible rulemaking to improve the dispute process for consumers under the FCRA.[153] The CFPB also has engaged in supervision[154] and enforcement[155] activity with respect to consumer reporting agencies and furnishers to ensure their

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[151] SBREFA Outline at 19; 89 FR 51682, 51695 (June 18, 2024).

[152] *See, e.g.*, https://www.consumerfinance.gov/about-us/newsroom/cfpb-addresses-inaccurate-background-check-reports-and-sloppy-credit-file-sharing-practices/ (background check AO); https://files.consumerfinance.gov/f/documents/cfpb_name-only-matching_advisory-opinion_2021-11.pdf (name-only matching AO).

[153] *See* https://mobile.reginfo.gov/public/do/eAgendaViewRule?pubId=202404&RIN=3170-AB24 (Unified Agenda entry listing disputes as long-term action item).

[154] *See, e.g.*, https://files.consumerfinance.gov/f/documents/cfpb_supervisory-highlights_issue-32_2024-04.pdf.

[155] *See, e.g.*, https://www.consumerfinance.gov/about-us/newsroom/cfpb-orders-td-bank-to-pay-28-million-for-breakdowns-that-illegally-tarnished-consumer-credit-reports/ (TD Bank); https://www.consumerfinance.gov/about-us/newsroom/cfpb-orders-toyota-motor-credit-to-pay-60-million-for-illegal-lending-and-credit-reporting-misconduct/ (Toyota Motor Credit); https://www.consumerfinance.gov/about-us/newsroom/cfpb-ftc-take-actions-against-transunion-illegal-rental-background-check-and-credit-reporting-practices/ (TransUnion).

compliance with the FCRA's accuracy and dispute requirements, and has filed multiple amicus briefs relating to the FCRA's accuracy and dispute requirements.[156]

As discussed in part IV.B, *Removal of the Financial Information Exception to the Creditor Prohibition on Obtaining or Using Medical Information*, the available evidence suggests that creditors can underwrite sufficiently to maintain a responsible lending operation without paid or unpaid medical debt information. The CFPB therefore concludes that an exception allowing creditors to consider paid medical debt information is not necessary or appropriate to protect legitimate operational, transactional, risk, consumer, and other needs. In addition, permitting paid or unpaid medical debt information to be included on consumer reports furnished to creditors would undermine the consumer privacy protections provided by this rule. With respect to the comment supporting positive credit reporting, the CFPB does not have any evidence that paid medical debt collection items are treated positively in any lending models.

The CFPB declines to amend the scope of this rule to prohibit certain parties from furnishing to consumer reporting agencies medical debt information. This rule removes an exception that pertains to creditors' use of medical debt information, and addresses how consumer reporting agencies' responsibilities, with respect to medical debt information, are impacted by the removal of the financial information exception now that creditors generally do not have a permissible purpose for consumer reports containing medical debt information.

With respect to the comment suggesting that CFPB instead strengthen Regulation F, the CFPB notes that it has done substantial work to strengthen Regulation F. In October 2020, the CFPB issued a final rule implementing the Fair Debt Collection Practices Act (FDCPA),

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[156] *See, e.g.*, https://www.consumerfinance.gov/about-us/blog/the-law-requires-companies-to-delete-disputed-unverified-information-from-consumer-reports/ (Suluki); https://www.consumerfinance.gov/compliance/amicus/briefs/nelson-v-experian-information-solutions-inc/ (Nelson).

addressing topics such as communications in connection with debt collection and prohibitions on harassment or abuse, false or misleading representations, and unfair practices in debt collection.[157] In December 2020, the CFPB issued a final rule amending Regulation F to provide additional requirements regarding validation information and disclosures provided at the outset of debt collection communications, prohibit suits and threats of suits regarding time-barred debt, and identify actions that must be taken before a debt collector may report information about a debt to consumer reporting agencies.[158] Most recently, in October 2024, the CFPB issued an advisory opinion to remind debt collectors of their obligation to comply with the FDCPA and Regulation F's prohibitions on false, deceptive, or misleading representations or means in connection with the collection of any medical debt and unfair or unconscionable means to collect or attempt to collect any medical debts.[159]

The CFPB also declines to implement the suggestion to differentiate between consumers who are unwilling to pay for the services provided and those who are genuinely unable to do so. These types of policies would undermine the consumer privacy protections provided by this rule, impose significant compliance burdens, and be difficult to administer and enforce.

The CFPB has done considerable work to promote financial literacy, and will continue to do so. However, consumer education will not address the principal concern solved by this rulemaking—that information about medical debt in credit underwriting is not necessary and appropriate to protect legitimate operational, transactional, risk, consumer, and other needs, nor consistent with Congress's intent to restrict the use of medical information for inappropriate

[157] 85 FR 76734 (Nov. 30, 2020).

[158] 86 FR 5766 (Jan. 19, 2021).

[159] 89 FR 80715 (Oct. 4, 2024).

purposes, and as a result, does not warrant an exception to the medical information privacy protections established by Congress.

Finally, the CFPB declines the suggestion to allow medical debt to remain on consumer reports, but give it much less weight than other debts. Not only would such a policy be difficult to administer and enforce, but it also does not address the principal concern solved by this rulemaking—that information about medical debt in credit underwriting is not necessary and appropriate to protect legitimate operational, transactional, risk, consumer, and other needs, nor consistent with Congress's intent to restrict the use of medical information for inappropriate purposes, and as a result, does not warrant an exception to the medical information privacy protections established by Congress.

Final Rule

For the reasons discussed in this part IV.C, *Limits on a Consumer Reporting Agency's Disclosure of Medical Debt Information*, the CFPB is finalizing § 1022.38 with amendments to § 1022.38(b)(2). New § 1022.38 to subpart D addresses how a consumer reporting agency's medical debt information reporting responsibilities are impacted when creditors are prohibited from obtaining or using medical debt information. A consumer reporting agency is permitted to include medical debt information in a consumer report furnished to a creditor for credit eligibility purposes only if the consumer reporting agency (1) has reason to believe the creditor intends to use the medical debt information in a manner not prohibited by § 1022.30; and (2) has reason to believe the creditor is not otherwise legally prohibited from obtaining or using the medical debt information, including by a State law that prohibits a creditor from obtaining or using medical debt information. Relatedly, the CFPB is finalizing the proposed removal of the example in § 1022.30(c)(3)(iii) which describes a creditor receiving medical information on a consumer report furnished by a consumer reporting agency.

FCRA section 604, entitled *Permissible purposes of consumer reports*, identifies an exclusive list of permissible purposes for which consumer reporting agencies may provide consumer reports.[160] The statute states that a consumer reporting agency may furnish consumer reports under these circumstances "and no other."[161] One such circumstance, covered by FCRA section 604(a)(3)(A), permits a consumer reporting agency to furnish a consumer report to a person which it has reason to believe "intends to use the information in connection with a credit transaction involving the consumer on whom the information is to be furnished and involving the extension of credit to, or review or collection of an account of, the consumer" (credit permissible purpose).[162]

Final § 1022.38(b)(1) addresses how consumer reporting agencies' responsibilities under FCRA section 604(a)(3)(A) are impacted by the removal of the financial information exception and related amendments to § 1022.30. As discussed in part IV.B, *Removal of the Financial Information Exception to the Creditor Prohibition on Obtaining or Using Medical Information*, the CFPB is finalizing the proposal to remove the financial information exception in § 1022.30(d). The result of removing the financial information exception is that a creditor will be prohibited from obtaining or using medical debt information—a subcategory of medical information—in connection with any determination of the consumer's eligibility for credit under

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[160] 15 U.S.C. 1681b(a) (providing that, "[s]ubject to subsection (c), any consumer reporting agency may furnish a consumer report under the following circumstances and no other").

[161] *Id.* Other sections of the FCRA identify additional limited circumstances under which consumer reporting agencies are permitted or required to disclose certain information to government agencies. *See* 15 U.S.C. 1681f, 1681u, 1681v; *see also, e.g.*, *FTC v. Manager, Retail Credit Co., Miami Beach Branch Off.*, 515 F.2d 988, 994-95 (D.C. Cir. 1975) (holding that 15 U.S.C. 1681s(a) authorizes the FTC to obtain consumer reports in FCRA enforcement investigations). Further, the Debt Collection Improvement Act of 1996, Pub. L. 104-134, 110 Stat. 1321, tit. III, section 31001(m)(1), allows the head of an executive, judicial, or legislative agency to obtain a consumer report under certain circumstances relating to debt collection. *See* 31 U.S.C. 3711(h).

[162] 15 U.S.C. 1681b(a)(3)(A).

the general prohibition in § 1022.30(b), unless a specific exception for obtaining and using medical information in § 1022.30(e) applies to the medical debt information. Under the final rule, a creditor who is legally prohibited from obtaining or using medical debt information in connection with a determination of the consumer's eligibility or continued eligibility for credit does not have a permissible purpose for a consumer report containing that information; the creditor could not plausibly intend to use that information in connection with a credit transaction. Similarly, a consumer reporting agency would not have reason to believe that a creditor who is legally prohibited from obtaining or using the medical debt information intends to use the information in connection with a credit transaction involving the consumer.[163] The CFPB therefore finalizes § 1022.38(b)(1) to explain the impact of the credit permissible purpose provision in FCRA section 604(a)(3)(A) on the FCRA section 604(g)(2) creditor prohibition as implemented in final § 1022.30.

The same is true under the final rule for any other legal prohibition under which creditors may neither obtain nor use medical debt information. Thus, the CFPB determines that amending proposed § 1022.38(b)(2) to include a similar provision to final § 1022.38(b)(1), to cover other scenarios in which a creditor is legally prohibited from obtaining or using medical debt information, is warranted. Regardless of the source of the prohibition, under the final rule, if a creditor is legally prohibited from obtaining or using medical debt information, a creditor does not have a permissible purpose for a consumer report containing that information; a creditor cannot plausibly intend to use that information in connection with a credit transaction. Final § 1022.38(b)(2) explains the impact of the credit permissible purpose provision in FCRA section

[163] 15 U.S.C. 1681b(a)(3)(A).

604(a)(3)(A) on any legal prohibition on creditors obtaining or using medical debt information. Final § 1022.38(b)(2) ensures that, independent of the prohibition in § 1022.30, a consumer reporting agency would generally still be prohibited from furnishing a consumer report containing medical debt information to a creditor who is legally prohibited from obtaining or and using the medical debt information.

Section 621(e) of the FCRA authorizes the CFPB to issue regulations as "necessary or appropriate to administer and carry out the purposes and objectives of [the FCRA], and to prevent evasions thereof or to facilitate compliance therewith."[164] The CFPB has determined that the limits on a consumer reporting agency's disclosure of a consumer's sensitive medical debt information to a creditor who is legally prohibited from obtaining or using such information are necessary or appropriate to administer and carry out the purposes and objectives of the FCRA, and to prevent evasions or to facilitate compliance.[165] In particular, the limitations on consumer reporting agencies in § 1022.38(b)(1) would markedly facilitate compliance for creditors by ensuring that creditors do not receive from consumer reporting agencies medical debt information that they are not permitted to obtain or use under FCRA section 604(g)(2) and § 1022.30. If consumer reporting agencies continued to furnish to creditors, in connection with eligibility determinations, consumer reports containing medical debt information, creditors would need to screen out such information to comply with the creditor prohibition in FCRA section 604(g)(2) and § 1022.30. Screening out medical debt information may be cumbersome for creditors, especially those that use automated underwriting processes. On the other hand, consumer reporting agencies could more easily implement automatic processes that remove

[164] *See* CFPA section 1088(a)(10)(E) (15 U.S.C. 1681s(e)).

[165] *See* 15 U.S.C. 1681s(e)(1).

medical debt information provided by medical information furnishers from those reports that are requested for credit eligibility determinations because medical information furnishers are required to identify themselves to consumer reporting agencies.[166] At least one commenter questioned this assertion, but the CFPB notes that the NCRAs have recently implemented reporting changes to remove certain medical debt information from consumer reports and therefore have shown they are capable of creating such infrastructure.[167]

The CFPB has also determined that § 1022.38(b) is necessary and appropriate to administer and carry out the purposes and objectives of the FCRA, especially that of "need[ing] to insure that consumer reporting agencies exercise their grave responsibilities with fairness, impartiality, and a respect for the consumer's right to privacy."[168] Medical information is uniquely sensitive and intimate information, and it thus advances the purposes and objectives of the FCRA to protect consumers' privacy by limiting the circumstances under which consumer reporting agencies may furnish medical debt information.

D. Example to Comply With Applicable Requirements of Local, State, or Federal laws

Proposal

During the SBREFA process, several financial institutions, furnisher small entity representatives, and debt collectors expressed concern about how the proposal under

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[166] *See* 15 U.S.C. 1681s-2(a)(9).

[167] Equifax, *First Changes to Reporting of Medical Collection Debt Roll Out July 1, 2022* (July 1, 2022), https://www.equifax.com/newsroom/all-news/-/story/first-changes-to-reporting-of-medical-collection-debt-roll-out-july-1-2022; Experian, *First Changes to Reporting of Medical Collection Debt Roll Out July 1, 2022* (July 1, 2022), https://www.experianplc.com/newsroom/press-releases/2022/first-changes-to-reporting-of-medical-collection-debt-roll-out-july-1-2022; TransUnion, *First Changes to Reporting of Medical Collection Debt Roll Out July 1, 2022* (July 1, 2022), https://newsroom.transunion.com/first-changes-to-reporting-of-medical-collection-debt-roll-out-july-1-2022/; PR Newswire, *Equifax, Experian and TransUnion Remove Medical Collections Debt Under $500 From U.S. Credit Reports* (Apr. 11, 2023), https://www.prnewswire.com/news-releases/equifax-experian-and-transunion-remove-medical-collections-debt-under-500-from-us-credit-reports-301793769.html.

[168] *See* 15 U.S.C. 1681(a)(4).

consideration to remove the financial information exception in § 1022.30(d) and prohibit consumer reporting agencies from including medical debt collections tradelines on consumer reports furnished to creditors for credit eligibility determinations would interact with repayment ability determination requirements under the Truth in Lending Act (TILA) and Regulation Z for mortgage loans and credit cards.[169] Stakeholders stated that these laws require creditors to consider all of a consumer's current debt obligations, such that the proposal under consideration would impede their ability to make the required determination in compliance with Federal law. A small entity representative recommended that the CFPB consider (1) stating what creditors should tell consumers regarding whether medical debt information should be disclosed on applications for credit, and (2) providing to creditors information about any limitations on financial institutions' use of consumer-provided medical information for underwriting.

In the NPRM, the CFPB proposed to eliminate current § 1022.30(d). The CFPB preliminarily found that the financial information exception was not necessary and appropriate to protect legitimate operational, transactional, risk, consumer, and other needs (including administrative verification purposes) as set forth in current § 1022.30(d). However, the CFPB preliminarily determined to not eliminate other exceptions, including the exception in § 1022.30(e)(1)(ii) for medical information necessary to comply with applicable local, State, or Federal laws, such as Regulation Z's ability-to-repay or pay requirements. In response to comments during the SBREFA process, the CFPB proposed an example in proposed § 1022.30(e)(6) to direct creditors and card issuers that are creditors regarding how to obtain and use medical information provided by the consumer in compliance with TILA and Regulation Z,

[169] SBREFA Report at 36.

as set forth in § 1022.30(e)(1)(ii), for purposes of compliance with the ability-to-repay rule under § 1026.43(c) for closed-end mortgages, the repayment ability rule under § 1026.34(a)(4) for open-end, high-cost mortgages, and the ability-to-pay rule under § 1026.51(a) for open-end (not home-secured) credit card accounts.

Under existing § 1022.30(c)(1), a creditor does not violate the prohibition on obtaining medical information in § 1022.30(b) if the creditor receives medical information pertaining to a consumer in connection with the creditor's determination of the consumer's eligibility for credit without specifically requesting such information. For example, if a consumer applies for a mortgage loan and the creditor has not specifically requested medical information on the application, but asks for all current debts or obligations, and the consumer self-discloses by providing medical information in the form of a monthly medical payment plan, the creditor does not violate the prohibition on obtaining medical information. In this circumstance, under § 1022.30(e)(1)(ii), the creditor would be permitted to use this information by considering the existence and the amount of the medical payment plan as required in considering certain factors under § 1026.43(c)(2), such as the current debt obligations, consumer's monthly debt-to-income ratio, and residual income, in making the repayment ability determination required under § 1026.43(c)(1). Proposed § 1022.30(e)(6) also would have provided that, in accordance with § 1026.43(c)(3)(iii), the creditor would not be required to independently verify the existence and amount of the consumer's monthly medical payment plan if the consumer's application states a current debt, even if that debt is not shown in the consumer report. This is also consistent with Regulation Z comment 43(c)(3)-6 describing a situation where a consumer, through the application, provides a creditor with information on a debt obligation that is not listed on a consumer report. Therefore, the creditor would not violate the prohibition on obtaining or using

medical information in § 1022.30(b) if the creditor obtains and uses medical information disclosed by the consumer on their application as an ongoing payment obligation in response to a general inquiry about debts or obligations.

Proposed § 1022.30(e)(6) would have explained that a creditor (for mortgage loans) or card issuer (for credit cards) relying on the specific exception for compliance with applicable laws at § 1022.30(e)(1)(ii) is not permitted to obtain or use medical information from a consumer report. In the proposed rule, the CFPB preliminarily determined that the creditor or card issuer can comply with the applicable laws using the information provided by the consumer on the application, including any medical information received from the consumer in response to a general inquiry about debts or obligations; therefore, it would not be necessary or appropriate for a creditor or card issuer to use medical information contained in a consumer report in order to comply with the applicable laws. As explained in part IV.C, *Limits on a Consumer Reporting Agency's Disclosure of Medical Debt Information*, the CFPB also believed it would be administratively difficult for consumer reporting agencies to determine which information in a consumer's credit file is necessary for a particular creditor's compliance with the requirement to make a repayment ability determination and which information is not. In the context of creditors' obligations to make repayment ability determinations under Regulation Z, determining the medical debt information that would be relevant to ability-to-repay or pay rules, as well as the administrative burdens of segmenting this information out, is impractical for a consumer reporting agency to undertake. For the reasons discussed in the NPRM, the CFPB preliminarily found that preventing creditors from purposefully obtaining—and under new § 1022.38, consumer reporting agencies from furnishing—medical information on consumer reports for credit eligibility purposes will both ease burdens on consumer reporting agencies and prevent

attempts by creditors to evade the rule by requesting consumer reports in the hopes of learning indirectly the same sensitive medical information the rule prohibits creditors from soliciting directly under the guise of compliance with the ability-to-repay or pay rules.

In the proposed rule, the CFPB preliminarily determined that creditors would not need to begin obtaining medical information from consumers under the proposed rule if they do not already do so. For example, the CFPB did not intend the NPRM to change any existing law or guidance regarding the extent to which creditors may rely on consumer reports to assess consumers' current obligations in complying with repayment ability determination requirements.[170]

The CFPB requested feedback on this aspect of the proposed rule and whether that proposal would assist a creditor or card issuer in making its repayment ability determination under TILA/Regulation Z. The CFPB also sought comment on whether amendments should be made to § 1022.30(e)(1)(ii) to reflect the language in proposed § 1022.30(e)(6)—providing that a creditor or card issuer may not obtain or use medical information from a consumer reporting agency to comply with the ability-to-repay rule under 12 CFR 1026.43(c) for closed-end mortgages, the repayment ability rule under 12 CFR 1026.34(a)(4) for open-end, high-cost mortgages, or the ability-to-pay rule under 12 CFR 1026.51(a) for open-end (not home-secured) credit card accounts—or if the language in proposed § 1022.30(e)(6) is sufficient to explain how creditors can comply with the repayment ability determination requirements under TILA/Regulation Z.

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[170] *See, e.g.*, Regulation Z comment 51(a)(1)(i)-7 ("A card issuer may consider the consumer's current obligations based on information provided by the consumer or in a consumer report."); *see also* § 1026.43(c)(3)(iii) ("[I]f a creditor relies on a consumer's credit report to verify a consumer's current debt obligations and a consumer's application states a current debt obligation not shown in the consumer's credit report, the creditor need not independently verify such an obligation.")

Comments

Many industry commenters and several individual commenters submitted comments indicating that the NPRM contradicts TILA's and Regulation Z's ability-to-repay requirements. One industry commenter asserted that the proposed rule is likely to create compliance challenges with regard to TILA and Regulation Z, which require creditors to make a reasonable, good faith determination of a consumer's ability to repay any residential mortgage loans. Another industry commenter asserted that the CFPB has the responsibility to create rules regarding ability-to-repay requirements for mortgage lending in TILA and the CFPB's own rules require among other things, that a creditor consider all of a borrower's outstanding liabilities at the time of loan origination. This commenter asserted that (1) the NPRM 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 consumer reporting agencies; and (2) 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. Another industry commenter asserted that the NPRM would conflict with TILA, which requires the reasonable and good-faith determination that the consumer has the ability to repay before a mortgage loan is made.

One consumer reporting agency asserted that the CFPB in the NPRM did not adequately address industry concerns regarding creditors' ability to assess a borrower's ability to repay. This commenter asserted that it is not adequate to just allow lenders to ask the borrower directly for all current debts, and the borrower may include medical debt information in response. This commenter asserted that consumers might decline to include the information, and even if consumers provided information, creditors would be unable to verify its accuracy.

One trade group commenter representing banks asserted that (1) banks would face significant potential uncertainty about compliance and liability if the final rule is unclear on how to comply with the mortgage ability-to-pay rules in Regulation Z; and (2) the CFPB must provide additional assurances regarding the inclusion or exclusion of medical debt information from mortgage-related calculations.

Two industry trade group commenters representing banks and other financial institutions urged the CFPB to clarify that creditors are permitted to verify medical debt information received from the consumer in response to a general inquiry about debts or obligations using reliable third-party records that are not the credit report. These commenters also urged the CFPB to clarify that a creditor is permitted to consider debts listed on a consumer report that are not obviously medical debts. In this regard, the commenters urged the CFPB to amend Example 6 to provide that a creditor or card issuer is not required to independently verify that a debt listed on a consumer report is for purposes other than medical debt. Another industry commenter urged the CFPB to clarify that a creditor that considers a consumer's FICO score or a report of credit report attributes that could encompass medical debt does not violate the proposed prohibition on obtaining or using medical debt for credit eligibility determinations.

Also, an industry commenter representing credit unions noted that the CFPB and banking regulators have previously encouraged lenders to evaluate alternative data in making credit decisions, as evidenced by the CFPB's 2017 "Request for Information Regarding Use of Alternative Data and Modeling Techniques in the Credit Process." By restricting access to medical debt information, this commenter asserted that the CFPB would be limiting the very type of alternative data it has previously endorsed.

Several industry commenters also raised concerns that the proposed rule could increase exposure to enforcement action by other Federal agencies, and violations of State laws, related to the consumer's ability to repay. One commenter advocating for small entities argued that (1) a large medical debt may interfere with a consumer's ability to repay; (2) by not considering it, a consumer may become overextended and suffer financial embarrassment; and (3) small entities are concerned that if they do not consider the consumer's ability to repay and the consumer faces financial embarrassment, the small entity may be exposed to an enforcement action by other Federal agencies. One trade group representing community bankers asserted that the NPRM would create an irreconcilable regulatory contradiction between what the banking regulators require and what the CFPB will be preventing and prohibiting. This commenter indicated that it agrees with these other banking regulators because complete information and the accurate calculation of a borrower's ability to repay is needed to make prudent lending decisions that benefit both the bank and the borrower. One credit union trade group asserted that (1) credit unions are already required to accurately determine their member's ability-to-repay as a risk management requirement; and (2) the proposed rule creates an irreconcilable regulatory contradiction between what the financial regulators require and what the CFPB prohibits.

Many industry commenters and several individual consumer commenters also asserted that banning medical debt from being included in a consumer report would harm both consumers and creditors. They asserted that the proposed rule could lead to incomplete or inaccurate assessments of a borrower's ability to repay, potentially resulting in either overly restrictive lending practices or an increased risk of defaults due to approving loans for consumers who may not be able to afford them when all debts are considered. These comments are discussed in more detail in part VII, *CFPA Section 1022(b) Analysis*.

Several consumer group commenters, on the other hand, questioned industry concerns that the NPRM, if adopted, would contradict the requirements in TILA or Regulation Z. In particular, one of these consumer group commenters asserted that, following enactment of Colorado's law restricting medical debt on credit reports, there have been no reports of the other negative consequences in Colorado predicted by the debt collection industry's hired economist, such as increased financing for unqualified borrowers, decreased access for credit-qualified borrowers, difficulties in repairing credit scores, or conflicts with the ability-to-repay requirement in Regulation Z. Several other consumer group commenters and several individual commenters also asserted that medical debts are not a good predictor of general creditworthiness, nor representative of an individual's ability to repay debts.

Final rule

For the reasons discussed herein, the CFPB is finalizing Example 6 as proposed with one clarification as discussed below. The CFPB has determined that Example 6 does not conflict with the ability-to-repay or pay requirements in Regulation Z. The CFPB also has determined that Example 6 provides sufficient information for how creditors may comply with both the ability-to-repay or pay requirements in Regulation Z with respect to mortgages and credit card accounts and the changes in this final rule with respect to use of medical information. Final Example 6 describes a scenario where a consumer applies for a mortgage loan subject to Regulation Z § 1026.43(c) or § 1026.34(a)(4), or an open-end (not home-secured) credit card account subject to Regulation Z § 1026.51(a). In this scenario, the application does not specifically request medical information, but the consumer provides medical information on the application in response to a general inquiry about debts or obligations. Final Example 6 explains that the creditor or the card issuer is permitted under § 1022.30(e)(1)(ii) to use such medical information in connection with any determination of the consumer's eligibility, or continued

eligibility, for credit only to the extent required by the applicable Federal law and implementing regulation. Final Example 6 also explains that a creditor or card issuer is not permitted to obtain or use any medical information from a consumer reporting agency under § 1022.30(e)(1)(ii) to comply with the ability-to-repay rule under Regulation Z § 1026.43(c) for closed-end mortgages, the repayment ability rule under Regulation Z § 1026.34(a)(4) for open-end, high-cost mortgages, or the ability-to-pay rule under Regulation Z § 1026.51(a) for open-end (not home-secured) credit card accounts, because the creditor or card issuer can comply with those rules using information provided by the consumer. Consistent with the proposed rule, the CFPB has determined that a creditor or card issuer can comply with the applicable laws using the information provided by the consumer, including any medical information received from the consumer on the application in response to a general inquiry about debts or obligations; therefore, it would not be necessary or appropriate for a creditor or card issuer under § 1022.30(e)(1)(ii) to use medical information contained in a consumer report in order to comply with the applicable laws.

The final rule revises Example 6 from the proposal, however, to make clear that this example only relates to the exception under § 1022.30(e)(1)(ii), and a creditor or card issuer may obtain and use medical information for purposes of Regulation Z's ability-to-repay or pay determinations pursuant to other exceptions in § 1022.30(e), as applicable. See parts IV.B.3, *Medical Information Related to Income, Benefits, or the Purpose of the Loan,* and VI.A, *Consumer-Authorized Transaction History*. The CFPB has determined that this final rule does not conflict with the use of alternative data in complying with Regulation Z's ability-to-repay or pay requirements. For instance, if a consumer authorizes a creditor to access transaction information from a Regulation E account, a Regulation Z credit card, or facilitation of payments

from a Regulation E account or Regulation Z credit card, as the creditor might obtain through the exception under § 1022.30(e)(1)(x)(A)(*1*), and that transaction information happens to contain medical information, such as payments on a medical payment plan, the creditor is permitted under § 1022.30(e)(1)(ii) to use such medical information in connection with any determination of the consumer's eligibility, or continued eligibility, for credit only to the extent required by the applicable Federal law and implementing regulation, and is permitted to use such medical information under § 1022.30(e)(1)(x) to the extent the creditor satisfies the additional requirements of that exception stated in § 1022.30(e)(1)(x)(B) and (C).

With respect to the ability-to-repay requirements in Regulation Z § 1026.43(c), final Example 6 also contains additional information on the interplay between the ability-to-repay requirements in Regulation Z § 1026.43(c) and final § 1022.30(e)(1)(ii). Again, under this scenario discussed in final Example 6, the creditor has not specifically requested medical information on the application, but the consumer provides information on a current debt obligation, such as a monthly medical payment plan, that is medical information. For mortgages subject to Regulation Z § 1026.43(c), creditors typically ask consumers on applications to disclose their current debt obligations/liabilities, but the applications do not specifically request medical information.[171] To the extent that consumers provide medical information in response to this general request for debt information, creditors generally are required to consider such medical debt information under § 1026.43(c)(2).[172] Final Example 6 explains that the creditor is permitted under § 1022.30(e)(1)(ii) to consider the existence and the amount of the medical

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[171] *See, e.g.*, Fannie Mae, *Uniform Residential Loan Application (Form 1003)*, https://singlefamily.fanniemae.com/delivering/uniform-mortgage-data-program/uniform-residential-loan-application (last visited Nov. 25, 2024).

[172] *See* 12 CFR 1026.43(c)(2), (3)(iii); Regulation Z comment 43(c)(3)-6.

payment plan as required in Regulation Z § 1026.43(c)(2) in considering factors under Regulation Z § 1026.43(c)(2), such as the current debt obligations, consumer's monthly debt-to-income ratio, and residual income, in making the repayment ability determination required under Regulation Z § 1026.43(c)(1). In this circumstance, final Example 6 explains that the creditor would not be required to independently verify the existence and amount of the monthly medical payment plan, as provided for under Regulation Z § 1026.43(c)(3)(iii) and comment 43(c)(3)-6, describing a situation in which a consumer provides a creditor with information on a debt obligation that is not listed on a consumer report. As discussed above, two industry trade group commenters urged the CFPB to clarify that creditors are permitted under § 1022.30(e)(1)(ii) to verify medical debt information received from the consumer in response to a general inquiry about debts or obligations using reliable third-party records that are not the credit report. However, while Regulation Z § 1026.43(c)(3) generally requires creditors to use reasonably reliable third party records to verify any information the creditor relies upon under Regulation Z § 1026.43(c)(2) to make the repayment ability determination required by Regulation Z § 1026.43(c)(1), Regulation Z § 1026.43(c)(3)(iii) and comment 43(c)(3)-6 clarify that if a creditor relies on a consumer's credit report to verify a consumer's current debt obligations and a consumer's application states a current debt obligation not shown in the consumer's credit report, the creditor need not independently verify such an obligation. Consistent with final § 1022.38, medical debt information generally will not appear on credit reports. Accordingly, creditors may not rely on the exception in § 1022.30(e)(1)(ii) to obtain and use medical information to independently verify such medical debt obligation. A creditor, however, may obtain and use

medical information to verify such medical debt obligations pursuant to other exceptions in § 1022.30(e), as applicable.[173]

The CFPB notes that with respect to Regulation Z § 1026.34(a)(4) for open-end, high-cost mortgages, situations also may arise where the creditor has not specifically requested medical information on the application, but the consumer provides information on a current debt obligation, such as a monthly medical payment plan, that is medical information. For mortgages subject to Regulation Z § 1026.34(a)(4), creditors typically ask consumers on applications to disclose their current debt obligations/liabilities, but the applications do not specifically request medical information.[174] To the extent that consumers provide medical information in response to this general request for debt information, creditors generally are required to consider such medical debt information under § 1026.34(a)(4). In complying with Regulation Z § 1026.34(a)(4), comment 34(a)(4)(ii)(B)-1 discusses the scenario where a consumer lists an obligation on an application but the credit report does not reflect such obligation. Comment 34(a)(4)(ii)(B)-1 makes clear that the creditor is responsible for considering such an obligation under Regulation Z § 1026.34(a)(4), but the creditor is not required to independently verify the obligation. Thus, a creditor is permitted under § 1022.30(e)(1)(ii) to consider the existence and the amount of the medical payment plan as required in § 1026.34(a)(4) in making the repayment ability determination required under Regulation Z § 1026.34(a)(4). The CFPB notes, however,

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[173] Section 307 of the Economic Growth, Regulatory Relief, and Consumer Protection Act (EGRRCPA), among other things, directs the CFPB to prescribe ability-to-repay rules for Property Assessed Clean Energy (PACE) financing. Pub. L. 115-174, 132 Stat. 1296, 1347 (2018). The CFPB issued a final rule on December 17, 2024. As finalized, the PACE rule applies the existing framework of Regulation Z § 1026.43(c) to PACE transactions in the same manner as the framework applies to other closed-end mortgages, with adjustments to account for the unique nature of PACE financing.

[174] Fannie Mae, *Uniform Residential Loan Application (Form 1003)*, https://singlefamily.fanniemae.com/delivering/uniform-mortgage-data-program/uniform-residential-loan-application (last visited Nov. 25, 2024).

that because Regulation Z § 1026.34(a)(4) and comment 34(a)(4)(ii)(B)-1 do not require creditors to independently verify a debt obligation that a consumer provides to a creditor that is not listed on a consumer report, creditors may not rely on the exception in § 1022.30(e)(1)(ii) to obtain and use medical information to independently verify such medical debt obligation. A creditor, however, may obtain and use medical information to verify such medical debt obligations pursuant to other exceptions in § 1022.30(e), as applicable.

With respect to the ability-to-pay rule under Regulation Z § 1026.51(a) for open-end (not home-secured) credit card accounts, the CFPB notes that card issuers typically do not ask consumers on applications to disclose their debt obligations. Instead, card issuers typically obtain a consumer's debt obligations from a consumer report. Consistent with the NPRM, the CFPB has determined that creditors would not need to begin obtaining medical information from consumers under the final rule if they do not already do so. For example, the CFPB does not intend the final rule to change any existing law or guidance regarding the extent to which creditors may rely on consumer reports to assess consumers' current obligations in complying with repayment ability determination requirements. Specifically, Regulation Z comment 51(a)(1)(i)-7 provides that a card issuer may consider the consumer's current obligations based on information provided by the consumer or in a consumer report. Thus, a card issuer may continue to rely on the consumer report to obtain information about a consumer's current obligations and is not required under § 1026.51(a)(1) to request information from the consumer on the application about their debt obligations. The CFPB has determined that this is true even though a consumer report under this final rule will not contain information about a consumer's medical debt obligations. Further, as with the ability-to-repay provisions discussed above, because § 1026.51(a)(1) does not require card issuers to verify any current debt obligations that

may be listed on an application, a card issuer may not rely on the exception in § 1022.30(e)(1)(ii) to obtain and use medical information to independently verify a medical debt obligation listed on a consumer's application. A card issuer, however, may obtain and use medical information to verify such medical debt obligations pursuant to other exceptions in § 1022.30(e), as applicable.

The CFPB declines to amend Example 6 to clarify that creditors and card issuers are permitted to consider debts listed on a consumer report for purposes of the ability-to-repay or pay requirements in Regulation Z that are not obviously medical debts and are not required to independently verify that a debt listed on a consumer report is for purposes other than medical debt. The CFPB also declines to clarify that creditors or card issuers that consider a consumer's FICO score or a report of credit report attributes that could encompass medical debt do not violate the proposed prohibition on obtaining or using medical information for credit eligibility determinations. The CFPB has determined that this additional guidance is not necessary. The restriction in § 1022.30(b) only applies to medical information, and creditors and card issuers must consider the definition of "medical information" as defined in § 1022.3(k) to determine if particular information meets that definition.

With respect to ability-to-repay or pay requirements imposed by other Federal agencies, and State laws, the CFPB notes that final § 1022.30(e)(1)(ii) permits a creditor to obtain and use medical information pertaining to a consumer in connection with any determination of the consumer's eligibility, or continued eligibility, for credit to comply with applicable requirements of local, State, or Federal laws. The CFPB did not receive comments from other Federal regulators or State regulators indicating that the proposed rule was in conflict with ability-to-repay or pay requirements imposed by other Federal agencies or State laws, as applicable. The CFPB also is not aware of any reported negative consequences of State laws generally limiting

consumer reporting agencies from reporting medical debt on credit reports (*e.g.*, Colorado), such as conflicts with the ability-to-repay or pay requirement in Regulation Z. Also, the CFPB is not aware of any ability-to-repay or pay requirements of other regulators or State laws that specifically require a creditor to obtain medical information from consumer reports. Thus, a creditor or card issuer can comply with the applicable laws using any medical information provided by the consumer, including any medical information received from the consumer on the application in response to a general inquiry about debts or obligations; therefore, it would not be necessary or appropriate under § 1022.30(e)(1)(ii) for a creditor or card issuer to use medical information contained in a consumer report in order to comply with the applicable laws.

V. Effective Date

The CFPB proposed an effective date for this final rule of 60 days after publication in the *Federal Register* in accordance with the Administrative Procedure Act, which generally requires that rules be published not less than 30 days before their effective dates.[175] The CFPB received eight comments from industry, government, trade association, and non-profit stakeholders on the proposed effective date. Several of these commenters argued that the proposed 60-day implementation period is unfeasible and that businesses would require more time to adjust to the changes to the FCRA. More specifically, five commenters stated that the proposed rule's changes to FCRA compliance would require small entities to train employees, obtain legal advice, and invest time and resources into complying with the rule. Industry and government stakeholders provided a range of alternative effective dates for the CFPB to consider ranging

[175] 5 U.S.C. 553(d).

from 12 to 36 months while a non-profit commenter expressed support for the proposed effective date. Additionally, one trade association commenter advocated for a phase-in period to the rule.

The CFPB has considered these comments and determines to finalize the effective date as proposed. The CFPB finds that the compliance costs to creditors will be low since creditors will likely need to do very little to comply with the rule to the extent that creditors currently only utilize medical debt information provided through consumer reports, which the CFPB understands is creditors' main source of medical debt information. In such cases, so long as the consumer reporting agency providing the consumer report has complied with the rule, no medical debt information would be conveyed to the creditor, unless the consumer reporting agency has reason to believe the creditor intends to use the medical debt information in a manner not prohibited by the creditor prohibition. Creditors who currently obtain and use medical debt information (and other prohibited medical information) from other sources will need to establish controls to ensure that they do not obtain or use the medical debt information in a manner prohibited by the rule. Consumer reporting agencies will need to make coding changes to exclude data identified as medical information from consumer reports sent to creditors. However, the CFPB expects this to be a relatively simple coding change, particularly for the NCRAs and the consumer reporting agencies that obtain consumer reports from NCRAs for resale because the NCRAs already limit their reporting of medical collections. In addition, consumer reporting agencies may have already scoped out this kind of coding change to comply with reforms in several States. Thus, the rule will take effect 60 days after publication in the *Federal Register*.

VI. Other Comments

A. Consumer-Authorized Transaction History

In the NPRM, the CFPB noted that consumer reporting agencies could incur additional compliance costs if medical information furnishers do not notify consumer

reporting agencies of their status as required by FCRA section 623(a)(9), and, similarly, that creditors could incur additional compliance costs if they use consumer reports that contain medical debt information notwithstanding § 1022.38.

Several commenters raised concerns along these lines about the proposal's interaction with the CFPB's Required Rulemaking on Personal Financial Data Rights (PFDR Rule), which could result in transmission of medical information that is not identified as such.[176] Specifically, a bank trade association commented that prohibiting creditors from considering medical debts and expenses could impede the development of cashflow underwriting, which considers the general inflows and outflows from a consumer's depository account. This commenter highlighted cashflow underwriting's value for expanding credit to underserved populations and argued that limiting the use of medical debt information could restrict the predictive power of this method. And an industry trade association commented that the proposal could pose challenges for data aggregators in the open banking system because no clear mechanism exists for identifying medical debt accounts. This commenter recommended that the CFPB require data providers to identify when a consumer is authorizing access to a medical account.

The CFPB is modifying the proposal to better allow consumers to authorize access to their accounts containing medical information for cashflow underwriting purposes. Final § 1022.30(e)(1)(x)(A)(*1*) provides, in part, that a creditor may consider medical information that is included in the transaction information of an account for a consumer financial product or service described in 12 CFR 1033.111(b)(1) through (3), and accessed with the consumer's

[176] Required Rulemaking on Personal Financial Data Rights, 89 FR 90838 (Nov. 18, 2024), https://files.consumerfinance.gov/f/documents/cfpb_personal-financial-data-rights-final-rule_2024-10.pdf.

authorization. This new provision is independent of the PFDR Rule and applies in situations where the PFDR Rule does not apply to the consumer-authorized access.

As the CFPB has recognized in the PFDR Rule and elsewhere,[177] the use of cashflow data in underwriting offers substantial benefits to consumers, especially consumers who have a limited credit history or do not have a credit file with a nationwide consumer reporting agency. For example, among consumers who do have credit scores, a study by FinRegLab found that cash-flow underwriting can help identify consumers who have low traditional credit scores but are actually a low credit risk for lenders.[178] Allowing creditors to consider cashflow data may increase access to credit or lower prices for consumers. But, as discussed above in connection with debts owed to third-party lenders, it is not operationally feasible for creditors or consumer reporting agencies to easily identify transactions that pertain to a medical debt. Without either the ability to easily filter out medical-debt transactions, or the ability to consider medical debts or expenses, creditors would be unable to fully assess the outflows from a consumer's account. Accordingly, the CFPB has determined that it is necessary and appropriate to protect legitimate operational, transactional, risk, consumer, and other needs, including permitting actions necessary for administrative verification purposes, and consistent with FCRA's intent to restrict the use of medical information for inappropriate purposes, to allow creditors to consider medical information included in the transaction history of a consumer's account with the consumer's authorization.

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[177] *See, e.g.*, Alexei Alexandrov, Alyssa Brown, & Samyak Jain, Consumer Fin. Prot. Bureau, *Looking at credit scores only tells part of the story – cashflow data may tell another part* (July 2023), https://www.consumerfinance.gov/about-us/blog/credit-scores-only-tells-part-of-the-story-cashflow-data/.

[178] FinRegLab, *The Use of Cash-Flow Data in Underwriting Credit* (July 2019), https://finreglab.org/wp-content/uploads/2019/07/FRL_Research-Report_Final.pdf.

Final § 1022.30(e)(1)(x)(A)(*1*)'s exception applies to medical information contained in an account for a consumer financial product or service described in 12 CFR 1033.111(b)(1) through (3). 12 CFR 1033.111(b) provides a definition of "covered consumer financial product or service" for purposes of the PFDR Rule. This term means a consumer financial product or service, as defined in 12 U.S.C. 5481(5), that is: (1) A Regulation E account, which means an account, as defined in Regulation E, 12 CFR 1005.2(b); (2) A Regulation Z credit card, which means a credit card, as defined in Regulation Z, 12 CFR 1026.2(a)(15)(i); or (3) Facilitation of payments from a Regulation E account or Regulation Z credit card, excluding products or services that merely facilitate first party payments.[179] Such accounts include checking accounts, savings accounts, digital wallets, and other accounts that provide data about a consumer's income, expenses, and spending. This transaction data is generally the type of data that financial institutions would need to access to engage in cashflow underwriting.

Final § 1022.30(e)(1)(x)(A)(*1*) also specifies that the medical information must have been accessed with the consumer's authorization. The PFDR Rule establishes authorization procedures for third parties seeking to access consumer data for purposes such as cashflow underwriting. As described in detail in the PFDR Rule, these authorization procedures and obligations are designed to ensure that consumers understand the data access they are authorizing and are able to exercise meaningful control with respect to such access.[180] Accordingly, a creditor satisfies final § 1022.30(e)(1)(x)(A)(*1*)'s requirement that it obtain medical information

[179] As the PFDR Rule explains, a "first party payment" is "a transfer initiated by the payee or an agent acting on behalf of the underlying payee." 89 FR 90838, 90990 (Nov. 18, 2024) (to be codified at 12 CFR 1033.111(b)(3)). "First party payments include payments initiated by loan servicers." *Id.*

[180] *See id.* at 90920-50.

"with the consumer's authorization" if it accesses consumer data following procedures that comply with—or in situations not covered by the rule, conform to—the PFDR Rule.

The CFPB declines to require data providers or data aggregators to identify medical accounts. To the extent that the accounts discussed by the commenter are covered by the PFDR Rule because they are Regulation E accounts, Regulation Z credit cards, or payment facilitation products and services, final § 1022.30(e)(1)(x)(A)(*1*) allows consumers to authorize access to the cashflow data from such accounts. To the extent such accounts fall outside the coverage of the PFDR Rule, such a requirement is beyond the scope of this rulemaking. The CFPB notes, however, that nothing in this rule or the PFDR Rule prevent industry from developing such an identification system.

B. FCRA Section 605(a)(6) – Information Excluded from Consumer Reports: Name, Address, and Telephone Number of any Medical Information Furnisher

Industry commenters asserted that the creditor prohibition in FCRA section 604(g)(2) does not prohibit creditors from obtaining or using financial aspects of medical information because FCRA section 604(g)(2) has a parenthetical cross-referencing FCRA section 605(a)(6). Specifically, commenters contended that the parenthetical cross-referencing FCRA section 605(a)(6) has the effect of allowing creditors to obtain or use medical information so long as it is restricted or reported using codes that do not reveal the specific provider or the nature of such services, products, or devices. This reading of FCRA section 604(g)(2) is contrary to the approach that the CFPB's predecessor agencies used when initially creating the provisions of Regulation V being repealed in this final rule; they expressly stated that "Section 604(g)(2) of the FCRA prohibits creditors from either obtaining or using medical information pertaining to a consumer in connection with any determination of the consumer's eligibility, or continued

eligibility, for credit."[181] In fact, were the commenters' position the correct reading, industry would have no need for the regulatory exemptions being repealed in this final rule—at least with respect to medical information in consumer reports that is treated in the manner required under 15 U.S.C. 1681c(a)(6), which the CFPB understands constitutes the bulk of the medical information that creditors consider in connection with credit-eligibility determinations. In full, FCRA section 604(g)(2) reads: "*Limitation on creditors*. 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* [*i.e.*, section 605(a)(6) of the FCRA]) pertaining to a consumer in connection with any determination of the consumer's eligibility, or continued eligibility, for credit."[182]

The CFPB believes that commenters misunderstand the plain text, context, and history of FCRA sections 604(g)(2) and 605(a)(6), which were enacted via two separate provisions of the FACT Act. Properly understood, the relevant sections of the FACT Act—sections 411 and 412—contemplate two separate mechanisms, regulating two different types of entities and on two different prescribed schedules, for ensuring protections for consumers' medical information in the financial system: (1) the limitation on *creditors'* use of medical information in underwriting under FCRA section 604(g)(2), subject to exceptions the Agencies might authorize in a final rule to be issued six months after the enactment of the FACT Act, and (2) the requirement under FCRA section 605(a)(6) that *consumer reporting agencies* mask certain

[181] 70 FR 70664, 70664 (Nov. 22, 2005).

[182] 15 U.S.C. 1681b(g)(2) (emphasis added).

information in consumer reports, to take effect fifteen months after the enactment of the FACT Act.

First, FACT Act section 411,[183] titled "Protection of Medical Information in the Financial System," added the bulk of FCRA section 604(g)—including the creditor prohibition—but did not add a parenthetical cross-referencing FCRA section 605(a)(6). FACT Act section 411 required the Agencies to issue final regulations by six months after the enactment of the FACT Act and tethered the effective date of the creditor prohibition in FCRA section 604(g)(2) to those regulations.[184]

Second, FACT Act section 412,[185] titled "Confidentiality of Medical Contact Information in Consumer Reports," added several complementary provisions related to how consumer reporting agencies are to identify and appropriately protect medical information on consumer reports. FACT Act section 412 added FCRA section 623(a)(9), requiring persons whose primary business is providing medical services, products, or devices (or their agents or assignees) and who furnish information to consumer reporting agencies to notify the agencies of their status as medical information furnishers.[186] FACT Act section 412 authorized the FTC to "issu[e] model guidance or prescribe[e] reasonable policies and procedures, as necessary" to ensure that a

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[183] FACT Act section 411(a), 117 Stat. 1999-2001.

[184] FACT Act section 411(d), 117 Stat. 2002 (providing that FCRA section 604(g)(2), as enacted in FACT Act section 411(a), shall take effect on the later of (1) 90 days after the Agencies' issuance of final regulations under FCRA section 604(g)(5), or (2) the date specified in such final regulations). Although FACT Act section 411(a) required the Agencies to issue regulations under FCRA section 604(g)(5) by six months after the FACT Act's December 4, 2003 enactment, they did not publish interim final rules under FCRA section 604(g)(5) until June 10, 2005. *See* Fair Credit Reporting Medical Information Regulations, 70 FR 33958 (June 10, 2005); *see also* Fair Credit Reporting Medical Information Regulations, 70 FR 70664 (Nov. 22, 2005) (subsequent final rule).

[185] FACT Act section 412, 117 Stat. 2002-03.

[186] FACT Act section 412(a), 117 Stat. 2002.

medical information furnisher notifies the consumer reporting agencies of its status.[187] Then, FACT Act section 412 added FCRA section 605(a)(6), which generally prohibits consumer reporting agencies from reporting to any third parties (*i.e.*, not just creditors) the "name, address, and telephone number of any medical information furnisher" that has notified the agency of its status, unless "such name, address, and telephone number" are restricted or reported using codes for confidentiality.[188] In conjunction with this new requirement for consumer reporting agencies, FACT Act section 412 inserted in FCRA section 604(g)(1) and (g)(2), as "technical and conforming amendments," the parentheticals cross-referencing FCRA section 605(a)(6).[189] Recognizing that medical information furnishers and consumer reporting agencies would need time for implementation, Congress stated that the "amendments made by [FACT Act section 412] shall take effect at the end of the 15-month period beginning on the date of enactment of this Act."[190]

Commenters appear to posit an unlikely and odd legislative maneuver whereby Congress simultaneously passed a law and repealed it in substantial part when commenters assert that the

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[187] FACT Act section 412(e), 117 Stat. 2003.

[188] FACT Act section 412(b), 117 Stat. 2002. FCRA section 605(a)(6) exempts from its restrictions consumer reports "provided to an insurance company for a purpose relating to engaging in the business of insurance other than property and casualty insurance." *Id.* (15 U.S.C. 1681c(a)(6)(B)).

[189] FACT Act section 412(f), 117 Stat. 2003.

[190] FACT Act section 412(g), 117 Stat. 2003. Before the text of FCRA section 604(g)(2), as set forth in FACT Act section 411(a), itself took effect, the FACT Act section 412(f) "technical and conforming" amendment inserted in FCRA section 604(g)(2) the parenthetical cross-referencing FCRA section 605(a)(6). Congress contemplated that the text of FCRA section 604(g)(2) set forth in FACT Act section 411(a) could take effect within approximately nine months after the enactment of the FACT Act (*i.e.*, *before* the FACT Act section 412(f) "technical and conforming" amendment adding the parenthetical referring to FCRA section 605(a)(6) would take effect)—but Congress also provided that FCRA section 604(g)(2) could take effect later, *i.e.*, if the Agencies specified a later date in their final regulations. *See* FACT Act section 411(a), 117 Stat. 2001 (requiring Agencies to issue final regulations under FCRA section 604(g)(5) within six months of the FACT Act's enactment); FACT Act section 411(d), 117 Stat. 2002 (providing that FCRA section 604(g)(2), as set forth in FACT Act section 411(a), could take effect on the later of 90 days after issuance of final regulations under FCRA section 604(g)(5) or the date specified in those final regulations).

parenthetical cross-referencing FCRA section 605(a)(6) (added by FACT Act section 412) in large part negates the creditor prohibition in FCRA section 604(g)(2) (added by FACT Act section 411). As noted above, the two sections of the FACT Act contemplate two separate mechanisms, regulating two different types of entities and on two different prescribed schedules, for ensuring protections for consumers' medical information in the financial system. Accordingly, as Congress indicated by designating the parenthetical in FCRA section 604(g)(2) a "technical and conforming amendment," the parenthetical reference to "medical information treated in the manner required under section 605(a)(6)" is nothing more than an acknowledgment in the first mechanism that the second exists. In other words, Congress anticipated that the Agencies would be considering regulatory exceptions in their upcoming regulations, and to ensure that any of the Agencies' upcoming regulatory exceptions under FACT Act section 411 would also be consistent with the separate "name, address, and telephone number" confidentiality provisions of FACT Act section 412, Congress added a cross-reference. This cross-reference serves to emphasize that if the Agencies' upcoming regulations included regulatory exceptions to the creditor prohibition in FCRA section 604(g)(2), creditors would nonetheless still be prohibited from obtaining or using a consumer report containing the "name, address, and telephone number" of a health care provider unless such name, address, and telephone number are restricted or reported using codes for confidentiality.

Commenters' interpretation of the parenthetical, which was added through FACT Act section 412, would swallow much of the creditor prohibition that Congress added through FACT Act section 411. Contrary to commenters' assertion, the parenthetical merely ensures consistency between FACT Act section 411 and section 412, so that—notwithstanding any agency regulation creating regulatory exceptions to the creditor prohibition—consumer reports containing medical

information obtained or used by creditors would restrict the "name, address, and telephone number" of a health care provider or otherwise report using codes for confidentiality. Besides ensuring the confidentiality of the "name, address, and telephone number," FACT Act section 412 does not otherwise change the broad creditor prohibition in FCRA section 604(g)(2), which Congress added through FACT Act section 411. As recognized by the prudential regulators, FCRA "section 604(g)(2) prohibits all creditors from obtaining or using key financial information that is also medical information in the credit underwriting process," and "[s]ection 604(g) does not contain any specific statutory exception to this broad [creditor] prohibition."[191] Commenters are thus incorrect to assert that the creditor prohibition that Congress added through FACT Act section 411 distinguishes between financial and non-financial aspects of medical information; rather, the only exceptions are exceptions pursuant to regulatory determinations under FCRA section 604(g)(3)(C) (by the FTC, Federal banking agencies, NCUA, or applicable State insurance authority) or pursuant to regulations under FCRA section 604(g)(5) (by the Federal banking agencies and NCUA).[192]

C. Implications for Other Laws

Some commenters supporting the proposed rule stated that the rule would help to further strengthen existing consumer protections provided by other laws, such as the FDCPA[193] and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).[194] Several commenters opposing the proposed rule stated that the rule unnecessarily duplicates or overlaps with these

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[191] 70 FR 33958, 33962 (June 10, 2005).

[192] *Id.* Congress subsequently (through the CFPA) transferred to the CFPB primary regulatory authority for the FCRA. Pub. L. 111-203, 124 Stat. 1955, 2004 (2010). *See also* 15 U.S.C. 1681b(g)(3)(C), (5)(A).

[193] 15 U.S.C. 1692 *et seq.*

[194] Pub. L. 104-191, 110 Stat. 1936 (1996).

and other Federal statutes and regulations addressing debt collection, abusive conduct, privacy issues, discrimination, and consumer credit eligibility.[195] These laws are discussed below and include, among others, the Patient Protection and Affordable Care Act[196] and the No Surprises Act.[197] Some commenters also went further and stated that the proposed rule is in conflict with some provisions of other laws. For example, commenters asserted that the proposed rule may cause creditors to violate ECOA[198] if, in lieu of medical debt information, potential creditors rely more heavily on non-medical debt information about consumers that is less predictive and potentially biased. Commenters also contended that the proposed rule would require handling of sensitive information across multiple entities in violation of the HIPAA and the Gramm-Leach-Bliley Act (GLBA)[199] and would impede creditors' ability to make repayment ability determinations required under TILA and Regulation Z. Another commenter asserted that the proposed rule does not comport with CFPB enforcement actions related to abusive acts or practices. With respect to HIPAA, some commenters stated that the proposed rule would conflict with HIPAA's provisions permitting covered entities (such as health care providers) to use and disclose protected health information, with certain limits and protections, for treatment, payment, and health care operations activities. Another commenter asserted that the proposed rule contradicts bankruptcy law generally, under which a bankruptcy filer is required to pay back at least some portion of their debt.

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[195] Comments regarding State laws, and responses thereto, are discussed in part IV.C, *Limits on a Consumer Reporting Agency's Disclosure of Medical Debt Information*, above.

[196] Pub. L. 111-148, 124 Stat. 119 (2010).

[197] Pub. L. 116-260, div. BB, tit. I, 134 Stat. 2758 (2020).

[198] 15 U.S.C. 1691 *et seq.*

[199] 15 U.S.C. 6801 *et seq.*

The FDCPA and the CFPB's implementing regulation, Regulation F, 12 CFR part 1006, govern certain activities of debt collectors, as that term is defined in the FDCPA. Among other things, the FDCPA and Regulation F prohibit debt collectors from engaging in unfair, deceptive, or abusive conduct when collecting or attempting to collect debts and require debt collectors to make certain disclosures to consumers in debt collection. Effective November 30, 2021, a new provision of Regulation F requires a debt collector to take certain actions intended to convey information about the debt to the consumer before furnishing information on that debt to a consumer reporting agency.[200]

The HIPAA and the Department of Health and Human Services' (HHS) implementing regulations[201] also limit or regulate the use, collection, and sharing of certain health information. Among other things, the HIPAA, as implemented by HHS regulations, sets national standards for the protection of individually identifiable health information by health plans, health care clearinghouses, and health care providers, as well as the security of electronic protected health information.

The Patient Protection and Affordable Care Act revised section 501(r) of the Internal Revenue Code such that non-profit hospitals may lose their non-profit tax status if they fail to evaluate patients for eligibility for financial assistance before the hospital takes certain types of collection actions.[202]

The No Surprises Act protects participants, beneficiaries, and enrollees in group health plans and group and individual health insurance coverage from surprise medical bills when they

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[200] *See* 12 CFR 1006.30(a).

[201] *See* 45 CFR parts 160 and 164.

[202] *See* 26 U.S.C. 501(r)(6).

receive, under certain circumstances, emergency services, non-emergency services from nonparticipating providers at participating health care facilities, and air ambulance services from nonparticipating providers of air ambulance services.[203] In addition, the No Surprises Act, among other things, requires certain health care facilities and providers to disclose Federal and State patient protections against balance billing and sets forth complaint processes with respect to potential violations of the protections against balance billing and out-of-network cost sharing.[204] The No Surprises Act also includes certain protections for uninsured (or self-pay) individuals from surprise medical bills.[205] Several Federal agencies have published rules implementing the No Surprises Act.[206]

ECOA and the CFPB's implementing regulation, Regulation B, 12 CFR part 1002, make it illegal for a creditor to discriminate against an applicant in any aspect of a credit transaction on the basis of race, color, religion, national origin, sex (including sexual orientation and gender identity), marital status, or age (provided the applicant has the capacity to contract), on the fact that all or part of the applicant's income derives from a public assistance program, or on the fact that the applicant has in good faith exercised any right under the Consumer Credit Protection Act.[207] The general rule stated in § 1002.4(a) "covers, for example, application procedures,

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[203] *See* Requirements Related to Surprise Billing; Part I, 86 FR 36872 (July 13, 2021). The protections against surprise billing also apply to health benefits plans offered by carriers under the Federal Employees Health Benefits (FEHB) Act. *See* 5 U.S.C. 8901(p).

[204] *See* Requirements Related to Surprise Billing; Part I, 86 FR 36872 (July 13, 2021).

[205] *See* Requirements Related to Surprise Billing; Part II, 86 FR 55980 (Oct. 7, 2021).

[206] *See, e.g., id.* (interim final rule issued by Office of Personnel Management; Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare and Medicaid Services, Department of Health and Human Services); Requirements Related to Surprise Billing; Part I, 86 FR 36872 (July 13, 2021) (same).

[207] 15 U.S.C. 1691(a); 12 CFR 1002.4(a); 86 FR 14363 (Mar. 16, 2021).

criteria used to evaluate creditworthiness, administration of accounts, and treatment of delinquent or slow accounts."[208]

The GLBA and the CFPB's implementing regulation, Regulation P, 12 CFR part 1016, require financial institutions subject to the CFPB's jurisdiction to provide their customers with notices concerning their privacy policies and practices, among other things. They also place certain limitations on the disclosure of nonpublic personal information to nonaffiliated third parties, and on the redisclosure and reuse of such information. Other parts of the GLBA, as implemented by regulations and guidelines of certain other Federal agencies (*e.g.*, the Federal Trade Commission's Safeguards Rule and the prudential regulators' Safeguards Guidelines), set forth standards for administrative, technical, and physical safeguards with respect to financial institutions' customer information.

TILA[209] and the CFPB's implementing regulation, Regulation Z, 12 CFR part 1026, impose disclosure and other requirements on creditors. For example, TILA and Regulation Z generally prohibit creditors from making mortgage loans unless they make a reasonable and good faith determination that the consumer will have the ability to repay the loan. TILA and Regulation Z also contain ability-to-pay requirements for credit cards.

Commenters provided no evidence that the proposed rule would conflict with other Federal laws. For example, while they pointed to HIPAA implementing regulations permitting covered entities, such as health care providers, to furnish payment information to consumer reporting agencies, they did not address the fact that the proposed rule would not have imposed any obligations or restrictions on furnishers. Nor would the rule unnecessarily duplicate or

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[208] Regulation B comment 4(a)-1.

[209] 15 U.S.C. 1601 *et seq.*

overlap with other laws; to the contrary, issuing this final rule will effectuate a congressionally enacted restriction on creditors' utilization of medical information and further strengthen consumer protections. Moreover, § 1022.30(e)(1)(ii) permits a creditor to obtain and use medical information pertaining to a consumer in connection with any determination of the consumer's eligibility, or continued eligibility, for credit to comply with applicable requirements of local, State, or Federal laws. For example, how to obtain and use medical information provided by the consumer in compliance with TILA and Regulation Z, as set forth in § 1022.30(e)(1)(ii), is discussed in part IV.D, *Example to Comply With Applicable Requirements of Local, State, or Federal laws,* above. With respect to the CFPB's pending enforcement actions, as referenced by a commenter, the CFPB notes that enforcement actions alleging unfair, deceptive, or abusive acts or practices under the CFPA are tethered to their particular facts and circumstances.

D. Other comments regarding legal authority

Industry commenters asserted that the CFPB lacked authority to issue this rule, arguing that the rule constituted a matter of vast economic and political significance subject to the "major questions" doctrine. Industry commenters also contended that reliance on the words "necessary and appropriate" in Congress's delegations of authority to the CFPB does not provide an intelligible principle to guide agency action and would violate the "nondelegation" doctrine.

Consistent with the discussion above, the CFPB has the legal authority to implement this rule. First, the CFPB has determined that the FCRA authorizes it to issue this rule and that the rule does not run afoul of the major questions doctrine. The rule merely (1) amends (including by revoking in substantial part) a discretionary exemption previously issued under expressly conferred rulemaking authority, thereby giving effect to a congressionally enacted restriction on creditors' utilization of medical information, and (2) prohibits consumer reporting agencies from providing creditors information that they cannot consider in underwriting in any event. Far from

"claim[ing] the power to resolve a matter of great political significance,"[210] the CFPB here is removing a discretionary, insufficiently supported regulatory barrier to the implementation of an express statutory restriction on creditors obtaining or using medical information in connection with lending decisions. As the discussion of the rule's benefits and costs in part VII.E, *Potential Benefits and Costs to Consumers and Covered Persons*, demonstrates, the rule will not "involve[] hundreds of billions of dollars of impact," as have other rules triggering the major questions doctrine.[211] Nor is this a case in which an agency has "claim[ed] to discover in a long-extant statute an unheralded power."[212] Instead, the rule here returns to FCRA section 604(g)(2) the effect it would have had if the Agencies had not adopted the financial information exception. Further, Congress itself recognized that the CFPB has "comparative expertise"[213] to make the determination at the heart of this rulemaking: It expressly provided that the CFPB may determine whether an exemption like the financial information exception is "necessary and appropriate to protect legitimate operational, transactional, risk, consumer, and other needs" related to consumer-credit transactions.[214] The rule thus does not have the hallmarks of a regulation potentially subject to the major questions doctrine.

Second, the CFPB has determined that this rule does not run afoul of the nondelegation doctrine, which provides that it is unconstitutional for Congress to delegate its legislative powers to an actor in another branch of government, such as an executive agency. The consensus articulation that has emerged in Supreme Court jurisprudence is that Congress does not

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[210] *West Virginia v. EPA*, 597 U.S. 697, 743 (2022) (Gorsuch, J., concurring).

[211] *Mayfield v. Dep't of Labor*, 117 F.4th 611, 616 (5th Cir. 2024).

[212] *West Virginia*, 597 U.S. at 724 (majority opinion) (citation omitted).

[213] *Id.* at 729 (citation omitted).

[214] 15 U.S.C. 1681b(g)(5).

impermissibly delegate legislative authority if the statute contains an "intelligible principle" to guide the relevant actor in exercising its statutory authority.[215] Under this standard, the Court has upheld broad delegations, such as "to regulate in the 'public interest,'" "to set 'fair and equitable' prices and 'just and reasonable' rates," and "to issue whatever air quality standards are 'requisite to protect the public health.'"[216] Here, Congress's delegations of authority to the CFPB, in FCRA sections 604(g)(5) and 621(e), and CFPA section 1022(b)(1), meet that standard.

VII. CFPA Section 1022(b) Analysis

The CFPB has considered the potential benefits, costs, and impacts of the rule. In the proposal, the CFPB requested comment on the impact analysis, as well as submissions of additional data that could inform its consideration of the impacts of the proposed rule. The CFPB has incorporated the information provided by commenters in the analysis and estimates that follow. This section contains an analysis of the benefits and costs of the rule for consumers, consumer reporting agencies, creditors, and other entities, such as health care providers and debt collectors.

A. Statement of Need

The FCRA supports the fairness, accuracy, and privacy of personal information in consumer reporting. Among the protections in the FCRA for consumers' medical information, FCRA section 604(g)(2) generally restricts creditors from obtaining or using medical information in connection with credit eligibility determinations, absent a regulatory exception. FCRA section 604(g)(5) requires that the CFPB determine that any such exception be necessary

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[215] *See, e.g.*, *Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 472 (2001) (quoting *J.W. Hampton, Jr., & Co. v. United States*, 276 U.S. 394, 409 (1928)).

[216] *Gundy v. United States*, 588 U.S. 128, 146 (2019) (plurality opinion).

and appropriate and consistent with the intent of FCRA section 604(g)(2) to restrict the use of medical information for inappropriate purposes. The CFPB is also authorized under section 621(e) of the FCRA to issue regulations as may be necessary or appropriate to administer and carry out the purposes and objectives of the FCRA, and to prevent evasions thereof or to facilitate compliance therewith. The CFPB anticipates that the rule will enhance consumer privacy by removing the financial information exception at § 1022.30(d) that currently permits creditors to consider medical debt information and medical information about expenses, assets, and collateral, among other types of medical information, in underwriting decisions under certain circumstances.

Medical debt is prevalent in the United States, with 20 percent of households reporting that they had medical debt in 2022.[217] Reflecting this prevalence, medical collections have recently comprised the majority of credit collection tradelines found on consumer reports.[218] Like other information on consumer reports, medical collections information may be used by creditors to assess a consumer's ability to handle credit obligations.

Medical collections may result from unplanned expenditures, making medical collections information on consumer reports a potentially noisy or inaccurate signal of a consumer's ability to meet credit obligations. In the United States, high health care prices, uneven insurance coverage, complex health insurance networks, and cost-sharing features of health insurance may cause unexpected or chronic illnesses to result in large medical bills for individual consumers. Due to opaque medical pricing and billing practices, consumers often do not know the cost of

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[217] Consumer Fin. Prot. Bureau, *CFPB Estimates $88 Billion in Medical Bills on Credit Reports* (Mar. 1, 2022), https://www.consumerfinance.gov/about-us/newsroom/cfpb-estimates-88-billion-in-medical-bills-on-credit-reports/.

[218] Consumer Fin. Prot. Bureau, *Medical debt burden in the United States*, at 5 (Mar. 1, 2022), https://www.consumerfinance.gov/data-research/research-reports/medical-debt-burden-in-the-united-states/.

medical services at the time those services are incurred, and may receive medical bills that they are uncertain they actually owe.[219] Some consumers are unable to pay these bills on time, and some of these past-due medical bills eventually become medical collections.

Multiple consumer advocates and at least one researcher submitted comments agreeing with the CFPB's understanding of how many consumers acquire medical debt, though one individual stated that only a fraction of medical debt is the result of an unavoidable emergency. The CFPB understands that 72 percent of consumers with medical debt reported that the debt originated from a one-time or short-term medical expense, such as for treatment from an accident or a single hospital stay, implying that a substantial fraction of medical debt results from unplanned expenditures.[220]

Another factor that potentially makes medical collections an imprecise signal is that they are unevenly reported. Many health care providers allow debt collectors to furnish to consumer reporting agencies, while others do not. Because of this, it is possible for consumers' medical debt in collections to be included unevenly on consumer reports, potentially leading to different financial outcomes. While a consumer could theoretically be able to factor this into their decision when selecting a health care provider, it is more likely that a consumer is not aware of which health care providers furnish and usually does not choose a health care provider based solely on a health care provider's collection policies, if they consider them at all.[221]

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[219] *See* Consumer Fin. Prot. Bureau, *Complaint Bulletin: Medical billing and collection issues described in consumer complaints*, at 7-8 (Apr. 20, 2022), https://www.consumerfinance.gov/data-research/research-reports/complaint-bulletin-medical-billing-and-collection-issues-described-in-consumer-complaints/.

[220] Lunna Lopes et al., Kaiser Fam. Found., *Health Care Debt In The U.S.: The Broad Consequences Of Medical And Dental Bills* (June 16, 2022), https://www.kff.org/report-section/kff-health-care-debt-survey-main-findings/.

[221] Noam M. Levey, *Hundreds of Hospitals Sue Patients or Threaten Their Credit, a KHN Investigation Finds. Does Yours?*, KFF Health News (Dec. 21, 2022), https://kffhealthnews.org/news/article/medical-debt-hospitals-sue-patients-threaten-credit-khn-investigation/.

When creditors base underwriting decisions on information that is unevenly reported and potentially erroneous, an economic tradeoff arises. Creditors balance the probabilities of making two types of error when deciding whether to lend to consumers. The first type of error occurs when creditors lend to consumers who are unable to repay the loan. The second type of error occurs when creditors choose not to lend to consumers who are able and willing to repay. Creditors lose potential revenues when they decline credit for consumers with reported medical collections. Similarly, consumers, who would have benefitted from access to credit, also lose from being denied credit because of reported medical collections.

The likelihood of making each of these types of error is affected by the informativeness of the signal medical collections provide to creditors. When medical collections are reported for debts that do not exist (for instance, because medical bills have been paid by insurance) and are prevalent, using this information will tend to increase the likelihood of the second type of error, without reducing the likelihood of the first type of error. In that situation, creditors who use medical collection information would benefit from not considering this information in their credit decisions. When medical collections are reported on the basis of debts that may in fact impair consumers' future repayment and are prevalent, creditors would experience a reduction in revenue if they do not consider medical collections in their credit decisions, due to an increase in the likelihood of the first type of error. As a result, whether creditors would benefit from not being able to consider medical collections in their credit decisions is an empirical question. As discussed in part XII, *Technical Appendix*, empirical analysis suggests that, on balance, preventing creditors from using medical collection information in credit decisions would result in creditors extending credit to more consumers without diminishing the average performance of newly opened credit accounts.

As noted by a researcher commenter, credit scores that exclude or underweight medical debt were created in response to market demand, but market forces have not yet driven creditors to cease using medical debt information in underwriting. The CFPB agrees that if creditors could in fact benefit from disregarding medical debt information when making credit decisions, one would expect that creditors would have abandoned the practice out of their own profit motive. While, as discussed above, the industry has trended in this direction in recent years, the transition has not occurred fully, or quickly. The CFPB hypothesizes that the nexus of current contracts, expectations, and institutional structures that govern creditors' behavior prevents markets from moving to a potentially better equilibrium outcome. For instance, the market for mortgages is heavily driven by the secondary market for those loans. Similar factors likely drive creditor behavior in other consumer loan markets. Mortgage originators must follow underwriting practices that are expected by buyers in the secondary market, or they will not be able to securitize their loans. Since consideration of medical debt information has been expected by the market (if only implicitly through the use of commercially available credit scores), it is difficult for any one firm to move away from using that information, even if doing so would not increase risks for investors.[222]

The rule would generally prohibit creditors from considering medical debt information from consumer reports in underwriting decisions. Consequently, the incentive for medical debt holders and collectors to furnish to consumer reporting agencies would decrease. As a result, the rule would enhance consumers' privacy with respect to their medical information, while also reducing the likelihood that the uneven reporting of medical collections would affect credit

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[222] Loretta J. Mester, Fed. Rsrv. Bank of Phila., *What's the Point of Credit Scoring?*, Bus. Rev., at 6 (Sept./Oct. 1997), https://www.philadelphiafed.org/-/media/frbp/assets/economy/articles/business-review/1997/september-october/brso97lm.pdf.

outcomes. While the rule would reduce the amount, though not necessarily the quality, of information on which creditors can base underwriting decisions, the CFPB expects that, over time, those credit scoring models that currently use medical collections would be adjusted to reweight the remaining information on consumer reports. In the long run, the expected adjustments to credit scoring models may help markets move toward a more efficient allocation of credit.

Adjustments to credit scoring models may result in credit being extended to more consumers who are able and willing to repay their credit obligations. This may allow consumers to benefit from increased access to credit and creditors to increase overall revenues. Moreover, since medical collections tradelines on consumer reports are prone to error, removing medical debt from consumer reports could reduce the need for dispute resolution, potentially saving time and resources for consumers, consumer reporting agencies, and furnishers of medical debt information.

B. Baseline for Consideration of Costs and Benefits

The impact analysis compares the rule's potential benefits and costs against a baseline in which the CFPB takes no regulatory action. This baseline includes existing Federal and State law and current furnishing practices. Under the baseline, creditors are generally allowed to consider medical collections information on consumer reports in underwriting decisions due to the financial information exception at § 1022.30(d).

Over the last few years, the three NCRAs implemented several changes in the consumer reporting of medical debt. In September 2017, as part of a settlement with 31 State attorneys general, the NCRAs implemented a 180-day waiting period before including furnished medical

collections on consumer reports.[223] In July 2022, the NCRAs voluntarily extended the waiting period from 180 days to one year and removed all paid medical collections from consumer reports. Finally, in April 2023, the NCRAs voluntarily removed both paid and unpaid medical collections under $500 from consumer reports.[224]

A researcher commenter cited research showing that these voluntary NCRA reporting changes disproportionately benefited consumers in census tracts that had higher average incomes or had larger white shares of the population. The commenter stated that disparities in credit access persist for consumers who live in lower-income or non-white communities. The CFPB agrees and its own research has reached similar findings.[225]

It is the CFPB's understanding that health care providers and debt collectors they contract with currently use three types of collection practices to collect medical debt, often in combination: contacting consumers by mail, phone, or other means; debt collection litigation; and furnishing medical collections information to consumer reporting agencies. The impact analysis considers how health care providers and debt collectors may respond to the rule by increasing their use of the first two collection practices if furnishing becomes a less effective means of inducing payment.

The evolving landscape of State laws and consumer reporting practices may change medical collections reporting in the absence of the rule, affecting the baseline. The voluntary

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[223] Press Release, Atty. Gen's. Off., State of Ohio, *Attorney General DeWine Announces Major National Settlement with Credit Reporting Agencies*, (May 20, 2015), https://www.ohioattorneygeneral.gov/Media/News-Releases/May-2015/Attorney-General-DeWine-Announces-Major-National-S.

[224] Fredric Blavin et al., Urban Wire, Urban Inst., *Medical Debt Was Erased from Credit Records for Most Consumers, Potentially Improving Many Americans' Lives* (Nov. 2, 2023), https://www.urban.org/urban-wire/medical-debt-was-erased-credit-records-most-consumers-potentially-improving-many.

[225] Ryan Sandler & Zachary Blizard, Consumer Fin. Prot. Bureau, *Recent Changes in Medical Collections on Consumer Credit Records Data Point*, at 4 (Mar. 2024), https://files.consumerfinance.gov/f/documents/cfpb_recent-changes-medical-collections-on-consumer-credit-reports_2024-03.pdf.

changes recently implemented by the NCRAs could be reversed at any time, and such reversals would tend to amplify the impacts of the rule.

In the current state of the world, creditors are generally allowed to consider medical debt information in underwriting decisions, including medical collections information found on consumer reports. Some recently passed State laws establish when medical collections information originating from these States can be furnished to consumer reporting agencies or included on consumer reports.[226] As a result of their voluntary reporting changes, the only medical collections that the NCRAs currently include in their consumer reports are those that: (1) are more than one year past due, (2) are for collection amounts greater than $500, and (3) are unpaid, in addition to those that (4) would not violate State laws that restrict or prohibit consumer reporting of medical collections. By August 2023, after the voluntary NCRA changes were fully implemented but before most of the State-level changes took effect, an estimated 5 percent of consumers had medical collections on their consumer reports.[227] The rule removes these remaining medical collections from, and generally prohibits future medical collections from being included in, consumer reports provided to creditors.

C. Data and Evidence

1. Primary sources

The CFPB's analysis of costs, benefits, and impact is informed by data from a range of sources. As discussed in part III.A, when the interventions discussed in this rule were part of the broader Consumer Reporting Rulemaking, the CFPB convened a Small Business Review

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[226] *See, e.g.*, Colo. Rev. Stat. section 5-18-109; N.Y. Pub. Health Law art. 49-A; 2024 Conn. Act 24-6; 2024 Va. Acts ch. 751.

[227] Ryan Sandler & Zachary Blizard, Consumer Fin. Prot. Bureau, *Recent Changes in Medical Collections on Consumer Credit Records Data Point*, at 3 (Mar. 2024), https://files.consumerfinance.gov/f/documents/cfpb_recent-changes-medical-collections-on-consumer-credit-reports_2024-03.pdf.

Advisory Panel in October 2023 to gather input from small businesses. The discussions at the panel meetings and the comment letters submitted by small entity representatives during this process were presented in a Panel Report completed in December 2023. The CFPB also invited and received feedback on the proposals under consideration from other stakeholders, including stakeholders who were not small entity representatives. The impact analysis is further informed by academic research, reports on research by industry and trade groups, practitioner studies, and comment letters received by the CFPB. Where used, these specific sources are cited in this analysis.

The CFPB also used its own Consumer Credit Information Panel (CCIP) to estimate the potential impacts of the proposed rule on consumers and creditors. The CCIP is a 1-in-50, nationally representative sample of deidentified consumer reports from one of the three NCRAs. The data allowed the CFPB to conduct analyses of the effect of medical collections information on the success of a consumer's application for credit (determined by whether a creditor's inquiry following such an application led to the origination of a credit account or, in other words, inquiry success) and future credit account delinquencies. Such analyses are useful for quantifying the rule's potential impacts to consumers and creditors. Because the CCIP data are drawn from consumer reports from a single NCRA and because medical collections are unevenly reported, the data might not contain all medical collections that exist in the United States.

To quantify health care providers' exposure to unpaid medical bills, the CFPB used data from the Hospital Cost Reporting Information System (HCRIS), which is administered by the Centers for Medicare and Medicaid Services. The HCRIS data contain annual cost reports filed by Medicare-certified hospitals in the United States. The data comprise information on hospitals, their revenues, operating costs, and bad debt expenses not reimbursable by Medicare. While

almost all hospitals file these cost reports, the data do not include unpaid medical debts owed to health care providers that are not hospitals.[228]

Due to these data limitations, the analysis presented in this part generally provides a qualitative discussion of the rule's costs and benefits and includes quantitative estimates whenever possible.

Multiple commenters, including at least one bank trade association, consumer reporting agency trade association, and consumer reporting agency, as well as multiple debt collectors and researchers, stated that the CFPB did not adequately gather data and estimate impacts in the proposed rule. The CFPB uses available data, economic reasoning, and evidence provided by commenters to justify its conclusions in the below impact analysis. The Supreme Court has acknowledged that executive branch decision-making relies on imperfect data, and "[t]he APA [Administrative Procedure Act] imposes no general obligation on agencies to conduct or commission their own empirical or statistical studies."[229] In this rule the CFPB has gone beyond the minimum requirements of the APA and section 1022(b)(2)(B) of the CFPA by conducting its own statistical study, documented in the Technical Appendix.

2. ACA International Survey

The CFPB requested data that can be used to quantify the analysis of impacts, or submission of studies that contain relevant estimates that can be used in the analysis of impacts. The CFPB received a research report commissioned by a debt collection industry trade association which critiqued several elements of the analysis in the proposal and introduced some

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[228] Nat'l Pub. Radio, *Nursing homes are suing friends and family to collect on patients' bills* (July 28, 2022), https://www.npr.org/sections/health-shots/2022/07/28/1113134049/nursing-homes-are-suing-friends-and-family-to-collect-on-patients-bills.

[229] *FCC v. Prometheus Radio Project*, 592 U.S. 414, 427 (2021).

new evidence. The CFPB discusses the findings of that report (referred to as the Report) below.[230]

The Report documents the results of a survey of members of ACA International, a debt collector trade association, executed in two "waves" which surveyed different samples of 19 debt collectors, for a total of 38 surveyed debt collectors across both waves. The first wave of the survey was fielded in the last two months of 2023 and the second wave of the survey was fielded in May 2024. Both waves asked about medical debt referrals and collections in the first and second quarters of 2022 and 2023, as well as in the fourth quarter of 2023.[231] The surveys also requested the debt collectors' predicted changes in medical debt collection rates if they were no longer permitted to use consumer reporting as a debt collection practice. Broadly, the surveyed debt collectors reported lower referrals and collected amounts in 2023 than in 2022 and reported lower expected medical debt collection rates if consumer reporting was not permitted. The CFPB does not find the results of this survey to be reliable evidence of the likely effects of the rule.

Beyond specific concerns about the results of the surveys in the Report, which the CFPB describes below, the CFPB notes that the surveys do not appear to have been representative of the debt collection industry. The Report does not provide information on how these debt collectors were selected for the surveys, and it is unlikely that these 38 debt collectors are representative of the 2,100 members of ACA International, much less representative of debt

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[230] Andrew R. Nigrinis, *Economic Analysis of the Consumer Financial Protection Bureau's Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information (Regulation V)* (July 2024), https://policymakers.acainternational.org/wp-content/uploads/2024/07/AndrewNigrinisEconomicAnalysis-CFPB-FCRA-NPRM-July2024.pdf. The Report was included as an exhibit to a comment by the debt collector trade association commenter, and also submitted by its author in his individual capacity.

[231] The Report does not describe how respondents to the first wave of the survey provided data for the fourth quarter of 2023 when they were surveyed before the end of that quarter.

collectors overall.[232] The Report does not provide data on the states in which the 38 debt collectors are located in, but rather the states in which the debt collectors' referring "client accounts" (which the CFPB assumes to mean health care providers) are located. Across both surveys, nearly 47 percent of the client accounts held by surveyed debt collectors—almost half—were located in California. In contrast, data from the 2017 Economic Census indicate that only around 10 percent of collection agencies were located in California.[233] The survey responses are not weighted to be more representative of debt collection nationwide. The overrepresentation of California medical debt may be especially likely to bias the inferences drawn from the surveys, as the CFPB understands that California's consumer protections that impact the debt collection industry are more robust than those in other states.[234] Additionally, just under 12 percent of survey respondents' client accounts were from Southern states, but medical debt is heavily concentrated in Southern states. Ninety-nine of the 100 counties with the largest shares of adults with medical collections are located in the South, as described in research cited by the Report.[235] The survey is unlikely to be representative of debt collectors in the South who may be more likely to have medical debt as a large share of their portfolio. As such, although the CFPB

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[232] ACA Int'l, *ACA International Advocacy Fact Sheet*, at 5 (2022), https://www.acainternational.org/wp-content/uploads/2022/WI/Advocacy-Booklet-May2022-FINAL.pdf.

[233] *See* U.S. Census Bureau, *2017 Economic Census Data*, https://www.census.gov/programs-surveys/economic-census/year/2017/economic-census-2017/data.html (last revised Feb. 27, 2024).

[234] California imposed new conditions on the sale of hospital medical debt to debt buyers in 2022, including that the hospital has either found the patient ineligible for financial assistance (income above 400 percent of the Federal poverty level and annual out-of-pocket costs at the hospital lower than the lesser of 10 percent of the patient's current family income or the patient's family income in the prior 12 months) or found the patient has not responded to attempts to offer financial assistance for 180 days. A previous law prohibits collection actions before 150 days after initial billing if the patient lacks coverage or may have high medical costs. *See* 2021 Cal. AB 1020. In addition, after this survey was performed, California's governor signed a law on September 24, 2024 to pass its own prohibition on credit reporting agencies including medical debts in consumer credit reports. SB 1061.

[235] Frederic Blavin et al., Urban Inst., *Brief: Which County Characteristics Predict Medical Debt?* (June 15, 2022), https://www.urban.org/research/publication/which-county-characteristics-predict-medical-debt.

discusses the specific arguments of the Report that are based on its survey of ACA International members, on balance the CFPB determines that this survey does not provide reliable evidence that can be relied upon to evaluate the benefits, costs and impacts of this final rule.

The Report includes aggregated dollar amounts of medical debt referred to debt collectors from health care providers ("referrals") and total collections recovered, as reported by the 38 survey respondents. The Report indicates that, for survey respondents, there were more referrals to debt collectors by health care providers in 2023 than in 2022, though the Report does not discuss whether this difference is statistically significant. The Report interprets this result as showing that consumers have lowered willingness to pay their medical bills after the voluntary NCRA reporting changes were completed in April 2023.

Setting aside the issue of representativeness discussed above, the CFPB finds that the increase in medical collection referrals among survey respondents documented in the Report is not likely due to the voluntary changes by the NCRAs in 2022 and 2023. First, the Report does not account for growth in health care costs. National health expenditure spending grew by 4.1 percent in 2022 and was expected to grow by 7.5 percent in 2023.[236] This would explain much of the growth in referral amounts between 2022 and 2023 by itself. The data in the Report also show indications of seasonality, which the Report makes no effort to adjust for. That is, referrals may be routinely higher in the winter compared to the spring, such that the Report's comparison of the referrals in the second quarter of 2022 to the first quarter of 2023 primarily captures this seasonal change. Indeed, the Report shows that referral amounts are much closer to the 2022 amounts by the fourth quarter of 2023. Additionally, the Report finds that referrals fell

[236] Ctrs. for Medicare & Medicaid Servs., *NHE Fact Sheet*, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet (last modified Sep. 10, 2024).

between June 2022 and December 2023 in the South, where medical debt is more prevalent than other regions. If there were declines in referral amounts because of the voluntary NCRA reporting changes, they would have been more likely to occur in the fourth quarter of 2023 than in the second quarter, because the removal of debts under $500 from consumer reports did not occur until April 2023, but this is not what the data show. Given these concerns, the CFPB determines that it cannot rely upon the Report as evidence that health care provider referrals were impacted by the voluntary NCRA reporting changes, and thus would be likely to be impacted by this final rule.

The Report constructed collection rates by dividing the aggregate collection data by the aggregate referral data for each debt collector, in each quarter. The Report provided median collection rates in each quarter by geographic region and for the United States overall. Collection rates are similar across the first two quarters of 2022 and the first quarter of 2023, but there appears to be a sizable reduction in the median collection rate in the second quarter of 2023, falling to 11.7 percent from 14.5 percent in the second quarter of 2022. Collection rates fell to 9.6 percent by the fourth quarter of 2023.[237] The Report interprets this as showing that consumers were receiving a message that medical debts do not need to be paid during this time period.

Despite the surveys' methodological flaws outlined above, taking the data of the Report at face value, the CFPB does not agree with the interpretation that consumers were more likely to believe that medical debts do not need to be paid in the second quarter of 2023, in comparison to

[237] The text of the Report compares the first quarter of 2022 to the fourth quarter of 2023. As discussed above in this final rule, the CFPB would expect and the Report shows significant seasonality in debt collection, such that comparing the first quarter of one year to the fourth quarter of another year is likely to pick up this seasonal variation, rather than any impacts of the voluntary changes by the NCRAs. As such, the CFPB focuses on the comparison between the second quarter of 2022 and the second quarter of 2023.

the second quarter of 2022. Instead, the CFPB expects that this change in the collection rate is, in large part, the result of the removal of medical debts under $500. After medical debts under $500 could no longer be reported to the NCRAs as of April 2023, debt collectors may have prioritized alternative mechanisms for collecting older debts under $500 which, absent the voluntary change, they may have collected through collection tools including consumer reporting. This change in debt collection practices may have temporarily reduced collection rates until debt collectors implemented equally effective practices for debts under $500, or until debt collectors changed the types of debt for which they accept referrals, as debt collectors could choose not to service debt that they expect would only be collectable with the use of consumer reporting. The CFPB expects there may be a similar temporary reduction in collection rates under the rule.

The Report also summarizes debt collectors' subjective expectations as to how a cessation of consumer reporting of medical debts would impact collection rates, using survey responses from the debt collector respondents.[238] The CFPB does not find these results to be a reliable way of estimating the likely impacts of this final rule. The CFPB does not believe that the respondents to the survey of ACA members possessed any means to provide a precise numerical forecast of the effect of the proposal on collection rates. Instead, the survey responses convey the subjective, qualitative opinions of the surveyed debt collectors, who have a financial interest in overestimating the costs of the proposal (to the extent that higher estimated costs reduce the likelihood that the proposal is finalized). While qualitative views can be valid, it is not appropriate to treat these as quantitative measures that can be aggregated and used to calculate median and mean values, as the Report does. The Report indicates that the median debt collector

[238] The CFPB notes that the rule would not prevent debt collectors from furnishing medical debt information which could be included on consumer reports sent to landlords, employers, other debt collectors, or consumers, so these estimates may overestimate the impact of the rule.

expected the collection rate[239] to decrease by 2.0 percent if debt collectors ceased consumer reporting.[240] In the South, where the highest concentrations of medical collections occur, the median expected change was 1.0 percent.

The Report argues that, if anything, the subjective estimates of the ACA International survey respondents understate the likely impact of the proposed rule. The Report states that respondents' expected reductions in collection rates were comparable to estimates from the Nevada Hospital Association (NHA) of the likely impact of Nevada State legislation that would prevent medical debts from being included on consumer reports for at least 60 days. The Report states that because the proposed rule would instead prevent medical debts from ever being included on consumer reports, respondents' estimates in response to the survey should have been higher than the NHA estimates. However, the Report misstated the requirements of the Nevada legislation. This State law requires debt collectors to provide written notification to a consumer 60 days before they take any action, not just consumer reporting, to collect a medical debt.[241] This State law is not equivalent to the final rule and the CFPB does not interpret the NHA estimate as implying that ACA International survey respondents underestimated the impacts of the rule.

The Report uses its survey of ACA International members and publicly available data sources to estimate the impact of the rule on the aggregate amount of recoverable medical debt.

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[239] Though the Report describes this as a "liquidation rate", it appears to be equivalently measured as the dollar amount collected divided by the dollar amount referred, which the Report also describes as a "collection rate." The CFPB uses "collection rate" throughout its discussion.

[240] The CFPB focuses on responses from the later wave of the survey documented in the Report, as this took place after the voluntary changes by the NCRAs and some recent changes in State laws, and thus is closer to the baseline.

[241] Br. for the Nev. Hosp. Ass'n as Amicus Curiae, *Aargon Agency, Inc. v. O'Laughlin*, 70 F.4th 1224 (9th Cir. 2023), https://www.acainternational.org/wp-content/uploads/2022/04/Dkt-13-Motion-to-file-Amicus-Curiae-Brief-Amicus-Curiae-Brief.pdf (filed Apr. 12, 2022).

The Report uses estimates for the existing stock of medical debt that would be impacted by the rule, as well as the flow of new medical debt. The CFPB does not find these estimates to be reasonable, as described below.

The Report assumes that the aggregate amount of medical debt that would be impacted by the rule is about $220 billion, based on an estimate from the Kaiser Family Foundation (KFF) of the total amount of medical debt outstanding. The CFPB estimates that approximately $50 billion in medical collections is currently included on consumer reports.[242] The CFPB expects that the stock of medical debt that is not included on consumer reports comprises debt that is at least seven years old and therefore cannot be included on a consumer report under the FCRA, debt that is not subject to consumer reporting because of NCRA policies or the preferences of the debt holder, and debt that may be eligible for consumer reporting but is not reported because the debt holder expects that reporting would not sufficiently increase the likelihood of payment. Recovery rates of debts that fall into these three categories will not be directly affected by the rule, so the CFPB's $50 billion estimate is a better approximation of the relevant inventory of medical debt.

To estimate the annual flow of medical debt that newly appears on consumer reports, the Report cited Kluender et al. (2021), which found that 13 percent of consumers incurred medical debt, with a mean value of $2,396, in 2020.[243] The Report used an estimate of 258.3 million adults in the United States and concluded that new medical debt accrues at a rate of $80.46

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[242] *See* Ryan Sandler & Zachary Blizard, Consumer Fin. Prot. Bureau, *Recent Changes in Medical Collections on Consumer Credit Records Data Point*, at 4 (Mar. 2024), https://files.consumerfinance.gov/f/documents/cfpb_recent-changes-medical-collections-on-consumer-credit-reports_2024-03.pdf.

[243] Raymond Kluender et al., *Medical Debt in the US, 2009-2020*, JAMA (July 20, 2021), https://jamanetwork.com/journals/jama/fullarticle/2782187.

billion per year. Though the Report used the KFF total inventory of medical debt to estimate the stock of medical debt, it used medical collections information provided on consumer reports to estimate the flow of medical debt. The CFPB agrees with the Report's decision to use medical collections included on consumer reports, as this reflects the portion of medical debt that will be impacted by the rule. However, the data from 2020 are outdated and do not reflect the amount of medical debt that is included on consumer reports at this rule's baseline. The CFPB assumes that the ratio between the stock and flow of consumers with medical collections included on consumer reports would have remained unchanged between 2020 and 2023, even though the stock and flow would have both responded to the voluntary NCRA reporting changes. Using evidence from Kluender et al. (2021), the CFPB finds that this flow-to-stock ratio was 0.73 in 2020.[244] The CFPB found that in June 2023, 15.6 million consumers had medical collections on their consumer reports.[245] Applying the ratio from Kluender et al. (2021) allows the CFPB to estimate that 11.4 million consumers incur medical collections on their consumer reports each year. The CFPB assumes that this flow of medical collections would be of similar dollar amounts to the stock of medical collections because Kluender et al. (2021) found that the difference between flow and stock medical collections was just $29.[246] The CFPB found that the average amount of a medical collection on a consumer report in June 2023 was $3,148.70.[247] Therefore,

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[244] *See id.* at Tbl.

[245] Ryan Sandler & Zachary Blizard, Consumer Fin. Prot. Bureau, *Recent Changes in Medical Collections on Consumer Credit Records Data Point* (Mar. 2024), https://files.consumerfinance.gov/f/documents/cfpb_recent-changes-medical-collections-on-consumer-credit-reports_2024-03.pdf.

[246] *See* Raymond Kluender et al., *Medical Debt in the US, 2009-2020*, at Tbl., JAMA (July 20, 2021), https://jamanetwork.com/journals/jama/fullarticle/2782187.

[247] Ryan Sandler & Zachary Blizard, Consumer Fin. Prot. Bureau, *Recent Changes in Medical Collections on Consumer Credit Records Data Point* (Mar. 2024), https://files.consumerfinance.gov/f/documents/cfpb_recent-changes-medical-collections-on-consumer-credit-reports_2024-03.pdf.

the CFPB estimates that new medical debt in collections that appears on consumer reports accrues at an annual rate of approximately $36 billion.[248]

The Report next applies the mean expected change in the collection rate for the debt collectors included in its surveys, estimating that there would be an 8 percent reduction in expected collection rates. The CFPB understands that the median better approximates the expected impact of the rule because it reduces the influence of outlier survey responses, and further expects that the results from the second wave of the survey better reflect conditions under the baseline because debt collectors had ample time to understand and respond to the NCRA reporting changes. Therefore, though the CFPB disagrees that these survey responses are informative as described above, the CFPB uses a 2 percent reduction in collection rates in its estimation of the change in recoverable medical debt under the rule below.

The Report applies an 8 percent reduction in expected collection rates to the entire stock and flow of estimated medical debt, which assumes that medical debt has a 100 percent expected collection rate at baseline. This is contrary to evidence in the Report, which showed that the median collection rate was just 9.6 percent amongst survey respondents in the most recent quarter for which they were surveyed. Therefore, the Report's 8 percent reduction in the collection rate should have been applied to the Report's estimated collection rate, which would find that collection rates would fall from 9.6 percent to 8.8 percent under the rule.[249]

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[248] This estimate is not equivalent to the annual flow of medical debt because most medical debt is not included on consumer reports and, since June 2022, medical debt must be at least one year past due before it can be added to a consumer report. Instead, this estimate provides the annual flow of medical debt that newly appears on a consumer report.

[249] Though the Report exclusively describes survey respondents' expectations for the change in collection rates under the proposal in percent terms, it is possible that survey respondents interpreted this request in percentage point terms instead. In this case, the collection rate would be expected to fall from 9.6 percent to 1.6 percent.

The Report uses a present value of growing perpetuity formula to estimate the indefinite loss of recoverable medical debt under the rule. The Report assumes a 5.11 percent discount rate and a 4.1 percent annual growth rate to estimate that there would be a $654.87 billion loss in recoverable medical debt over an infinite time horizon.

The CFPB produces its own estimate for the aggregate loss in recoverable medical debt under the rule based on the evidence provided in the Report. The CFPB uses a 2 percent change in the collection rate, such that collection rates would fall from 9.6 percent to 9.4 percent under the rule, as well as its estimates for the stock and flow of medical debt, $50 billion and $36 billion, respectively. The CFPB uses the Report's 4.1 percent annual growth rate but assumes a 2 percent discount rate, as recommended by the Office of Management and Budget (OMB) in their guidance to regulatory agencies for cost and benefit analyses.[250] Additionally, the CFPB only considers a 10-year time horizon, as OMB has no guidance for the discount rate in an infinite horizon.[251] Applying a standard discounted cash flow formula, the CFPB estimates a reduction in recoverable medical debt of approximately $900 million under the rule.[252]

The Report interprets its estimate of the reduction in collection rates under the proposed rule as the cost for health care providers, rather than for medical debt holders overall. Many health care providers sell medical debt to debt buyers, who then retain the legal right to collect on the debt. The CFPB is not aware of the portion of medical debt that is held by health care

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[250] Off. of Mgmt. & Budget, *OMB Circular No. A-4* (Nov. 9, 2023), https://www.whitehouse.gov/wp-content/uploads/2023/11/CircularA-4.pdf.

[251] The OMB's long-term estimates only go so far as 150 years, with increasingly smaller discount rates. Off. of Mgmt. & Budget, *OMB Circular No. A-4 Appendix* (Nov. 9, 2023), https://www.whitehouse.gov/wp-content/uploads/2023/11/CircularA-4Appendix.pdf.

[252] If the survey respondents' expected change in collection rates under the proposal is provided as a percentage point change, instead of a percent change, then the collection rate in this estimate would fall from 9.6 percent to 7.6 percent under the proposal. The estimate for the 10-year reduction in recoverable medical debt in this scenario is approximately $8 billion.

providers but understands that the aggregate estimates of the reduction in medical debt recoverable under the rule would only partially impose direct costs on health care providers.

3. Brevoort and Kambara (2014)

In the proposed rule, the CFPB cited previous CFPB research by Brevoort and Kambara (2014), which showed that medical collections tradelines are less predictive of serious delinquency than nonmedical collections.[253] This research showed that, holding credit scores constant, a consumer who has more medical collections than nonmedical collections may be less likely to become seriously delinquent within two years than a consumer with more nonmedical than medical collections.

Multiple commenters, including a bank trade association, a consumer reporting agency trade association, a debt collector trade association, a health care provider, a NCRA, a researcher, and an individual, disputed the relevance of this research to the proposed rule. A NCRA commenter analyzed its own data in response to Brevoort and Kambara (2014) and found that consumers with medical collections have delinquency rates that are at least 8 percent higher than consumers with nonmedical collections. The commenter did not state whether it held other consumer characteristics constant while making this comparison. The commenter further found that adding medical collections to a model with nonmedical collections increased predictive fit by 34 percent. However, the commenter did not provide any details about the other variables included in this model. The CFPB expects that a model with few variables would experience a

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[253] Kenneth P. Brevoort & 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. *See also* Kenneth P. Brevoort & Michelle Kambara, *Are All Collections Equal? The Case of Medical Debt*, 11:4 J. Credit Risk, at 73-97 (Dec. 2015).

large increase in predictive fit from the addition of most consumer report characteristics: if the model does not perform well at baseline, there is ample margin for predictive fit to improve. This does not imply that medical collections would increase predictive fit by 34 percent, or at all, in models used for credit scoring or credit eligibility determinations.

Broadly, the CFPB agrees that Brevoort and Kambara (2014) would be more relevant to the rule if it were updated with more recent data or included some additional analyses as suggested by commenters. Since the impact of the rule derives from the prohibition on reporting of medical collections, the CFPB conducted new research, described in the Technical Appendix to the NPRM and included below in part XII, that isolated the effect of reporting from other effects that the presence of medical collections may have on consumers' financial outcomes. Based on this research, the CFPB expects that medical collections can be removed from underwriting models without significantly reducing their ability to predict serious delinquency if underwriting models continue to include other variables that are sufficiently predictive of delinquency risk. The Technical Appendix shows that medical collections reporting likely reduces access to credit and creditor revenue.

D. Coverage of the Rule

Part VIII.B.4 provides a discussion of the estimated number and types of entities potentially affected by the rule.

E. Potential Benefits and Costs to Consumers and Covered Persons

The CFPB assessed the potential benefits and costs of the rule using the data and evidence described above, as well as comments submitted in response to the proposal. Based on the information available, the CFPB concludes that the rule is likely to confer a number of benefits, and limited costs, on consumers and covered persons. In brief, the CFPB expects that consumers will experience increased access to credit and a reduction in the use of consumer

reporting to induce payment of medical collections, including those that may be inaccurate. The CFPB expects that the marginal loans provided under the rule would be similarly profitable to those that creditors provide at baseline, leading to increased revenue for creditors. The CFPB does not expect that consumers would be significantly less likely to pay their bills under the rule, and as a result, expects limited impacts on the revenues of health care providers and debt collectors. All potential benefits and costs are described in more detail below.

1. Consumer willingness to pay medical bills

Consumers facing debt collection attempts may pay or settle debts to remove the tradelines from their consumer reports, as medical collections are removed from the NCRAs' consumer reports when paid.[254] Previous research from the CFPB found evidence indicating that some consumers may act to remove medical collections from their consumer reports when they plan to apply for a mortgage.[255] This suggests that furnishing can be an effective tool for inducing payment of debts. To the extent this is true, the rule could reduce consumers' willingness to pay those medical debts that would or might be sent to collections and ultimately be furnished at baseline.

Several health care providers, debt collectors, consumers, health care trade associations, the SBA Office of Advocacy, and at least one researcher and one credit union, stated that, with fewer repercussions for medical debt, consumers would not pay their medical debts under the proposed rule. Several debt collectors, at least one healthcare provider and one debt collection trade association stated that, because consumer willingness to pay medical bills would be lower

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[254] Bus. Wire, *Equifax, Experian, and TransUnion Support U.S. Consumers with Changes to Medical Collection Debt Reporting* (Mar. 18, 2022), .

[255] Alyssa Brown & Eric Wilson, Consumer Fin. Prot. Bureau, *Consumer Credit and the Removal of Medical Collections from Credit Reports* (Apr. 2023), https://files.consumerfinance.gov/f/documents/cfpb_consumer-credit-removal-medical-collections-from-credit-reports_2023-04.pdf.

under the proposed rule, there would be decreased recoveries and revenue for debt collectors and health care providers as a result. Multiple debt collector commenters provided specific estimates for expected reductions in recovery rates and revenues. At least one debt collector commenter and at least one health care provider stated that they expect a revenue decline close to 9 percent because of decreased recovery. A debt collector commenter in the SBREFA process stated that there would be a significant decrease in the number of individuals with overdue medical debt who take proactive steps to resolve their accounts as a result of the proposed rule. In contrast, a consumer advocate commenter stated that consumers would be more likely to pay, even partially, if the proposed rule reduced coercive collection tactics. Another consumer advocate commenter stated that consumers would still pay their medical debts and there would be limited revenue impacts to health care providers, because health care providers and debt collectors have other strategies for inducing payment besides furnishing medical debt information to consumer reporting agencies.

The CFPB acknowledges that if consumers are no longer concerned that medical collections will appear on their consumer report when they are seeking credit, they may have less incentive to pay their medical collections. However, the CFPB expects that only a few consumers would pay their medical collections in response to consumer reporting or the threat of consumer reporting under the baseline, but would not pay their medical collections in response to alternative collection mechanisms under the rule. This is because at the baseline most consumers with medical debt face little consequence from furnishing of a medical collections tradeline, for several reasons. For one, consumers would need to have medical collections over $500, as medical collections tradelines below $500 are suppressed at baseline. Also, consumers who have medical collections generally have fairly low credit scores, which already constrain their access

to credit. [256] As such, further reducing scores through the furnishing of medical collections may not have a meaningful impact on access to credit. The CFPB cannot precisely estimate the number of consumers who would be disincentivized to pay medical collections due to the rule, but at baseline fewer than 5 percent of consumers have medical collections, and as a result the share of consumers who would be disincentivized to pay is quite small, since it must necessarily be less than 5 percent.[257]

Multiple debt collectors, at least one health care provider, a credit union trade association, and an individual consumer commented that the proposed rule would encourage consumers to ignore eligibility for enrollment in support programs that help patients pay medical bills, including patient financing programs and other forms of financial assistance, because there would no longer be consequences for unpaid medical bills. The CFPB does not expect that consumers will respond to the rule by ignoring financial assistance. Consumers will remain liable for their medical debts, and it is implausible that removing the prospect of future consumer reporting will lead to many consumers forgoing support that would help them pay these debts.

The rule is unlikely to substantially impact aggregate revenue for health care providers, as most health care revenue does not consist of consumers paying their bills after receiving treatment. The vast majority of health care providers' revenues comes from insurance (*e.g.*, Medicare, Medicaid, private insurance) and other third-party payers. Indeed, out-of-pocket

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[256] The average credit score for consumers with medical collections in June 2023 was 582. *See* Ryan Sandler & Zachary Blizard, Consumer Fin. Prot. Bureau, *Recent Changes in Medical Collections on Consumer Credit Records Data Point* (Mar. 2024), https://files.consumerfinance.gov/f/documents/cfpb_recent-changes-medical-collections-on-consumer-credit-reports_2024-03.pdf.

[257] Ryan Sandler & Zachary Blizard, Consumer Fin. Prot. Bureau, *Recent Changes in Medical Collections on Consumer Credit Records Data Point*, at 3-4 (Mar. 2024), https://files.consumerfinance.gov/f/documents/cfpb_recent-changes-medical-collections-on-consumer-credit-reports_2024-03.pdf.

spending by consumers at baseline only accounts for about 12 percent of personal health care expenditures.[258] This means that there is less margin for consumers that do not pay their bills to have a significant impact on personal health care expenditures.

Indeed, as at least one debt collector commenter stated, recovery rates for medical collections are already low on accounts with outstanding balances. In the proposal, the CFPB estimated that approximately 2.5 percent of medical collection accounts are recovered by debt collectors who furnish medical collections information to the NCRAs, based on the share of medical collections tradelines marked as paid on consumer reports before these tradelines were removed by the NCRAs in 2022.[259] The CFPB requested comment or data submissions that could better approximate the share of medical debts placed with debt collectors that are ultimately recovered. Two commenters stated that historical recovery rates on bad medical debts were between 18.2 and 24.8 percent but did not cite a source for this statistic.[260] Multiple health

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[258] The CFPB calculated this estimate by dividing the aggregate amount of out-of-pocket spending in 2020 by the aggregate amount of personal health care expenditures in 2020. Personal health care expenditures represent health expenses directly related to patient care, such as hospital care, physicians' and dentists' services, prescription drugs, eyeglasses, and nursing home care, and accounts for the largest shares of total national health expenditures. *See* Ctrs. for Medicare & Medicaid Servs., *Health Expenditures by state of provider: summary tables (ZIP),* https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet (last modified Sept. 10, 2024); Ctrs. for Medicare & Medicaid Servs., *National Health Expenditures 2022 Highlights* (Dec. 13, 2023), https://www.cms.gov/newsroom/fact-sheets/national-health-expenditures-2022-highlights; Nat'l Ctr. for Health Stat., U.S. Ctrs. for Disease Control & Prevention, *Health Care Expenditures*, https://www.cdc.gov/nchs/hus/topics/health-care-expenditures.htm (last reviewed Aug. 2024).

[259] Approximately 2.5 percent of medical collections were marked as paid in the five years before paid medical collections were removed from consumer reports in June 2022. Consumer Fin. Prot. Bureau, *Paid and Low-Balance Medical Collections on Consumer Credit Reports* (July 27, 2022), https://www.consumerfinance.gov/data-research/research-reports/paid-and-low-balance-medical-collections-on-consumer-credit-reports/.

[260] This range appears to come from a model form letter provided to debt collectors and healthcare providers by a consumer reporting industry trade group, but that form letter also does not cite a source for the statistic. *See* Meduit, *CFPB Proposed Regulation Comment Samples* (Aug. 2024), https://www.cdiaonline.org/wp-content/uploads/2024/08/Meduit.pdf. However, this is consistent with other industry sources on bad debt recovery rates for medical debt. *See, e.g.*, MD Clarity, *RCM Metrics Bad Debt Recovery Rate*, https://www.mdclarity.com/rcm-metrics/bad-debt-recovery-rate (last visited May 22, 2024). According to a Healthcare Financial Management Association (HFMA) report, the industry expectation is health care providers will

care provider commenters stated that they expected bad debt liquidation to fall by 10.9 percent under the proposed rule. The commenters stated that this estimation was based on updated research from 2024 but did not provide a citation or supporting evidence.

The CFPB notes that the relevant quantity for this analysis is not the recovery rate on medical debts overall, which includes debts that are paid after patient outreach by the medical provider and other collection methods that will still be available under the rule. Instead, the relevant quantity is the recovery rate for medical debts that are placed with a debt collector and furnished to a consumer reporting agency. While the CFPB does not have a precise estimate of this quantity, clearly this will be less than the recovery rate for bad debts overall, as some debts are furnished only after other collection methods have failed. However, the CFPB acknowledges that the 2.5 percent figure from the cited 2022 research report seems low. From its market monitoring activities, the CFPB is aware that debt collectors have often engaged in a "pay for delete" practice, under which they offer to consumers to remove a debt collections tradeline in exchange for making payment. To the extent this occurred prior to the implementation of the voluntary NCRA removal of paid medical collections from consumer reports in 2022, there was a possibility that medical collections tradelines that were in fact paid would never be marked paid on consumers' credit reports, leading to an undercount of medical collections tradelines that were ever paid. Using evidence provided in comments, the CFPB believes that 25 percent is a conservative estimate of the baseline recovery rate for medical debts overall, while the baseline recovery rate for medical debts that are furnished to a consumer reporting agency is less than 25 percent.

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recover only 30 percent of amounts billed after discharge. Healthcare Fin. Mgmt. Ass'n, *Address Patient Financial Risk in Pre-Service to Boost Revenue and Earn Loyalty* (July 12, 2018), https://www.hfma.org/revenue-cycle/financial-counseling/61208/.

Because recovery rates are low at baseline, even if all consumers with medical debt would not pay their medical debt in collections under the rule, health care providers' overall costs would not be greatly increased. The CFPB's analysis of hospital-level cost reports from the Healthcare Provider Cost Reporting Information System (HCRIS) provided by the Centers for Medicare and Medicaid Services (CMS) indicates that 72 percent of hospitals had non-Medicare bad debt expenses in 2021.[261] The CFPB's analysis showed that these bad debt expenses on average represent about 6 percent of total costs in 2021 for hospitals that had non-Medicare bad debt. Assuming that health care providers achieve a 25 percent recovery rate and bad debt expenses account for 6 percent of total costs at baseline, the CFPB estimates that bad debt expenses would rise to at most 8 percent of total costs on average. However, this is almost certainly an overestimate for the increase in bad debt costs to health care providers. Bad debt recovery rates almost certainly will not decrease to zero, since health care providers will continue to use other collection practices, such as patient outreach, phone calls and other communications by debt collectors, and debt collection litigation.

A debt collector trade association submitted the results from a poll of 165 health care providers who attended a webinar. The results showed that 8 percent of the polled health care providers estimated a less than 6 percent reduction in their revenue as a result of the proposed rule, 23 percent estimated a 6 to 10 percent reduction, 36 percent of respondents expected a 10 to

[261] 2021 is the latest year for which the cost report data are available. Hospitals classify medical bills as bad debt expenses when they determine that consumers are unlikely to repay. Non-Medicare bad debt consists of past-due medical bills from patients who are not Medicare beneficiaries. *See* Am. Hosp. Ass'n, *Uncompensated Hospital Care Cost Fact Sheet* (Feb. 2022), https://www.aha.org/fact-sheets/2020-01-06-fact-sheet-uncompensated-hospital-care-cost and Ctrs. for Medicare & Medicaid Servs., *Hospital Provider Cost Report Data Dictionary* (Dec. 13, 2023), https://data.cms.gov/resources/hospital-provider-cost-report-data-dictionary.

15 percent decrease in revenue, 17 percent of respondents expected a 15 to 20 percent decrease, and 16 percent of the respondents expected a loss in revenue greater than 20 percent.

One health care provider stated that, if patients do not pay, it would experience an annual impact of $10 million on its business and predicted that it would close within 6 months as its margins are extremely tight. At least one health care provider stated that reimbursement is already low because reimbursements from Medicare and commercial payers that follow the Medicare fee schedule have dropped 44 percent over the past 10 years. One debt collector trade association commenter stated that the CFPB has not studied what the impact of the rule will be on Medicare co-pays and deductibles if consumers stop paying their medical bills.

The CFPB notes that the above comments regarding health care provider revenue and bill payment rates implicitly assume that consumers will stop paying medical bills or will no longer be required to pay these bills. As discussed above, this is not a reasonable assumption. Consistent with existing practice, many consumers will be charged at point of sale or have to pay an outstanding bill to continue to be a patient at a non-emergency health care provider. Consumers will continue to be legally responsible for their medical bills, and all other methods of collection that are available at baseline will remain available under the rule. Indeed, most consumers with medical debt do not have medical collections tradelines on their consumer reports as discussed above, and, even though medical debts do not appear on their consumer reports, those consumers are still responsible for their debts and often pay those debts if they have the financial means to do so. And the CFPB has no evidence to conclude that patients are regularly engaging in strategic non-payment of medical bills—as opposed to non-payment due to financial distress or error. The CFPB calculated potential reductions in recoverable medical debt in this final rule based on the total amount of medical collections on consumer reports not because this is a likely

or plausible outcome, but rather because this calculation places an upper bound on the potential costs to health care providers stemming from the rule.

The CFPB acknowledges that there has been no study of the impact of the rule on Medicare co-pays and deductibles specifically. However, if anything, the CFPB expects that consumers with Medicare coverage will be less impacted by the rule because they are less likely to have medical debt than other populations.[262]

Multiple health care provider and debt collector commenters stated that hospitals have low operating margins, such that a small reduction in payments could force hospitals to only provide profitable services, or to close their doors. The CFPB understands that some hospitals and other health care providers may have low operating margins (nearly half of hospitals are nonprofits)[263] and recognizes that significant revenue reductions can theoretically result in the closure of some health care providers. As indicated above, the CFPB does not share commenters' views on the magnitude of these revenue reductions, or that these revenue reductions would not be offset by other business adjustments.

Multiple debt collector, health care provider, and consumer commenters cited the Report's prediction of an estimated first year loss of $24 billion for health care providers that over time may range from $82 billion to $655 billion in losses. A consumer advocate commenter stated that this $24 billion estimate was inflated. At least one health care provider commenter

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[262] Roughly half as many adults aged 65 and older had medical or dental debt relative to adults aged 50 to 64, which may be due to the nearly universal Medicare coverage among adults aged 65 and older. Alex Cottrill et al., Kaiser Fam. Found., *What are the consequences of health care debt among older adults?* (July 26, 2024), https://www.kff.org/medicare/issue-brief/what-are-the-consequences-of-health-care-debt-among-older-adults/.

[263] W. Pete Welch et al., U.S. Dep't of Health & Hum. Servs., *Ownership of Hospitals: An Analysis of Newly-Released Federal Data & A Method for Assessing Common Owners* (Aug. 2023), https://aspe.hhs.gov/sites/default/files/documents/582de65f285646af741e14f82b6df1f6/hospital-ownership-data-brief.pdf.

cited the Report's finding that medical debt collection rates would fall by more than 8 percent under the proposed rule. The CFPB found serious flaws in the Report's research methodology, detailed in part VII.C, *Data and Evidence*, and expects the costs of the rule would be substantially lower. Using the evidence provided in the Report, the CFPB estimated a $900 million reduction in recoverable medical debt over 10 years under the rule, which would only partially be borne by health care providers because the loss would be shared with debt collectors and debt buyers.

Although recent changes in the reporting of medical collections due to actions by the NCRAs and State laws are part of the baseline, these changes provide a benchmark to gauge the plausible effects of the rule. Some commenters provided information suggesting that the actions by the NCRAs to remove medical collections tradelines that are paid, less than one year past due, or less than $500 resulted in substantial reductions in debt collector recoveries.

Commenters, including at least one health care provider and one debt collector, stated that most medical debts are ineligible to be furnished to the three NCRAs because their average balance is under $500. One debt collector commenter reported that the average balance of medical accounts referred to them for collection services by health care providers between 2021 and 2023 was $414. To the extent that debt collectors are referred debts under $500 and rely on debt collection practices other than consumer reporting for those medical debts at baseline, the CFPB understands that the impact of the rule will be lower. Debt collectors that have updated their strategies for collecting medical debts under $500 may have lower costs by applying those strategies to medical debts over $500 under the rule.

Multiple debt collector and health care provider commenters provided quantitative estimates for recent changes in recoverable medical debt experienced, which may have been impacted by the voluntary NCRA reporting changes.

One debt collector commenter stated that their recovery rate had dropped from 17.1 percent in 2022 to 12.7 percent by 2024.

A health care provider commenter stated that their recoverable amounts had fallen by 7 percent since medical collections under $500 were removed from consumer reports, while a debt collector commenter stated they had experienced a 25 percent decline in recoverable amounts in the same time frame.

One debt collector commenter stated that their business experienced a 7.37 percent decline in revenue in 2023 compared to 2022. The commenter experienced an additional 12 percent decline in revenue in the first two quarters of 2024. The commenter attributed this decline to the NCRA reporting changes.

The SBA Office of Advocacy commented that one small debt collector entity reported a $369,637 decline in dollars collected since the changes by the NCRAs in 2022 and 2023.

One debt collector commenter stated that, when the consumer reporting agencies banned the reporting of medical debts under $500, they observed a 13 to 22 percent decrease in the recovery of past due medical debts below $500.

At least one debt collector commented that decreases in recovery rates in States, such as New York and Colorado, which banned all consumer reporting of medical debt around the same time as the changes by the NCRAs, were comparable to changes in States which only experienced the NCRA changes. This suggests that the rule will not reduce recovery rates above and beyond the reductions that have already occurred under the baseline.

These comments did not state that reductions in recoverable amounts were specific to medical debts that were directly impacted by the NCRA reporting changes, and the trends described by commenters may reflect more general changes in medical debt collection that are unrelated to consumer reporting.

As discussed above, the rule may impose reductions in revenue for medical debt holders if the removal of medical collections from some consumer reports leads to lower recoverable medical debt amounts. This cost may be passed through to health care providers that sell medical debt to debt buyers, instead of placing the debts with a third-party debt collector to collect on the provider's behalf. These debt buyers often also engage in debt collection and furnish medical collections information to consumer reporting agencies. Debt buyers purchase these bundles of medical debt from health care providers at a price that is a fraction of the nominal value of the medical bills.[264] Because the rule may reduce the effectiveness of furnishing medical collections as a collection practice, the CFPB expects debt buyers' demand for medical debt bundles sold by health care providers to potentially decrease. If so, the resulting decrease in the price of medical debt bundles would reduce the revenues of health care providers who sell past-due bills. However, the revenues of health care providers that at baseline do not allow debt buyers to furnish medical collections information on debts they sell would not be affected in this way.

The CFPB requested data from health care providers to help quantify their potential reduction in revenues from the sale of medical debt bundles to debt buyers. One debt collector commenter stated that the rule would reduce the incentive for patients to resolve their debt, which would, in turn, negatively affect health care providers that rely on the ability to collect or

[264] Fed. Trade Comm'n, *The Structure and Practices of the Debt Buying Industry*, at 22-23 (Jan. 2013), https://www.ftc.gov/reports/structure-practices-debt-buying-industry.

sell their patient receivables, but no comments provided quantitative information on this point. The CFPB does not have data with which to quantify the magnitude of this expected decrease in the price of medical debt bundles on the secondary market, nor does it have information on the current prevalence of health care providers allowing debt buyers to furnish medical collections information to consumer reporting agencies.

2. Changes in insurance

To the extent that health care provider revenue is impacted by the rule, contracts between health care providers and health insurers, as well as between consumers and health insurers, may be renegotiated to mitigate potential reductions in revenue and reflect changes in the incentives faced by these entities. In theory, consumers may be less likely to demand health insurance if they perceive medical debt to be less costly. In practice, the CFPB does not expect that the rule will significantly impact the demand for or health insurance because pharmaceutical drugs generally require point-of-sale payment, the majority of other direct-to-consumer health care costs are charged point-of-sale before obtaining service, and the other consequences of non-payment remain.

Several debt collectors and individuals commented that health care providers may minimize the risk of patient nonpayment under the proposal by renegotiating contracts with insurers so that they receive a higher portion, or the entirety, of the cost of patient care directly from the insurer. Commenters including debt collectors, an individual, an attorney group representing health care providers, and a debt collector trade association, stated that increased costs for insurers under the proposal would be passed on to consumers through higher premiums, copays, and deductibles. Conversely, at least one health care provider stated that the proposal would induce insurers to pay a smaller portion of the cost of patient care to health care providers, because the cost to consumers of higher patient responsibilities would be lower.

The CFPB understands that hospitals contract with many payors and contract provisions vary significantly across and within hospitals, with most contracts containing multiple contracting methodologies.[265] For example, according to the American Medical Association, physicians face a large set of options when negotiating the terms and conditions of payments, and use several reimbursement methodologies and structures.[266] Negotiation is costly for both health care providers and insurers, given the number and complexity of contracts. Additionally, as discussed above, the CFPB has determined that reductions in medical debt recovery rates and recoverable amounts would be limited under the rule. Accordingly, the CFPB expects that most health care providers and insurers will not choose to renegotiate their contracts under the rule, because the fundamental negotiating incentives (for providers to receive higher reimbursement and insurers to pay lower reimbursement), and relative negotiating power, would not change. Therefore, the extent to which costs will be passed through to consumers through higher premiums, copays, or deductibles will be limited.

Commenters including a debt collector and a health care provider stated that the proposal would prevent health care providers from receiving insurance information from consumers, including coordination of benefits and accident claim forms, because the cost of communicating this information would outweigh the benefit of having insurers pay for medical bills.

Under the rule, consumers will remain liable for medical debt, and the cost of coordinating benefits, for most consumers, would be lower than the cost of the potential debt.

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[265] Morgan A. Henderson & Morgane C. Mouslim, *Facts About Hospital-Insurer Contracting*, 30:2 Am. J. Managed Care (Feb. 12, 2024), https://www.ajmc.com/view/facts-about-hospital-insurer-contracting.

[266] Am. Med. Ass'n, *Payor Contracting 101* (2021), https://www.ama-assn.org/system/files/payor-contracting-toolkit.pdf.

The CFPB expects health care providers to continue to receive insurance information from consumers.

Commenters including debt collectors, health care providers, individuals, and a debt collector trade association stated that, under the proposed rule, consumers may be more likely to be uninsured or under-insured because there would be no incentive for patients to purchase insurance if they expect not to have to pay their medical bills. One debt collector trade association cited a webinar poll of 165 health care providers reporting that 74.9 percent of respondents thought that "[t]here is a moderate or high chance th[e] proposed rule would impact a patient's view of the need for insurance." Some health care providers who submitted comments to the SBREFA Outline stated that the removal of medical debt from consumer reports would "eliminate" a consumer's incentive to pay for a health insurance plan, especially for consumers that are young and in good health. The providers stated that, as a result, the cost of health insurance will increase for those that do want or need to be insured. Several commenters including debt collectors, health care providers, an individual, and a debt collector trade association stated that the proposal would lead to adverse selection in health care insurance markets, and that health care insurance markets would enter a "death spiral." In contrast, at least one consumer advocate commenter highlighted that it is irrational for consumers to choose to get sued over a larger debt received without health insurance and that other debt collection methods would prevent reductions in the insurance rate.

The CFPB understands that the predominant factor in whether a consumer is likely to have health insurance is whether they have access to affordable health care coverage, as opposed to other factors. Uninsured consumers cite "coverage not affordable" and "not eligible for

coverage" as the most common reasons for lacking health insurance.[267] Furthermore, even absent consideration of the other debt enforcement mechanisms, consumers benefit from health insurance coverage when paying for pharmaceutical drugs or non-emergency health care services, where point-of-sale payment requirements are common. The rule will have no impact on the real or perceived value of health insurance for those health care costs. The CFPB expects that the rule would be unlikely to affect either access to health insurance or its affordability and has therefore determined that changes to the insured population will be minimal under the rule. Additionally, because there would be minimal changes to the insured population, the CFPB does not expect adverse selection or changes in premiums as a result of the rule.

3. Operational changes

In theory, to the extent that health care providers face reductions in revenue due to the rule, they may implement operational changes to mitigate such potential reductions in revenue. Potential changes include altering how and when consumers pay for health care, refusing nonemergency care for consumers with outstanding balances, reducing the amount or type of services, or ceasing to provide services altogether. However, the CFPB does not expect the rule will generally impact health care provider revenue to an extent that would justify these operational changes, given the costs associated with implementing such changes.

Multiple commenters including individuals, debt collectors, health care providers, researchers, health care trade associations, and debt collector trade associations stated that health care providers may be more likely to require upfront payments or other alternative payment schemes like membership-based or concierge-based services. One debt collector trade

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[267] Jennifer Tolbert et al., Kaiser Fam. Found., *Key Facts about the Uninsured Population* (Dec. 18, 2023), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.

association commenter provided results from a webinar poll of 165 health care providers, indicating that 72 percent of respondents would require full or partial upfront payments for non-emergencies if consumer reporting of medical debts was eliminated. Several commenters, including health care providers, debt collectors, and individuals, stated that even insured consumers would need to pay for health care upfront and out of pocket. The commenters stated that the onus of working with insurers to receive health care payments would be shifted from health care providers to consumers.

Available evidence shows that most health care providers currently have policies and procedures for pre-service or point-of-service payment of most medical bills.[268] Consequently, there would not be much margin for health care providers to begin requiring upfront payments under the final rule. Multiple health care providers, debt collectors, consumer advocates, individuals, and health care trade association commenters rejected this argument and stated that the presence of these policies does not mean that patients always pay before receiving health care. While it may be true that health care providers do not always require payment before providing health care, it is also true that many health care providers do require upfront payment or require recurring patients to eventually pay upfront before continuing to see the health care provider. And upfront payment for drugs is the universal market norm. In addition, the CFPB understands that health care providers lose revenue when they do not receive payment for services, but they also forego revenue if they do not provide health care to consumers who cannot pay upfront but who would have paid their medical bills after the service was provided, or

[268] According to an HFMA survey, 96 percent of health care industry respondents reported having pre-payment or point-of-service collection policies and procedures. Healthcare Fin. Mgmt. Ass'n, *Analyzing pre-payment and point-of-service collections efforts* (Aug. 15, 2021), https://www.hfma.org/technology/analyzing-pre-payment-and-point-of-service-collections-efforts/.

whose insurance would have paid for the majority of the overall bill. It is unlikely that a small decrease in the recovery rates of furnished medical collections under the rule would cause health care providers to substantially change their operational and billing procedures in light of already existing incentives that determine payment policies.

Health care providers, researchers, debt collectors, and debt collector trade associations commented that some consumers may increase their use of third-party credit products to meet increased upfront payment requirements. Some commenters described these third-party credit products as high-interest or predatory. Commenters including debt collectors, a health care provider, a credit union trade association, and an individual consumer stated that, as a result of the proposed rule, there would be reduced options for debt repayment because consumers that use third-party credit products to pay for medical care would not be offered low- or no-interest payment plans by their health care providers.

The CFPB understands that many consumers, at baseline, use third-party credit products to pay their medical bills.[269] The CFPB expects that most consumers that rely on third-party credit products to pay for health care would do so regardless of whether payments were required upfront. Affected consumers may incur third-party credit debt instead of medical debt, which may be more costly if they are charged interest on the third-party credit debt and would have been charged less (or no) interest if the debt was owed to a health care provider or debt collector.

The CFPB expects that the rule would have a small or negligible impact on consumers' ability to access emergency medical care, as all hospital emergency rooms that receive Medicare funds are required to provide emergency medical care, irrespective of an individual's ability to

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[269] Consumer Fin. Prot. Bureau, *Medical Credit Cards and Financing Plans* (May 2023), https://files.consumerfinance.gov/f/documents/cfpb_medical-credit-cards-and-financing-plans_2023-05.pdf.

pay.[270] As an attorney group representing health care providers commented, emergency medical treatment for insured patients typically leads to copayments of less than $500, and uninsured patients typically qualify for charity care and have bills below $500 as well. Because medical collections under $500 are not included on consumer reports at baseline, the rule is unlikely to directly impact emergency health care. Additionally, because emergency services represent a significant share of health care spending, a significant portion of health care revenue would not be impacted by the rule.[271]

The CFPB received feedback from several health care providers during the SBREFA process stating that the proposed rule would lead them to deny non-emergency care to patients who cannot pay upfront or have not paid their previous balances in full. At least one health care provider commented that the proposed rule may cause health care providers to delay providing health care until they can verify that patients can afford to pay. Health care providers commented that, as a result of the proposed rule, consumers that are denied health care because they cannot meet payment requirements will use hospital emergency room services for non-emergency health care, which will lead to longer wait times and overburdened emergency rooms.

There could be a marginal increase in the number of health care providers who will not provide health care until the patient pays or who will stop providing services to the patient after a period of nonpayment, though, as discussed above, the forgone revenue from denying health care to patients whose insurance will pay the majority of the bill or who would have paid at a later

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[270] Ctrs. for Medicare & Medicaid Servs., *Emergency Room Rights*, https://www.cms.gov/priorities/your-patient-rights/emergency-room-rights (noting Emergency Medical Treatment and Active Labor Act, 42 U.S.C. 1395dd, protections) (last visited May 9, 2024).

[271] *See, e.g.*, Scott KW et al., *Healthcare spending in US emergency departments by health condition, 2006-2016*, PLoS One (Oct. 2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8550368/.

date is likely the reason some health care providers have not already shifted to this model. Those incentives would remain. In the case where a health care provider stops providing health care until a patient pays, some patients may use hospital emergency rooms and others may choose to forego care. The CFPB does not expect that a significant number of patients will seek these services at emergency rooms.

Debt collectors, health care providers, financial institutions, and research institutes commented that patients may delay seeking health care if they are unable to meet updated provider standards for pre-care payments. A debt collector further commented that if fewer people seek preventive care, more people will end up with long-term medical conditions. In contrast, a consumer advocacy organization and a State attorney general commented that the rule will allow patients to seek care without fearing harm to their consumer reports.

On balance, the CFPB expects most patients will seek the health care they need regardless of their financial situation.

Individuals, debt collectors, debt collection trade associations, health care providers, researchers, and health care trade associations stated that the proposed rule may cause health care providers to cut health care services, which would reduce health care access. At least one debt collector commented that even a 2 to 3 percent reduction in payments could cause health care providers to stop providing unprofitable services. At least one debt collector stated that the quality of health care may decline under the rule. Several commenters including individuals, health care providers, and debt collectors stated that health care providers may reduce their workforce to cut costs.

It does not seem plausible in practice that health care providers will reduce the extent or quality of services they provide in response to the rule. Reductions in the type of health care

provided, health care quality, or staffing levels would also reduce health care provider revenue, since fewer patients could be served, or patient demand for medical services may be reduced as a result of lower patient satisfaction. The CFPB expects that any reductions in health care provider revenue occurring under the rule would not justify limiting the types of provided health care services or providing lower quality of service.

Several commenters including researchers, individuals, health care providers, debt collectors, health care trade associations, debt collection trade associations, and financial institutions stated that health care providers may raise prices under the proposed rule. At least one debt collector trade association commented that 15 percent of health care respondents to a webinar poll stated that they would start or increase the use of legal strategies for collecting payments, with the increased costs being passed through to consumers through higher prices for health care services.

The CFPB does not expect that reductions in health care provider revenue or changes in collection strategies by health care providers under the rule would be significant enough to justify raising prices. As described in part VII.E.1, the CFPB expects that the reduction in health care provider revenue under the rule would be equal to no more than 2 percent of their total costs. Raising prices would require renegotiating contracts with insurers, as described in part VII.E.2, and the CFPB does not expect that limited reductions in revenue would justify the cost of these renegotiations. However, if some health care providers raise prices under the rule, higher prices would only partially be passed through to insured consumers, with the other portion passed on to health insurers. Higher prices would only partially be passed through to uninsured consumers as well, to the extent that these consumers receive financial assistance. For a more in depth discussion of changes in collection strategies, see part VII.E.4.

Multiple debt collectors, health care providers, debt collection trade associations, and financial institutions commented that health care providers may close as a result of the rule. One health care provider stated that if consumers stopped paying their bills as a result of the rule, it would reduce their revenues by $10 million and they would close within six months. Several commenters stated that increased health care provider closures, especially in rural areas, will require patients to drive further to access health care. At least one debt collector stated that small health care providers, if they do not close, may be acquired by larger companies leading to reduced market competition.

The CFPB agrees that, if patients stopped paying their medical bills, and health care providers could not compensate for reductions in revenue through renegotiating contracts with insurers, many health care providers may cease operating. However, as discussed above, the CFPB does not expect that patients will stop paying their medical bills under the rule.

A debt collector stated that the NCRA reporting changes have caused health care providers to reduce staffing, reduce the types of services they provide, require upfront payment for services, consider using litigation to recoup debts from consumers, or close their doors completely. The commenter also stated that insurance companies have raised premiums while lowering the benefits covered. The commenter cited media articles about hospital closures in California as evidence of these changes.

The evidence cited by the commenter does not support the commenter's stated view that the NCRA reporting changes led to operational changes. The articles cited by the commenter do not mention the NCRA reporting changes or the importance of consumer reporting for debt collection. Instead, the articles describe low reimbursement rates for Medi-Cal patients, and high shares of some hospitals' population base that receive care through Medi-Cal, among other

concerns with rising costs of health care.[272] The CFPB expects that these factors, and not the NCRA reporting changes, were more likely the drivers of the impacts the commenter describes. As such, the CFPB finds that it is not likely that the final rule will lead to operational changes by health care providers, as the comments suggest. Regardless, California has already passed a bill prohibiting medical debt consumer reporting, so any impact on these health care providers will already be experienced absent this final rule.

Several debt collectors commented that debt collectors may change their staffing and payroll in response to the rule. One debt collector stated that in the last 12 months it had to double its number of staff to handle the increase in litigation. The SBA Office of Advocacy described a small entity that reported a 16 percent increase in payroll costs for the first quarter of the year after the NCRA reporting changes in 2023. In contrast, multiple commenters including debt collectors, individuals, and financial institutions stated that debt collection employees will be paid less or there will be staff reductions.

The CFPB acknowledges that debt collectors may need to increase or decrease staffing under the rule but does not have information sufficient to quantify this impact.

4. Use of other collection mechanisms

The potential for reductions in revenue due to the rule, as discussed above, may affect how health care providers or debt collectors use other collection mechanisms to collect unpaid

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[272] Madeline Ashley, *Los Angeles hospital on 'brink of closure'*, Becker's Healthcare Rev. (June 10, 2024), https://www.beckershospitalreview.com/finance/los-angeles-hospital-on-brink-of-closure.html. Ana B. Ibarra, *Hospital Closures, cuts in services loom for some communities. How the state may step in to help*, Cal Matters (Apr. 6, 2023), https://calmatters.org/health/2023/04/hospital-closures-california/. Ron Southwick, *One in five California hospitals at risk of closing: Report*, Chief Healthcare Executive (Apr. 13, 2023), https://www.chiefhealthcareexecutive.com/view/one-in-five-california-hospitals-face-risk-of-closing-report. Scott Wilson, *A hospital's abrupt closure means, for many, help is distant*, The Wash. Post (Nov. 16, 2023), https://www.washingtonpost.com/nation/2023/11/16/california-health-care-hospital-closing/.

medical debt, such as contacting consumers via mail and phone calls, as well as debt collection litigation.[273] While these collection mechanisms are available at baseline, health care providers and debt collectors may increase their reliance on these mechanisms to induce payments for certain consumers after the rule is implemented.

Contacting consumers via mail and phone calls is usually part of a comprehensive debt collection strategy. However, these collection mechanisms are time-consuming and labor intensive relative to furnishing, and may be less effective for inducing payment. Litigation is more costly than furnishing medical debt information to consumer reporting agencies for consumers, health care providers, and debt collectors. Debt collectors who were small entity representatives in the SBREFA process reported that the average cost of furnishing is $10 per account, compared to $500 for litigation.[274] Because medical debt litigation can impose relatively large costs, the CFPB has considered if such litigation would become more common under the rule.

Typically, when a medical bill is overdue, health care providers and debt collectors first contact consumers by mail or phone calls to seek payment. A debt collector trade association stated that, at baseline, entities that follow industry best practices will attempt several patient communications over a timeframe of 360 days, in line with the NCRAs' practice of waiting for one year past the date of first delinquency to include medical collections on consumer reports, before furnishing an outstanding medical debt to consumer reporting agencies. A financial trade

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[273] *See, e.g.*, Consumer Fin. Prot. Bureau, *Fair Debt Collection Practices Act Annual Report 2012* (Mar. 13, 2012), https://www.consumerfinance.gov/data-research/research-reports/fair-debt-collection-practices-act/; Emily Alpert Reyes, *Hospitals that pursue patients for unpaid bills will have to tell L.A. County*, L.A. Times (Aug. 6, 2024), https://www.latimes.com/california/story/2024-08-06/hospitals-report-medical-debt; Judith Garber, Lown Inst., *Which hospitals are suing patients? Investigation reveals hospital billing practices* (Feb. 17, 2023), https://lowninstitute.org/which-hospitals-are-suing-patients-investigation-reveals-hospital-billing-practices/.

[274] SBREFA Report at 38.

association and a debt collectors trade association stated that consumers, especially those that are unresponsive to mail and phone calls, sometimes first learn of a medical collection from their consumer report, such as when they are applying for credit.

In deciding whether to incorporate debt collection litigation into their debt collection strategy, medical debt holders take into consideration the laws that apply in their jurisdiction. Several debt collector commenters noted that litigation is not allowed as a means of inducing payment of medical debt in some jurisdictions. For example, New Mexico prohibits debt collection lawsuits against consumers whose incomes fall below 200 percent of the Federal poverty line.[275] These laws limit increases in debt collection litigation that may occur due to the rule.

In addition to restrictions on the use of debt collection lawsuits, recent changes to industry practices and State laws governing the furnishing of medical debt information also limit further increases in litigation that may occur due to the rule. In particular, the CFPB does not expect the rule to impact litigation for medical debts under $500, because any increases in litigation for those debts would have already occurred due to the voluntary NCRA changes that removed medical debts under $500 from consumer reports in April 2023. A debt collector commenter stated that health care providers in California have increased their use of litigation following the $500 restriction. This may also imply that further increases in litigation may be limited for certain types of overdue medical bills, such as those stemming from emergency room visits. For example, an attorney group representing health care providers stated that emergency room visits typically result in medical bills under $500 after insurance or financial assistance is

[275] Jack Pitsor, *Medical Debt: How States are Supporting Consumers*, Nat'l Conf. of State Legislatures (Jan. 26, 2022), https://www.ncsl.org/state-legislatures-news/details/medical-debt-how-states-are-supporting-consumers.

taken into account. Because the rule will not impact medical debts below $500, and because, where available, debt collection litigation is already an option at baseline, the CFPB expects that increases in litigation due to the rule will only occur for consumers with medical debts greater than $500. In addition, the CFPB does not expect the rule to cause increases in debt collection lawsuits in States that have already implemented the removal of medical collections from consumer reports. Similarly with the voluntary NCRA changes, the removal of medical collections from consumer reports will have already increased litigation risks for consumers in these States independently of this rule.

The CFPB does not have data or information available to estimate the extent to which the rule may affect the use of litigation over medical debts, relative to the baseline. The CFPB requested comment on this issue, particularly data or quantitative estimates of the expected changes in litigation were the rule to go into effect. Commenters, including debt collectors, health care providers, debt collector trade associations, a bank trade association, a credit union trade association, individuals, a researcher, and the SBA Office of Advocacy, stated generally that consumers may face increased litigation if the rule makes furnishing a less effective means of inducing payment. In particular, according to a debt collector trade association, 38 percent of respondents to a webinar poll of 165 health care providers stated that they would start or increase the use of legal strategies for collection.

However, these commenters did not provide quantitative estimates or data that can be used to estimate the expected changes in litigation. Historically, repayment rates for medical debt in collections have been quite low. As discussed in part VII.E.1, the CFPB believes that the recovery rate at baseline is less than 25 percent for medical debts that are furnished to a consumer reporting agency, which are the medical debts for which litigation might be more

likely to be used under the rule. Moreover, litigation is a relatively expensive option for debt holders. As such, pursuing additional lawsuits because of the rule is not likely to result in a significant increase in marginal net recovery rates.[276] For these reasons, the CFPB expects that any increase in overall litigation frequency would be limited.

The CFPB expects that any increase in overall litigation frequency due to the rule would be limited to certain types of consumers who live in States that have not already removed medical collections from consumer reports. The CFPB understands that, while consumer reporting sometimes results in the payment of overdue debt, existing research suggests that debt collection litigation more often leads to a default judgment in favor of the plaintiff, making debt collection litigation a more effective, albeit more costly, means of inducing payment.[277] These default judgments can lead to asset seizures or wage garnishment.[278] Because litigation can be costly, debt collection lawsuits would be more likely to be filed against consumers who have the means to pay a civil judgment, whether by having their wages garnished or liens placed on their assets. Moreover, a debt collector commenter stated that adverse judgments from litigation, such as bank levies or wage garnishments, would have a greater detrimental effect on consumers than being denied a loan or paying a higher risk adjusted rate on a loan.

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[276] As discussed in the *Consumer willingness to pay medical bills* part, two commenters stated that historically recovery rates on bad medical debts were between 18.2 and 24.8 percent. CFPB research suggests that only around 2.5 percent of medical collection accounts furnished to the NCRAs are ever reported as paid. *See* Consumer Fin. Prot. Bureau, *Paid and Low-Balance Medical Collections on Consumer Credit Reports* (July 27, 2022), https://www.consumerfinance.gov/data-research/research-reports/paid-and-low-balance-medical-collections-on-consumer-credit-reports/.

[277] The Pew Charitable Trs., *How Debt Collectors Are Transforming the Business of State Courts* (May 6, 2020), https://www.pewtrusts.org/en/research-and-analysis/reports/2020/05/how-debt-collectors-are-transforming-the-business-of-state-courts. Medical debt collection lawsuits tend to be filed in small claims courts and to involve amounts of less than $10,000.

[278] *Id.*

The type of consumer that will most likely see an increase in litigation risk under the rule is a consumer who would have paid or settled a medical debt if a collection was added to their consumer report but would not respond to other debt collection mechanisms. In the baseline, medical collections are removed from the NCRAs' consumer reports when paid.[279] Generally, the CFPB understands that consumers seeking credit may be more likely to pay medical collections included on their consumer reports, assuming they have the means to do so, to ensure these collections are removed and unobservable to creditors and improve their credit scores. These consumers may be more sensitive to the threat of medical debts being furnished or the availability of medical debt information to creditors than they would be to the threat of litigation. However, the CFPB understands that, at baseline, furnishing may induce some consumers who have an immediate need for credit to pay debts they do not actually owe or debts based on incorrect bills, and the rule may reduce the likelihood that these consumers pay spurious debts.[280]

For the subset of consumers who legally owe the debt, the rule may lead to increased debt resolution costs if the consumers are required to pay for the plaintiff's court filing fees or legal fees, which may occur for the majority of cases that end in a default judgement against the consumer. At least one debt collector who was a small entity representative in the SBREFA process suggested that the proposed rule would also lead to increased costs for consumers, if debt collectors are currently more likely to settle medical debts for less than the dollar amount owed when consumers respond to medical debt collections added to their consumer reports, but may

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[279] Bus. Wire, *Equifax, Experian, and TransUnion Support U.S. Consumers with Changes to Medical Collection Debt Reporting* (Mar. 18, 2022), https://www.businesswire.com/news/home/20220318005244/en/Equifax-Experian-and-TransUnion-Support-U.S.-Consumers-With-Changes-to-Medical-Collection-Debt-Reporting.

[280] *See, e.g.*, Consumer Fin. Prot. Bureau, *Fair Debt Collection Practices Act: CFPB Annual Report 2023*, at 2-5 (Nov. 2023), https://files.consumerfinance.gov/f/documents/cfpb_fdcpa-annual-report_2023-11.pdf (describing consumer medical collection complaints received by the CFPB).

not be willing to settle or will settle only for relatively higher amounts during the course of litigation.[281]

Should certain health care providers decide to increase their use of debt collection lawsuits, they may do so either by working with debt collectors to file debt collection lawsuits on their behalf, or by bringing the lawsuits themselves. Health care providers may sell medical debt to debt buyers who also engage in debt collection, thereby transferring ownership for the debt.[282] In such cases, the decision of whether to pursue litigation is made by the debt buyer, and they become the main plaintiff in a debt collection lawsuit.

However, some health care providers only assign medical debt to debt collectors while retaining ownership of the medical debt, and ultimately decide themselves whether to pursue debt collection litigation. When debt collection litigation happens this way, the debt collectors may be listed as plaintiffs even though it may be the health care providers that pay the bulk of the litigation costs. For example, debt collectors working with UC Health, the largest hospital system in Colorado, were reported to have filed 15,710 lawsuits from 2019 through 2023.[283] In this case, the medical debts were "assigned" to debt collectors, but UC Health retained ownership of the medical debts and shared a portion of the recovered payments with the debt collectors.

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[281] Comment from Jennifer Whipple, Collection Bureau Servs., Inc., RE: Small Entity Representative Jennifer Whipple's Comment to CFPB regarding the Small Business Review Panel regarding the Fair Credit Reporting Act Proposal, SBREFA Report app. A.

[282] Fed. Trade Comm'n, *The Structure and Practices of the Debt Buying Industry* (Jan. 2013), https://www.ftc.gov/reports/structure-practices-debt-buying-industry.

[283] John Ingold & Chris Vanderveen, *Colorado's largest hospital system is quietly suing thousands of patients every year over unpaid bills*, The Denver Post (Feb. 21, 2024), https://www.denverpost.com/2024/02/21/uchealth-medical-debt-lawsuits-colorado/.

Health care providers that choose to file more debt collection lawsuits on their own behalf because of the rule may incur a mix of fixed costs and variable litigation costs.[284] Fixed costs of litigation may include the costs of retaining and maintaining relationships with legal providers, as well as hiring additional staff. Health care providers that already take legal action against their patients might not need to incur these fixed costs. Using a random 10 percent sample of hospitals in the United States, a recent investigation found that over two-thirds of hospitals already take legal action to collect unpaid medical bills, implying that many health care providers currently have some capacity to file debt collection lawsuits at baseline.[285]

Separate from fixed costs are variable costs that increase with the number and complexity of the debt collection lawsuits that hospitals choose to pursue. These are primarily court filing fees and attorney fees. Court filing fees vary depending on the jurisdiction and the collection amounts, making it difficult to estimate costs that hospitals may face.[286] Health care provider commenters stated that court filing fees can be as high as $270 while serving fees can be as high as $200. Attorneys can be paid on an hourly basis or on a contingency fee basis. However, if health care providers already employ in-house attorneys or retain attorneys using a flat fee, this may reduce the need to pay additional attorney fees to pursue debt collection litigation. In addition, some jurisdictions allow health care providers to add filing fees, attorney fees, and

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[284] *See, e.g.*, Joseph Giuseppe R. Paturzo et al., *Trends in Hospital Lawsuits Filed Against Patients for Unpaid Bills Following Published Research About This Activity,* JAMA Network Open (Aug. 23, 2021), https://jamanetwork.com/journals/jamanetworkopen/article-abstract/2783297.

[285] Noam M. Levey*, Hundreds of Hospitals Sue Patients or Threaten Their Credit, a KHN Investigation Finds. Does Yours?*, KFF Health News (Dec. 21, 2022), https://kffhealthnews.org/news/article/medical-debt-hospitals-sue-patients-threaten-credit-khn-investigation/.

[286] *See, e.g.*, the fee schedule for Small Claims Court in Maryland, https://www.mdcourts.gov/legalhelp/smallclaims, the corresponding fee schedule for regular civil cases, https://www.mdcourts.gov/courts/feeschedules, a comparison between small claims and regular civil cases in California, https://selfhelp.courts.ca.gov/small-claims-or-limited-civil (all last visited May 12, 2024).

other litigation costs to the judgment amount, partially shifting some of the cost of pursuing debt collection lawsuits to consumers if health care providers secure a favorable judgment.[287] Because health care providers already have the option to pursue debt collection lawsuits or have otherwise adapted their collection mechanisms in response to industry changes and State laws under the baseline, the total costs of increased debt collection litigation would depend on how many additional medical debt collection lawsuits arise because of the rule. The CFPB does not have data to estimate the additional number of debt collection lawsuits that health care providers may pursue after the rule is implemented.

The CFPB requested information from health care providers on the costs and amounts involved in current debt collection litigation, as well as estimates or information that can be used to estimate the number of debt collection lawsuits that might result from the rule. Commenters, including debt collectors, health care providers, a debt collector trade association, individuals, a researcher, and the SBA Office of Advocacy stated that health care providers will face increased costs associated with litigation, because they anticipate that the rule will cause them to file more debt collection lawsuits against consumers. However, these commenters did not provide quantitative estimates or data that can be used to estimate the expected changes in health care providers' litigation costs. As discussed above, the CFPB expects that any increase in overall litigation frequency and costs would be limited to States that have not removed medical collections from consumer reports, and to health care providers within those States whose consumers have medical debts greater than $500.

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[287] Casey Tolan & Ed Lavandera, *Arkansas hospital sued thousands of patients over medical bills during the pandemic, including hundreds of its own employees*, CNN (Sept. 8, 2023), https://www.cnn.com/2023/09/08/us/arkansas-hospital-debt-collections-lawsuits-pandemic/index.html.

Rather than collecting unpaid medical bills themselves, health care providers may choose to contract with debt collectors. Debt collectors may switch to other collection mechanisms if consumer reporting agencies stop including medical collections information on consumer reports provided for credit eligibility determinations. To the extent that debt collectors rely primarily on furnishing to induce payment at baseline, the rule may reduce their profits if the other collection practices are costlier or less effective than furnishing.

Debt collectors may have to incur both fixed and variable costs to increase their use of collection mechanisms other than medical collections furnishing if the rule is finalized, including debt collection lawsuits. Fixed costs of litigation include the costs of hiring and maintaining relationships with attorneys. Debt collectors that already pursue debt collection lawsuits may not need to incur these fixed costs. Variable costs include court filing fees, which vary depending on the jurisdiction and the collection amounts, making it difficult to estimate the increase in costs that debt collectors may incur. Variable costs also include attorney fees, which can be paid on an hourly basis or on a contingency fee basis. If debt collectors already employ attorneys in house or under a flat-fee arrangement, this may reduce the need to pay additional attorney fees should they increasingly pursue debt collection lawsuits. However, as discussed above, it is possible that some debt collectors have at least partially incurred the fixed and variable costs of switching to collection practices that do not involve furnishing of medical debt given the recent voluntary NCRA changes and State laws. The CFPB requested further information on the collection activities of debt collectors to quantify these costs of debt collection litigation but did not receive relevant comments or data.

Debt collectors may also respond to the rule by increasing their use of debt collection lawsuits. In choosing whether to pursue debt collection litigation, debt collectors likely compare

the cost of litigation with the expected recovery amount in the event of a favorable judgment. Under the baseline, debt collectors also likely compare the expected cost effectiveness of litigation against furnishing, although they can choose to furnish and pursue litigation for the same debt. The CFPB does not have data to directly compare the relative efficacy of furnishing and litigation for inducing payment. However, the CFPB expects that per-lawsuit litigation costs may be lower for larger debt collectors, or for larger health care providers if they sue patients directly, given the potential for economies of scale. Comments received from debt collector small entity representatives during the SBREFA process indicate that furnishing medical collections information to NCRAs costs approximately $10 per account, while debt collection litigation costs approximately $500 per account.[288] Due to the cost difference, debt collectors likely incur furnishing costs on a much larger percentage of accounts than they incur litigation costs, and so this may represent either a net saving or net cost for debt collectors, depending on the specific firm's furnishing practices and increase in litigation activity. The CFPB requested comment on this issue but did not receive relevant comments or data on this subject.

In the proposed rule, the CFPB requested data to quantify the impacts on debt collectors. Commenters, including debt collectors and a law firm representing health care providers stated that they would need to increase their use of debt collection lawsuits. A debt collector stated that over the last 12 months, which the CFPB understands to cover the period of time after the voluntary NCRA changes, it had increased the number of lawsuits it filed each month by over 400 percent and had to double the number of staff handling litigation. Because the medical debts removed from consumer reports due to the voluntary NCRA changes were under $500, the

[288] SBREFA Report at 38.

commenter claimed that the remaining medical debts on consumer reports that will be affected by the rule are larger. Recent CFPB research shows that the average balance of medical collections included on consumer reports is around $3,100.[289] To the extent that consumers with larger medical debts have income or assets that can be used to repay in the event of a debt collection lawsuit against them, the CFPB expects that debt collectors will be more likely to litigate over larger medical debts.[290] As discussed above, the CFPB does not have data or information available to quantify this increase, and commenters did not provide such information.

Relative to furnishing medical collections information, contacting consumers through traditional methods of debt collection that include mail, phone, or other means such as text messages may be more time-consuming and expensive. In a comment letter responding to the proposed rule, the SBA Office of Advocacy stated that one small entity reported a 16 percent increase in payroll costs for first quarter of the year after the NCRA voluntary change that removed medical debts under $500 from consumer reports. Some debt collector small entity representatives stated during the SBREFA process that they expected to have to increase staffing by 10 percent as a result of the proposed rule. Increased staffing would impose additional labor costs. These small entity representatives also expect to incur fixed costs associated with "rewriting policies and procedures, training employees, updating systems, and renegotiating contracts" with health care providers.[291] The CFPB does not have further data to assess the

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[289] Ryan Sandler & Zachary Blizard, Consumer Fin. Prot. Bureau, *Recent Changes in Medical Collections on Consumer Credit Records Data Point* (Mar. 2024), https://files.consumerfinance.gov/f/documents/cfpb_recent-changes-medical-collections-on-consumer-credit-reports_2024-03.pdf.

[290] *See, e.g.*, Keith Ericson & Tal Gross, *Limits on Medical Debt Lawsuits*, The Abell Found. (Feb. 9, 2021), https://abell.org/wp-content/uploads/2022/02/Final20Medical20Debt20Report.pdf.

[291] SBREFA Report at 38.

relative prevalence, costs, and effectiveness of the various collection mechanisms that debt collectors use at baseline.

5. Availability of information on consumer reports used in underwriting

Under the final rule, creditors generally would not be permitted to use consumer report information related to medical debt in their determinations of consumers' eligibility for credit by utilizing the financial information exception at § 1022.30(d). This section below discusses possible impacts, including impact on creditors' underwriting practices and revenues, consumers' access to credit, debt collectors' assessments of consumers' ability to pay medical debts, and the revenue received by consumer reporting agencies for consumer reports.

Creditors use information from consumer reports, usually obtained from the NCRAs, to reduce the risk of lending to consumers who may be unable to repay. Removing medical collections information from consumer reports provided to creditors for credit eligibility determinations would reduce the information they contain relative to the baseline. In theory, if creditors expect medical collections information to be on consumer reports, or if they view medical collections information as critical to their assessment of the riskiness of lending to consumers, their willingness to pay consumer reporting agencies for consumer reports that do not contain medical collections information may decrease. However, creditors would likely find the remaining information on consumer reports to still be valuable, mitigating the reduction in demand for consumer reports that may result from the rule. Furthermore, the market for consumer reports used to underwrite credit is highly concentrated amongst the NCRAs. Lenders will not be in a position to refuse to obtain a consumer report because they will still need the information contained in consumer reports to underwrite, and so there is no plausible mechanism by which a lender's perceived reduction in consumer report quality would affect price. If there

were such a mechanism, consumers may face lower loan origination costs because consumer report fees are often passed on at loan origination to the borrower.

One NCRA SBREFA commenter stated that it considers medical collections as predictive of a consumer's repayment willingness and ability and believes that the complete removal of medical collections from consumer reporting would "degrade the accuracy of consumer reporting." As described above, some medical collections reflect inaccurate billing practices, and their inconsistent inclusion on consumer reports adds only a noisy signal of consumers' ability to pay. The CFPB expects that removing medical collections from consumer reports used in credit eligibility determinations would instead improve the accuracy of consumer reporting.

For purposes of complying with laws requiring an assessment of a consumer's ability to repay a loan, the rule allows creditors to consider medical debt information that consumers provide in response to general requests for information on a consumer's debt. The rule, however, does not allow creditors to obtain or use medical information from consumer reporting agencies for such purposes. The CFPB understands that creditors for many types of credit products do not generally ask explicitly for medical debt information on applications for credit at baseline, and instead rely on the medical collection information provided in consumer reports. Some forms of credit, like mortgages, more commonly require that an applicant report all debts on the credit application.[292] The rule will not change any existing law or guidance regarding the information that creditors must request from applicants.

Commenters, including a bank trade association, an NCRA, and a researcher stated that consumers may withhold medical debt information from creditors if more general requests on a

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[292] *See, e.g.*, Fannie Mae, *Uniform Residential Loan Application (Form 1003)*, https://singlefamily.fanniemae.com/delivering/uniform-mortgage-data-program/uniform-residential-loan-application (last visited Nov. 25, 2024).

credit application for a consumer's debt information do not specify medical debt. These commenters further stated that creditors would have no mechanism for verifying whether disclosed liabilities were accurate.

The CFPB does not agree with the commenters that the rule will generally prevent creditors from learning about the scope of consumers' liabilities. Creditors largely rely on consumers to provide information about their medical debts at baseline because most medical debts are not included on consumer reports, as discussed below. To the extent that creditors do explicitly ask for medical debt information at baseline, this rule changes the process by which creditors obtain medical debt information from consumers. Specifically, creditors will no longer be able to explicitly ask for information about medical debt. Instead, consumers will need to provide this information in response to a more general request for debt information.

To the extent that consumers are less likely to provide medical debt information in credit applications under the rule relative to the baseline, the CFPB does not expect this to impose major costs on creditors. For example, the Federal Housing Administration currently omits medical debt information from its calculations of debt-to-income ratios in mortgage underwriting.[293] This suggests that, to the extent consumers cease to provide their own medical debt information after the rule is issued, mortgage underwriters will likely adjust eligibility criteria to account for this change without significantly increasing repayment risk to creditors, including by placing more weight on other borrower characteristics. Additionally, few creditors explicitly ask for medical debt information at baseline; for example, the Uniform Residential Loan Application, required for loans sold to Freddie Mac and Fannie Mae, does not specifically

[293] U.S. Dep't of Hous. & Urban Dev., *Single Family Housing Policy Handbook 4000.1*, https://www.hud.gov/program_offices/housing/sfh/handbook_4000-1 (last visited Nov. 21, 2024).

request medical debt information.[294] The CFPB requested evidence for how the continued ability to observe medical debt on credit applications may impact creditors and consumers but did not receive relevant evidence.

The medical collections included on consumer reports comprise only a subset of consumers' medical debt for several reasons. First, not all medical debt, including past-due medical debt, is in collections at any given time, and not all medical debts that are in collections are included on consumer reports, for a variety of reasons. For one, a medical collection that appears on a consumer report from one NCRA may not appear on other consumer reports if the debt collector did not report to all three NCRAs. Additionally, the NCRAs entered into a settlement, called the National Consumer Assistance Plan (NCAP), with over thirty States' attorneys general in 2015 that required them to remove from consumer reports all medical collections that were paid by insurance, as well as ensure that medical collections were not included on consumer reports until they were at least 180 days past due from the date of first delinquency.[295] Since that agreement, the NCRAs have voluntarily removed many types of medical collections from consumer reports, including medical collections that were paid by any source, medical collections under $500, and medical collections that have not been outstanding for at least one year.[296]

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[294] Fannie Mae, *Uniform Residential Loan Application (Form 1003)*, https://singlefamily.fanniemae.com/delivering/uniform-mortgage-data-program/uniform-residential-loan-application (last visited Nov. 25, 2024).

[295] Assurance of Voluntary Compliance/Assurance of Voluntary Discontinuance (May 20, 2015), *In re Equifax Info. Servs.*, https://www.ohioattorneygeneral.gov/Files/Briefing-Room/News-Releases/Consumer-Protection/2015-05-20-CRAs-AVC.aspx.

[296] PR Newswire, *Equifax, Experian and TransUnion Remove Medical Collections Debt Under $500 From U.S. Credit Reports* (Apr. 11, 2023), https://www.prnewswire.com/news-releases/equifax-experian-and-transunion-remove-medical-collections-debt-under-500-from-us-credit-reports-301793769.html.

In addition, the medical collections that currently appear on consumer reports are rarely reported for the full seven years that the FCRA permits. Previous CFPB research found that fewer than half of medical collections over $500 were reported for longer than one year, and just over 10 percent were reported for at least four years.[297] Since the NCRAs' voluntary medical debt reporting changes were fully implemented in April 2023, the persistence of medical collection reporting has been substantially reduced. The CFPB analyzed CCIP data and found that fewer than half of the medical collections reported in May 2023 were reported in November 2023, and just 26 percent were reported in February 2024.

Finally, several states have passed laws that significantly restrict or prohibit consumer reporting of medical debt information.[298] Creditors that serve consumers for whom consumer reports will have medical collections removed pursuant to these State laws provide or will soon be providing credit without knowledge from consumer reports of their applicants' outstanding medical debt for reasons unrelated to this final rule.

Nationally representative surveys indicate that between 15 and 41 percent of adults had some form of outstanding medical debt between 2021 and 2022, depending on the definition of "medical debt" used.[299] However, only 14 percent of consumers had a medical collection on their

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[297] Consumer Fin. Prot. Bureau, *Paid and Low-Balance Medical Collections on Consumer Credit Reports* (July 27, 2022), https://www.consumerfinance.gov/data-research/research-reports/paid-and-low-balance-medical-collections-on-consumer-credit-reports/.

[298] *See* Colo. Rev. Stat. section 5-18-109; N.Y. Pub. Health Law art. 49-A; 2024 Calif. SB 1061; 2024 Conn. Act 24-6; 2024 Minn. Ch. 332C; 2024 New Jersey A3681; 2024 Ill. Pub. Act 103-0648; 2024 Va. Acts ch. 751.

[299] U.S. Census Bureau, *Wealth, Asset Ownership, & Debt of Households Detailed Tables: 2021* (2021), https://www.census.gov/data/tables/2021/demo/wealth/wealth-asset-ownership.html; Lunna Lopes et al., Kaiser Fam. Found., *Health Care Debt In The U.S.: The Broad Consequences Of Medical And Dental Bills* (June 16, 2022), https://www.kff.org/report-section/kff-health-care-debt-survey-main-findings/.

consumer report in 2022.[300] By June 2023, after the NCRAs' voluntary removal of all medical collections under $500 in April 2023, only 5 percent of people with a consumer report had a medical collection included on their consumer report.[301] Because most consumers with medical debt do not have medical collections on their consumer report, creditors that do not request medical debt information on credit applications provide credit accounts to many consumers who have medical debt without any knowledge of that debt under the baseline. The CFPB understands that medical collections are not primarily reported to the NCRAs to assist creditors in assessing delinquency risk, but rather to induce repayment.

The general prohibition of the use of consumer report information related to medical debt in creditors' determinations of consumers' eligibility for credit may affect the performance of creditors' loan portfolios if the absence of this medical debt information reduces the accuracy of creditors' assessments of delinquency risk. Indeed, the removal of information from the set of variables that can be used in underwriting models should not improve performance if models optimally assess risk at baseline. The variables included in underwriting models are generally selected because they are predictive of the risk of loss a creditor would experience from providing a new credit account to a given consumer. Creditors typically measure risk by predicting the probability that a new account will become at least 90 days past due (or "seriously delinquent") within two years of origination.

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[300] Consumer Fin. Prot. Bureau, *Paid and Low-Balance Medical Collections on Consumer Credit Reports* (July 27, 2022), https://www.consumerfinance.gov/data-research/research-reports/paid-and-low-balance-medical-collections-on-consumer-credit-reports/.

[301] Ryan Sandler & Zachary Blizard, Consumer Fin. Prot. Bureau, *Recent Changes in Medical Collections on Consumer Credit Records Data Point* (Mar. 2024), https://files.consumerfinance.gov/f/documents/cfpb_recent-changes-medical-collections-on-consumer-credit-reports_2024-03.pdf.

The evidence available to the CFPB indicates that the predictive performance of underwriting models would not be impaired by the removal of all medical collections information from consumer reports. Many creditors have voluntarily reduced or eliminated the use of medical collections from their underwriting standards, and indeed, credit scoring companies have either removed or differentiated medical collections in their models and found minimal or no negative effects on performance.[302] Furthermore, an industry analysis of the NCRAs' June 2022 voluntary medical debt reporting changes found that because

> the vast majority of the impacted consumers would likely have other derogatory information and FICO® Scores that remain low, the ability of FICO® Scores to rank order risk on the total population prior to these medical debt collections being excluded is almost identical to what lenders would experience with these medical debt collections excluded.[303]

The NCRAs' June 2022 medical debt reporting changes removed paid medical collections from consumer reports and required medical collections to be at least one year past the date of first delinquency before being included on consumer reports. Though these changes were more limited in scope than those in this rule, the CFPB expects that an ex-post analysis of the rule's impacts would draw a similar conclusion as the industry analysis above, given the

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[302] *See, e.g.*, Fed. Nat'l Mortg. Ass'n, *Single Family Selling Guide*, B3-2-03 (2021), https://selling-guide.fanniemae.com/#Public.20Records.2C.20Foreclosures.2C.20and.20Collection.20Accounts (noting that "[c]ollection accounts reported as medical collections are not used in the DU [Desk Underwriter] risk assessment"); Fed. Home Loan Mortg. Corp., *The Single-Family Seller/Servicer Guide*, 5201.1 (2022), https://guide.freddiemac.com/app/guide/section/5201.1. *See also* The White House, *Fact Sheet: The Biden Administration Announces New Actions to Lessen the Burden of Medical Debt and Increase Consumer Protection* (Apr. 11, 2022), 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/ (announcing changes to certain Federal government underwriting standards); Ethan Dornhelm, *The Impact of Medical Debt Collections on FICO Scores*, FICO Blog (July 13, 2015), https://www.fico.com/blogs/impact-medical-debt-collections-ficor-scores; VantageScore, *What was the rationale for removing Medical Debt from VantageScore 4.0?*, https://www.vantagescore.com/faq/what-was-the-rationale-for-removing-medical-debt-from-vantagescore-4-0/ (last visited May 9, 2024).

[303] Tommy Lee, Senior Director, Analytics & Scores, *Medical Collection Removals Have Little Impact on FICO Scores*, FICO Blog (June 30, 2022), https://www.fico.com/blogs/medical-collection-removals-have-little-impact-fico-scores.

CFPB's evidence in the Technical Appendix showing that there is sufficient information remaining on consumer reports to enable creditors to make credit eligibility determinations without the inclusion of medical collections information on those consumer reports. Consumers with medical collections on their consumer reports in June 2023, after the NCRA voluntary reporting changes were fully implemented, had an average credit score of 582, near the deep subprime cutoff;[304] additionally, more than 40 percent had at least one nonmedical collection and nearly 19 percent had no other tradelines.[305] The fact that a consumer has a thin credit file[306] and information about nonmedical collections will remain available to creditors under the rule, to the extent that creditors use these markers to assess delinquency risk.

An important remaining question is whether consumers with medical debt and medical collections on their consumer reports are meaningfully more likely to become seriously delinquent than consumers with medical debt but no medical collections on their consumer reports, again holding all else equal. If this were true, the rule would reduce the accuracy of assessments of delinquency risk.

Several commenters, including credit union trade associations, a bank trade association, a consumer reporting agency trade association, a debt collector trade association, a health care trade association, debt collectors, research institutions, researchers, a health care provider, members of Congress, and the SBA Office of Advocacy, expressed an expectation that the

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[304] Consumer Fin. Prot. Bureau, *Borrower risk profiles*, https://www.consumerfinance.gov/data-research/consumer-credit-trends/student-loans/borrower-risk-profiles/ (last visited May 9, 2024).

[305] Ryan Sandler & Zachary Blizard, Consumer Fin. Prot. Bureau, *Recent Changes in Medical Collections on Consumer Credit Records Data Point* (Mar. 2024), https://files.consumerfinance.gov/f/documents/cfpb_recent-changes-medical-collections-on-consumer-credit-reports_2024-03.pdf.

[306] A thin credit file is a consumer report that contains fewer than five credit accounts. Jennifer White, Experian, *What is a Thin Credit File?* (May 25, 2022), https://www.experian.com/blogs/ask-experian/what-is-a-thin-credit-file-and-how-will-it-impact-your-life/.

proposed rule would reduce the accuracy of assessments of delinquency risk. Conversely, multiple commenters, including consumer advocates and individuals, stated that medical debt is not a good predictor of delinquency risk.

Multiple commenters, including credit union trade associations and at least one debt collector, stated that the proposed rule would increase the likelihood of consumer bankruptcy because, absent the use of medical collections information in credit eligibility determinations, creditors would approve consumers for unaffordable loans and consumers would become overleveraged. A debt collector trade association commenter cited research suggesting that medical debt is the largest driver of consumer bankruptcy and stated that creditors would be exposed to default risk if they could not infer a consumer's bankruptcy risk through the use of medical debt information in underwriting.[307] However, a researcher commenter discussed the academic literature on the subject of medical debt and bankruptcy, and stated that, based on the cited evidence, fewer than 5 percent of bankruptcies of nonelderly adults are caused by hospitalization.[308]

The CFPB expects that creditors will have sufficient information to accurately assess a consumer's bankruptcy risk under the rule, as the evidence presented in the Technical Appendix shows that the rule would lead to an expansion of credit without added risk of delinquency.

One researcher commenter cited an academic study that considered how privacy ordinances impacted the likelihood of foreclosure in one Metropolitan Statistical Area between

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

[308] Carlos Dobkin et al., *The Economic Consequences of Hospital Admissions*, 108:2 Am. Econ. Rev. 308-52 (2018), https://doi.org/10.1257/aer.20161038.

2001 and 2006.[309] Three counties within the MSA enacted an opt-in ordinance in 2003, in which financial institutions had to receive consumers' permission to share their information, while two counties did not enact the opt-in ordinance. The study found that loan denial rates fell, and foreclosure rates in 2007-2008 rose in the counties that enacted an opt-in ordinance. The commenter stated that the proposed rule was akin to a privacy rule against medical debt information and that there would be increases in lending to unqualified borrowers under the proposed rule.

The study cited by the commenter is not specific to medical debt and includes all information about a consumer that would be available at a financial institution, making the study substantially broader in scope than the rule. Furthermore, the study does not support the commenter's claims, as the study explicitly states that the evidence in support of the relationship between the privacy ordinances and foreclosure rates is not causal.[310] Instead, the CFPB provided causal evidence in the Technical Appendix showing that the availability of medical collection information in underwriting does not reduce the delinquency risk faced by creditors. Because delinquency risk is indicative of foreclosure risk, the CFPB concludes that there is minimal risk of increased foreclosure rates under the rule.

One researcher commenter cited an academic study showing that an auto finance company increased its profits when it began using credit scores in its underwriting in 2001.[311] The CFPB does not see a direct implication from the results of this study to the rule and agrees

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[309] Jin-Hyuk Kim & Liad Wagman, *Screening Incentives and Privacy Protection in Financial Markets: A Theoretical and Empirical Analysis*, 46:1 RAND J. Econ. 1-22 (2015), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2317942.

[310] *See id.* at 23.

[311] Liran Einav et al., *The impact of credit scoring on consumer lending*, 44:2 RAND J. Econ. 249-74 (2013), https://web.stanford.edu/~leinav/pubs/RAND2013.pdf.

that credit scoring models can be valuable for creditors. However, no credit scoring model is entirely reliant on any one element of credit information, and at least one credit scoring company has voluntarily removed medical collections from its model with minimal changes in predictive performance.[312]

Numerous commenters, including debt collectors, credit union trade associations, health care providers, individuals, a financial trade association, a consumer reporting agency trade association, a debt collector trade association, a bank trade association, a consumer reporting agency, a consumer advocate, a health care trade association, a research institute, and a researcher stated that creditors would provide more credit to consumers with medical debt under the proposed rule. These commenters stated that this increased access to credit would harm creditors and consumers because many consumers with medical debt would not be able to afford the credit they were provided, causing them to default. Other commenters, including at least one research institute, health care provider, government official, an individual, as well as multiple researchers and consumer advocates, stated that consumers with medical debt would experience increased access to credit under the proposed rule without repercussions.

In the Technical Appendix, the CFPB finds that medical collection reporting did not change the delinquency risk faced by creditors, as credit accounts provided to consumers with medical collections that were included on their consumer report were no more or less likely to become seriously delinquent than credit accounts provided to consumers with medical collections that were not included on their consumer report. The CFPB expects that creditors and

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[312] VantageScore, *What was the rationale for removing Medical Debt from VantageScore 4.0?*, https://www.vantagescore.com/faq/what-was-the-rationale-for-removing-medical-debt-from-vantagescore-4-0/ (last visited May 9, 2024).

consumers will benefit from increased access to credit under the rule, as described in more detail below.

A debt collector trade association commented that the proposed rule would not increase access to mortgages for consumers with medical debt because creditors use several factors to make mortgage eligibility determinations and medical debt is unlikely to be the marginal, deciding factor. However, the CFPB uses evidence from the Technical Appendix to estimate that an additional 21,882 mortgages would be originated annually under the rule. Though this would be a small percent increase in the number of mortgages originated annually, it suggests that medical debt is a deciding factor for some mortgage originations.

Multiple debt collectors commented that consumers with credit profiles similar to those of consumers with medical debt would be less likely to receive credit or may receive worse terms under the proposed rule, as creditors would proxy for medical debt information with other available information. Two researchers commented that creditors would begin to engage in statistical discrimination, whereby they restrict access to credit or provide worse terms to protected classes that are more likely to have medical debt.

The CFPB finds in the Technical Appendix that the use of medical collections information in credit eligibility determinations does not reduce the delinquency risk faced by creditors, relative to a baseline in which medical collection information is not used because the information has not yet been added to a consumer report. This implies that underwriting models are oversaturated with information at baseline, meaning that they use more information than is necessary to optimally predict default risk. Furthermore, because medical collections information does not improve the predictiveness of credit eligibility determinations, holding other inputs constant, creditors would not find value from proxying for medical collection information. This

is especially true if creditors chose to proxy for medical collection information by membership in a protected class, which is illegal under the Equal Credit Opportunity Act and may therefore create the risk of costly litigation.[313]

A research institute commented that lenders may cease providing credit to low-income consumers because 2.9 million of the 19.9 million households with medical debt in 2021 had household income below the poverty threshold. However, using the same data set as the commenter, the CFPB finds that an almost identical share of households below the poverty line as households above the poverty line have medical debt: 14.8 percent of households with incomes below the poverty line have medical debt, compared to 15.1 percent of households with incomes above the poverty line.[314] As such, even if creditors desired to specifically exclude potential borrowers with medical debt, excluding low-income consumers would not accomplish this purpose, and as such it is unlikely that this outcome would occur.

Several commenters, including multiple credit union trade associations, debt collectors, individuals, financial trade associations, at least one bank trade association, at least one consumer reporting agency trade association, at least one health care provider trade association, and at least one health care provider, stated that consumers generally would experience reduced access to credit or receive worse terms under the proposed rule. These commenters stated that the proposed rule would impact access to credit for all consumers, not just those with medical debt, because creditors would experience higher default rates from providing too much credit to consumers with medical debt and would pass those costs on to all consumers by raising interest

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[313] *See* 12 CFR part 1002.

[314] U.S. Census Bureau, *Wealth, Asset Ownership, & Debt of Households Detailed Tables: 2021* (2021), https://www.census.gov/data/tables/2021/demo/wealth/wealth-asset-ownership.html.

rates or reducing the number or dollar amounts of originated loans. During the SBREFA process, debt collectors expressed similar concern that creditors would be concerned about the possibility of providing credit to consumers who cannot pay their medical debt under the proposed rule, leading creditors to raise interest rates and fees to account for anticipated increased delinquency rates.

The CFPB does not expect that creditors would experience any significant decline in their customers' willingness or ability to repay, or in account performance under the rule. Instead, the evidence available to the CFPB and described in the Technical Appendix suggests that the rule will enable creditors to provide more credit accounts that have similar delinquency risk to credit accounts in their baseline lending portfolio. The data used in the Technical Appendix does not include the terms of credit accounts, so the CFPB cannot estimate how the terms provided to consumers may change under the rule, though it understands that any changes in terms would likely not be limited to consumers with medical debt. However, the CFPB expects that creditors, overall, would experience an increase in profitable loan volume under the rule, as market frictions have prevented creditors from fully reaching this more profitable equilibrium at baseline, as described above in part VII.A, *Statement of Need*.

One researcher commenter stated that firms may become insolvent from mispricing risk under the proposed rule. However, many creditors currently approve applications for credit without full knowledge of consumer medical debts because most medical debts are not included on many consumer reports, as discussed above. Comparing the performance of credit accounts that creditors made without medical collections information to the performance of accounts made with this information would provide the most direct evidence on how the rule may impact account performance, and therefore, creditors' profits. Ideally, this analysis would be performed

with data from consumer reports linked with the timing and presence of consumers' outstanding and unreported medical debts. The CFPB does not have access to such linked data and is not aware of such data being available.

The research described in the Technical Appendix provides the closest feasible analysis of the potential effect of the rulemaking against the baseline by considering if the visibility of medical collections that remain on consumer reports enables creditors to provide fewer credit accounts that result in serious delinquency. The CFPB uses de-identified consumer report data from the CFPB's CCIP and leverages the 180-day waiting period for reporting medical collections implemented under NCAP.[315] The CFPB's research considers inquiries made by creditors to one of the NCRAs in response to an application for credit in the 180 days before a medical collection was added to a consumer report, using data after the NCAP 180-day waiting period was implemented in September 2017.[316] Credit applications made during this 180-day period were made by consumers who had outstanding, but unreported, medical collections. The CFPB's research finds that the characteristics of inquiries made before and after a medical collection's addition to a consumer report are similar; therefore, any difference in the likelihood that a credit application led to an opened line of credit, or in the performance of those opened lines of credit, is likely caused by whether or not the creditor observed the consumer's medical collection.

[315] *See* part XII, *Technical Appendix*.

[316] The April 2023 NCRA reporting changes were too recent to be the focus of the analysis in the Technical Appendix, but the appendix provides heterogeneity results for whether all medical collections were at least $500 to provide the closest analog to the current lending environment. The CFPB relies on these results to estimate the impact of the rule.

The CFPB uses a regression discontinuity design in the Technical Appendix to analyze how the presence of a medical collection on a consumer report when an inquiry is made affects the likelihood that the consumer opened a new account in connection with that inquiry. The CFPB's data cannot identify the cause of an unsuccessful inquiry, which may include a credit denial, unfavorable terms, or a change in the consumer's credit demand.[317] For all credit account categories, the CFPB's research finds lower inquiry success rates for inquiries made immediately after a medical collection is added to a consumer report, compared to inquiries made immediately before a medical collection is added. This implies that creditors use medical collections information to deny or worsen the terms of credit provided to applicants. Table 1 uses coefficients estimated in the Technical Appendix (provided in Column 1 of Table 7) to estimate the annual number of additional credit accounts that would be originated if medical collections were removed from all consumer reports, all else equal.

[317] The data used and empirical strategy of the CFPB's analysis are described in the Technical Appendix. This section describes the estimation of the effect of medical collection reporting on the likelihood that a hard pull of a consumer report (an inquiry) made by a creditor in response to a consumer's credit application led to an originated loan. Under the assumption that inquiries made just before and just after a medical collection is added to a consumer report have similar underlying delinquency risk and reflect similar consumer preferences for terms and other loan qualities, differences in inquiry success can be attributed to creditors' use of medical collections information in their underwriting processes. These assumptions are justified in the Technical Appendix.

Table 1: Estimated Changes in the Number of Originated Loans Under the Rule by Credit Account Type[318]

(1) Account type	(2) Estimated coefficient	(3) Baseline inquiry success rate	(4) Expected percent change in originated accounts	(5) Annual number of originated accounts	(6) Expected change in annual originated accounts
Credit card	-0.047***	26.0%	18.1%	2,014,427	364,611
Mortgage	-0.026*	17.2%	15.1%	144,915	21,882
Other loans	-0.014*	23.9%	5.9%	1,083,879	63,949

Estimates marked with *** are statistically significantly different from zero at the one percent confidence level. Estimates marked with * are statistically different from zero at the 10 percent confidence level.

For all credit account categories, the CFPB expects that more loans would be originated if all medical collections were removed from consumer reports provided to creditors under the rule. The estimates in Columns 5 and 6 are underestimates because not all originated loans can be connected to an inquiry in the CFPB's CCIP, as the data only include inquiries made to one NCRA, and many non-mortgage creditors pull consumer reports from only one or two NCRAs. Additionally, these estimates assume that credit demand would not change under the rule. The

[318] All credit accounts in the CFPB's CCIP (excluding collections and non-loan information, such as child support tradelines) are included in one of the three categories of Column 1. Estimated coefficients in Column 2 are taken from Table 7 in the Technical Appendix. Column 3 includes the baseline inquiry success rate for inquiries made when medical collections are reported in the sample of the Technical Appendix. These baselines differ from those in the Technical Appendix because the CFPB reports baseline inquiry success rates for inquiries made when medical collections are unreported in the Technical Appendix, as it is standard to provide the average of the dependent variable to the left of the threshold in regression discontinuity analyses. Column 4 calculates the estimated percent change in the number of loans that would be originated under the rule by first dividing the estimated coefficient in Column 2 by the baseline average inquiry success rate in Column 3. Column 4 is then multiplied by negative one because the coefficients in Column 2 were estimated for medical collections moving from being unreported to reported in the Technical Appendix, but the change here is estimated for medical collections moving from being reported to unreported. Column 5 includes the number of inquiries made by creditors for consumer reports with reported medical collections between May 2023 and October 2023 in the CFPB's CCIP, multiplied by 50 to create a national estimate from the CCIP's 2 percent sample, annualized by multiplying by 2, and then multiplied by the baseline inquiry success rate for people with reported medical collections in Column 3 to estimate the annual number of credit accounts originated. Column 6 multiplies Column 4 by Column 5 to calculate the expected change in the number of originated credit accounts under the rule.

CFPB's research in the Technical Appendix finds that consumers are more likely to apply for credit in the weeks before a medical collection is added to their consumer report than in the weeks after. However, the characteristics of credit applications made before and after a medical collection is added (and their associated consumers) do not appear to have any statistically distinguishable differences between them. This finding suggests that any increase in credit demand under the rule will not lead to declines in credit application quality.

The results in Table 1 provide evidence that creditors will provide more credit to consumers with medical collections under the rule. At baseline, the CFPB assumes that creditors only make loans to people with reported medical collections if those loans are profitable on average, holding consumer report characteristics constant. If the marginal loans that would be made under the rule have similar revenue potential to those made to consumers with reported medical collections at baseline, the increase in the number of loans made to people with medical collections would increase creditor profits. To estimate the revenue potential of originated accounts, the CFPB estimates the likelihood of serious delinquency within two years of a credit account's origination date for accounts that are opened in connection with an inquiry made in the 180 days before or after a medical collection is included on a consumer report. If creditors' use of medical collections information in their underwriting decisions reduces the delinquency risk of newly opened accounts, one would expect that credit provided to consumers with outstanding, but unreported, medical collections will have higher delinquency propensity than credit provided to consumers with outstanding and reported medical collections.

The CFPB tests this hypothesis, and estimates ranges for the number of delinquent loans that would be issued if medical collections were not included on consumer reports, as when the rule is finalized, in Table 2. These ranges also incorporate the evidence from the Technical

Appendix on how the number of newly originated loans would change, shown above in Table 1. The estimated coefficients from Column 1 of Table 8 in the Technical Appendix are listed in Table 2 in Column 2.

Table 2: Estimated changes in the number of seriously delinquent loans under the rule by credit account type[319]

(1) Account type	(2) Estimated coefficient	(3) Baseline D90+ rate	(4) Expected change in annual originated accounts	(5) Expected number of D90+ accounts within two years of origination at baseline D90+ rate	(6) Expected number of annual D90+ accounts within two years of origination at estimated delinquency rate for unreported medical collections
Credit card	0.000	20.7%	364,611	75,474	75,474
Mortgage	0.011	3.1%	21,882	678	438
Other loans	0.012	17.1%	63,949	10,935	10,168

None of the estimated coefficients are statistically significantly different from zero.

Table 2 shows that, for mortgages and other (not credit card and not mortgage) account types, accounts originated by consumers with reported medical collections have slightly higher delinquency propensity than accounts originated by consumers with unreported medical

[319] All credit accounts in the CFPB's CCIP (excluding collections and non-loan information, such as child support tradelines) are included in one of the three categories of Column 1. Estimated coefficients in Column 2 are taken from Table 8 in the Technical Appendix. Column 3 includes the baseline two-year serious delinquency propensity for loans opened when medical collections were reported in the sample of the Technical Appendix, though the CFPB provides baseline inquiry success rates for inquiries made when medical collections are unreported in the Technical Appendix, as is standard in reporting regression discontinuity results. Column 4 is copied from Column 6 of Table 1. Column 5 multiplies Column 3 by Column 4, describing the expected number of additional accounts that would be originated under the proposed rule and would be D90+ within two years at the baseline D90+ rate. Column 6 multiplies Column 4 by the difference between Column 3 and Column 2 (where Column 3 is reflected as a decimal instead of as a percent, *e.g.*, 20.7 percent is equal to 0.207), describing the expected number of additional accounts that would be originated under the proposed rule and would be D90+ within two years at the D90+ rate for accounts originated when consumers have unreported medical collections. Columns 2 and 3 are differenced instead of added because the coefficients in Column 2 were estimated for medical collections moving from being unreported to being reported in the Technical Appendix, but the expected impact of the proposed rule is for medical collections moving from being reported to being unreported.

collections. This is not consistent with creditors using medical collections information to reduce the delinquency risk of originated accounts. The coefficients are not statistically distinguishable from zero, so the evidence is only suggestive, rather than conclusive, that the expansion of credit under the rule would yield a rate of serious delinquency that is lower than the rate of serious delinquency currently faced by creditors for accounts they provide to consumers with reported medical collections. The CFPB interprets its findings as evidence against any significant increase in the rate of serious delinquency as compared to the rate of serious delinquency for accounts provided to consumers with reported medical collections at baseline. The CFPB notes that this claim holds if all else is equal under the rule.

If consumer demand for credit is affected by the rule, the credit applications that creditors receive may have different underlying delinquency risk. Some consumers may avoid applying for credit when a medical collection appears on their consumer report if they understand that this information lowers the likelihood that their credit application will be approved or provided with favorable terms. Removing medical collections from consumer reports used in credit eligibility determinations may lead these consumers to submit credit applications, which could lead to an increase or decrease in the delinquency risk of applicant pools. As discussed in the Technical Appendix, the CFPB finds that consumers are less likely to apply for credit after a medical collection is added to their consumer report; however, the underlying delinquency risk of the remaining credit applications is not statistically distinguishable from the delinquency risk of credit applications made before the medical collection is reported.

To provide further evidence for how credit demand may respond to the rule, the CFPB used data from the CCIP to estimate if the NCRAs' voluntary removal of medical collections

under $500 in April 2023 was associated with increased credit demand.[320] The CFPB found that consumers who had medical collections under $500 included on their consumer reports in the first quarter of 2023 were just 0.07 percent less likely to have an inquiry in the six months after medical collections under $500 were removed from their consumer reports. This suggests that credit demand is not responsive to the removal of medical collections from consumer reports, at least in the short run. In the long-run equilibrium, the CFPB expects that consumer demand for credit may increase without the use of medical collections information in underwriting, but the CFPB does not expect that either the underlying delinquency risk of consumers with medical collections that apply for credit, or creditors' ability to predict those consumers' delinquency risk, will change under the rule.

Creditors may change their underwriting processes in response to the rule, which may impact the allocation of credit. The CFPB's research in the Technical Appendix analyzed inquiries that were made when a subset of medical debt information was available to creditors on consumer reports. If creditors instead knew that they could not generally use any medical debt information in their underwriting processes, they may change their underwriting models to put more weight on other variables. The CFPB expects that these changes would improve model performance relative to the baseline, and as a result, delinquency rates may be lower under the rule.

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[320] The CFPB compared the credit demand of "treated" consumers, who had medical collections under $500 included on their consumer reports in the first quarter of 2023, to the credit demand of "control" consumers, who had medical collections under $500 included on their consumer reports in the last quarter of 2022, but not in 2023. Neither group had any medical collections over $500 on their consumer reports in 2023. The treated group was directly affected by the April 2023 removal of medical collections under $500, but the control group was not, though both groups likely have similar underlying delinquency risk and credit demand. The CFPB estimated a linear regression of a binary monthly indicator describing if consumers had an inquiry on their consumer report in each of the six months between May and October 2023 on a binary indicator describing whether the consumer was in the treated or control group. The regression further included month fixed effects. The coefficient was statistically significant at the ten percent level.

Although the CFPB does not estimate that there will be a significant number of additional seriously delinquent accounts as a result of the rule, the CFPB does not have data available that would enable it to calculate the monetary cost to creditors of potential additional delinquencies. The CFPB requested information on the dollar cost to creditors of an account that becomes seriously delinquent within two years of its origination. A researcher commenter stated that even if the probability of serious delinquency or default did not change under the rule, the Exposure at Default, or the dollar amount that the consumer is delinquent for, may be higher for credit card lenders under the rule. This would lead to a higher expected loss and reduced revenues.

The CFPB agrees that the profitability of a loan is not solely defined by whether it becomes delinquent or not. However, the other factors that determine profitability do not unambiguously point toward lower revenue for creditors due to the rule, all else equal. For example, credit card borrowers who carry a balance month-to-month (often termed revolvers), are more profitable for credit card companies than other types of consumers.[321] Therefore, higher credit limits for these consumers under the rule may lead to higher revenue. If this source of higher revenue does not balance higher costs of default, the CFPB expects that credit card lenders may reduce the credit limits they provide under the rule. The CFPB does not expect this outcome to be likely because credit card lenders already do not observe most medical debts, as most medical debts are not included on consumer reports and credit card lenders do not generally explicitly ask for medical debt information on credit applications.

Increases in access to credit may revert over the long run if credit scoring companies change their models or creditors change their underwriting practices in response to the rule.

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[321] Robert Adams et al., Bd. of Governors of the Fed. Rsrv. Sys., *Credit Card Profitability* (Sept. 9, 2022), https://www.federalreserve.gov/econres/notes/feds-notes/credit-card-profitability-20220909.html.

Other information on consumer reports could receive different weights to compensate for the loss of medical collection information, which could attenuate these increases or even reduce access to credit for some consumers. However, the CFPB understands that credit scoring companies and creditors would only implement these changes if the benefit from doing so outweighed the costs of changing these models and procedures. The results in the Technical Appendix suggest that medical collections reporting does not enable creditors to make fewer delinquent loans, implying that creditors on average would not experience any decline in revenue from the absence of this information. Accordingly, the expected small (or zero) benefit of recalibrating credit scoring models and underwriting practices may lead to longer-term increases in access to credit for consumers with medical debt.

Because commonly used commercial credit scoring models require a minimal number of credit tradelines to generate a score, some consumers may lose their credit scores if medical collections are removed from their consumer reports. For instance, FICO will only provide a credit score if the consumer has at least one credit account that is at least six months old and there has been activity on the credit account in the previous six months.[322] Similarly, VantageScore requires at least one tradeline with any activity before providing a score.[323] For consumers with few tradelines, the removal of medical collections could lead them to lose their credit score.

Multiple commenters, including at least one debt collector, health care provider, and an individual, agreed with this point, stating that the proposed rule would cause more people to have

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[322] Louis DeNicola, Experian, *Improve Credit: How to Establish Credit if You're Unscoreable* (Feb. 12, 2024), https://www.experian.com/blogs/ask-experian/how-to-establish-credit-if-youre-unscoreable/.

[323] *Id.*

thin credit files.[324] One NCRA commenter estimated that over three million consumers would lose their credit score under the proposed rule, though the commenter did not list the scoring model or models that provided the basis for their estimation.

To provide evidence for the scale of this effect, the CFPB analyzed CCIP data from the months immediately before and after the NCRAs' voluntary removal of medical collections under $500 in April 2023. This internal analysis estimated that these reporting changes caused approximately 5,500 consumers to lose their credit score, representing 0.03 percent of consumers who had all their medical collections removed because of the April 2023 reporting changes. The median credit score for these consumers before their medical collections were removed was 581. The CFPB estimated using consumer reports from January 2024 in CFPB's CCIP as the baseline that fewer than 1,000 consumers may lose their credit scores if all medical collections were to be removed from consumer reports. The median credit score for these consumers in January 2024 was 573. Though not having a credit score can reduce access to credit, so too does having a subprime credit score, and the generally low baseline credit scores of affected consumers indicate that any increase in the number of consumers without credit scores under the rule may not lead to an overall reduction in consumers' access to credit. Indeed, as stated by one NCRA, generally "no credit is better than bad credit" for the purposes of accessing credit.[325] Based on CFPB's analysis of the CCIP data, the CFPB expects that any reduction in access to credit because of an increase in the population of consumers without credit scores would be very small.

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[324] A thin credit file is a consumer report that contains fewer than five credit accounts. Jennifer White, Experian, *What is a Thin Credit File?* (May 25, 2022), https://www.experian.com/blogs/ask-experian/what-is-a-thin-credit-file-and-how-will-it-impact-your-life/.

[325] Jim Akin, Experian, *Credit Reports & Scores: Is No Credit Better than Bad Credit* (Oct. 3, 2022), https://www.experian.com/blogs/ask-experian/is-no-credit-better-than-bad-credit/.

Despite these potential negative effects, the CFPB expects that consumers who at baseline have medical collections on their consumer reports would generally experience increased access to credit under the rule, in part caused by increases in their credit scores. Multiple commenters, including consumer advocates, at least one research institute, and at least one researcher, stated that the proposed rule would lead to higher credit scores for consumers, though a bank trade association stated that any expected gains are speculative without access to credit scoring models. The CFPB agrees that existing research cannot conclusively describe how credit scores will be impacted by the rule, but the research sheds light on potential changes.

Consumers with medical collections on their consumer reports in August 2022 had credit scores that were 30 points higher in August 2023 than in August 2022, after the implementation of the voluntary removal of medical collections under $500 in April 2023; consumers without medical collections on their consumer reports in August 2022 experienced a one-point decline in their average credit scores by August 2023.[326] This suggests that the removal of medical collections under $500 may have increased credit scores by at least 30 points, on average, though there may be other differences between consumers with and without medical collections on their consumer reports in August 2022 that explain part of the difference in their credit scores.

Evidence from CFPB research suggests that consumers experience a 25-point increase in their credit score, on average, after their last medical collection is removed from their consumer report.[327] However, the causes of the studied medical collection removals were unknown, and

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[326] Fredric Blavin et al., Urban Wire, Urban Inst., *Medical Debt Was Erased from Credit Records for Most Consumers, Potentially Improving Many Americans' Lives* (Nov. 2, 2023), https://www.urban.org/urban-wire/medical-debt-was-erased-credit-records-most-consumers-potentially-improving-many.

[327] Alyssa Brown & Eric Wilson, Consumer Fin. Prot. Bureau, *Consumer Credit and the Removal of Medical Collections from Credit Reports* (Apr. 2023), https://files.consumerfinance.gov/f/documents/cfpb_consumer-credit-removal-medical-collections-from-credit-reports_2023-04.pdf.

there may be unobservable factors that caused both the medical collection removal and increases in consumer credit scores, so these results cannot be interpreted causally.

One researcher commenter identified several methodological limitations of the study that the commenter stated meant that the CFPB study did not capture the causal effect of removing medical collections on consumers' credit scores. While the CFPB does not agree with many of the specific methodological critiques made by the commenter, the CFPB stated in the proposal and again above that it does not see this evidence as causal and agrees with the commenter on this broader point.

Other CFPB research has leveraged the recent voluntary removal of medical collections tradelines below $500, finding that consumers for whom all medical collections were below $500 prior to the changes saw their credit scores increase 20 points more than consumers who had some medical collections tradelines above $500.[328]

One researcher commenter stated that this conclusion could not be validated because there is no control group.[329] The researcher commenter further stated that any increase in credit scores would lead to higher delinquency rates. With respect to the consequences of increases in credit scores for creditors, the CFPB does not agree that creditors will face higher delinquency

[328] Consumer Fin. Prot. Bureau, *Data Spotlight: Early Impacts of Removing Low-balance medical collections* (May 16, 2023), https://www.consumerfinance.gov/data-research/research-reports/data-spotlight-early-impacts-of-removing-low-balance-medical-collections/.

[329] Regression discontinuity is a widely used policy evaluation tool and is described in detail in the Technical Appendix. In this context, the "control group" includes consumers whose largest medical debt is just over $500, compared to the "treatment group" of consumers whose largest medical debt is just under $500. Under the assumptions adopted in this estimation strategy, assignment to the treatment or control group is as good as random, so the credit score difference can be attributed to the medical collection reporting change.

rates as a result. When a credit scoring company removed medical collections from its model in 2023, the company reported that there was minimal change in predictive performance.[330]

For a sample of fewer than 3,000 consumers who had their medical debts removed from their consumer reports after their debt was relieved by a nonprofit organization, Kluender et al. (2024) found that credit scores increased by an average of just three points; however, this sample may not be representative of all consumers with medical debts, as the reported collections were much older on average than most medical collections on consumer reports.[331]

VantageScore removed all medical collections from its credit scoring model in 2022 and reported that "millions of consumers may see an increase of up to 20 points in their VantageScore credit scores."[332] The CFPB expects that consumers may experience similar increases in their credit scores from other credit scoring companies if medical debt information is removed from consumer reports under the rule. Higher credit scores can lead to higher loan approval rates and more favorable terms.[333] The CFPB requested information on the dollar value to consumers of higher credit scores but did not receive relevant comments.

Several commenters, including debt collectors, individuals, and at least one health care provider, one researcher, and one debt collector trade association, commented that the proposed rule will make it more challenging for consumers to repair their credit scores. The commenters

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[330] VantageScore, *What was the rationale for removing Medical Debt from VantageScore 4.0?*, https://www.vantagescore.com/faq/what-was-the-rationale-for-removing-medical-debt-from-vantagescore-4-0/ (last visited May 9, 2024).

[331] Raymond Kluender et al., *The effects of medical debt relief: evidence from two randomized experiments*, Nat'l Bureau of Econ. Rsch. Working Paper No. 32315 (Apr. 2024), https://www.nber.org/system/files/working_papers/w32315/w32315.pdf.

[332] VantageScore, *VantageScore Excluding Medical Debt from Credit Scores* (Aug. 12, 2022), https://www.vantagescore.com/press_releases/vantagescore-excluding-medical-debt-from-credit-scores/.

[333] Consumer Fin. Prot. Bureau, *What is a credit score?* (Aug. 28, 2023), https://www.consumerfinance.gov/ask-cfpb/what-is-a-credit-score-en-315/.

stated that "clearing" or "resolving" medical debts from a consumer report signals that a consumer is a good credit risk. The CFPB understands that this concern is not accurate based on the way credit scores currently operate. In the past, it was possible for consumers to increase their credit scores by paying a collections item, as paid collections tradelines are typically treated as less negative than unpaid collections tradelines. However, currently there is no mechanism for paid medical collections to appear as a positive indicator because the NCRAs voluntarily removed paid medical collections from consumer reports in June 2022. Even before this change, the removal of a medical collection tradeline would typically be better for consumers' credit scores than a paid medical collections tradeline. Furthermore, it would typically be even better for the consumer to never have the medical collection appear on their consumer report in the first place, as under the rule.

At baseline, debt collectors may use information from consumer reports to determine a consumer's ability to pay the collection amount and to guide what collection practices will be most cost-effective. Debt collector small entity representatives, in their submitted comments during the SBREFA process, stated that they found medical debt information on consumer reports to be relevant to estimating whether a consumer will repay a debt that is in collections.[334] Under the rule, debt collectors will continue to be permitted to use medical debt information on consumer reports because debt collection is not considered a credit eligibility determination. The CFPB expects that, if medical debt information is a critical indicator of a consumer's ability to repay a debt in collections, debt collectors will continue to furnish medical debt information to consumer reporting agencies. Furthermore, debt collectors and health care providers may

[334] *Id.* at 36.

continue to furnish medical collections to consumer reporting agencies because consumer reporting agencies would still be able to include medical collections information on the reports that they provide for other non-credit eligibility determination purposes such as employment or insurance, or to consumers seeking a copy of their own consumer reports.

6. Compliance costs

Under the rule, consumer reporting agencies will need to ensure that medical information is removed from consumer reports that are provided to creditors for credit eligibility determinations, which will require significant changes to existing consumer reporting systems and databases. Compliance costs will be low because furnishers have an obligation to notify consumer reporting agencies of their status,[335] thus making their removal from certain consumer reports a simple coding adjustment, which the consumer reporting agencies will already have to do to comply with several states' laws. The rule also has the potential to reduce consumer reporting agencies' costs by reducing the number of consumer disputes. Creditors may incur compliance costs to update their underwriting systems. Creditors may also need to train and staff attorneys to ensure they continue to meet their obligations to assess a consumer's ability to repay under the Truth in Lending Act and Regulation Z.

Commenters noted that consumer reporting agencies may incur one-time costs to develop practices to comply with the rule. At least one credit union commenter and consumer reporting agency trade group commenter stated that removing medical debt from consumer reports would require significant changes to existing consumer reporting systems and practices. One consumer reporting agency commenter wrote that implementing the NCAP required working with

[335] *See* 15 U.S.C. 1681s-2(a)(9).

furnishers and took two years to complete. The commenter stated they would require at least the same amount of time to implement the changes needed to comply with the proposed rule.

The CFPB agrees that some consumer reporting agencies may need to add new code to computer systems and databases such that no medical debt information is contained in consumer reports provided to creditors for credit eligibility determinations. However, some operational and compliance costs that may have otherwise been caused by the rule may have already been incurred to some degree to comply with certain State laws as well as the NCAP changes, and the consumer reporting agencies should be able to scale those coding changes nationwide. The CFPB requested data that could be used to quantify costs that may be incurred or have already been incurred by consumer reporting agencies but did not receive relevant quantitative information.

A SBREFA commenter, not representing the NCRAs, posited that making the necessary changes would be a significant undertaking in terms of time and cost and that the NCRAs would have to reconfigure, test, and validate their current compliance programs. The CFPB agrees that compliance costs may be different for the three NCRAs (Equifax, Experian, and TransUnion) and Innovis compared to other consumer reporting agencies. The NCRAs and Innovis are known to provide a standardized reporting format to be used by furnishers, called Metro 2, and have organized their databases to process and screen data furnished in this format.[336] The Metro 2 format that the NCRAs and Innovis currently provide to furnishers may help facilitate

[336] The CFPB does not have information on whether other consumer reporting agencies also rely on the Metro 2 format. For an overview of how NCRAs and Innovis, another CRA, receive and screen furnished data, see Consumer Fin. Prot. Bureau, *Key Dimensions and Processes in the U.S. Credit Reporting System: A review of how the nation's largest credit bureaus manage consumer data*, at 19 (Dec. 2012), https://files.consumerfinance.gov/f/201212_cfpb_credit-reporting-white-paper.pdf.

compliance because tradeline information submitted by furnishers is already required to include codes that specify when a debt is a medical debt.[337]

Additionally, the three NCRAs currently do not include medical collections under $500, medical collections that are less than one year past due, or paid medical collections on any consumer report provided to third parties. The NCRAs also remove medical collections as required by State laws.[338] It is likely that the NCRAs already have systems in place to screen out any furnished medical collections that may violate these conditions. These systems may be specific to removing furnished medical collections from all consumer reports, rather than only from consumer reports provided to creditors for the purposes of a credit eligibility determination as required under the rule. It is possible that the NCRAs' and Innovis's screening process may have to be expanded such that they only selectively remove medical collections information from consumer reports as required by the rule, or they may choose to remove medical collections from all consumer reports. The CFPB does not have information that would allow it to predict how the NCRAs and Innovis would choose to comply with the rule.

Consumer reporting agencies that have different screening processes and databases that do not rely on the Metro 2 format may incur different compliance costs associated with their own systems, though, as noted above, some compliance costs may already have been incurred to comply with State laws, and efforts to comply with those state laws are likely replicable or scalable for a nationwide change. Consumer reporting agencies may incur costs to screen medical information provided by such furnishers, or for which there is no medical information

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[337] *Id.* at 16-19.

[338] *See, e.g.*, Colo. Rev. Stat. section 5-18-109; N.Y. Pub. Health Law art. 49-A; 2024 Conn. Act 24-6; 2024 Va. Acts ch. 751.

furnisher within the meaning of FCRA section 623(a)(9), from consumer reports provided to creditors for credit eligibility determinations. The CFPB requested comment and information on this potential compliance cost, general operational and compliance costs, and other possible one-time costs for consumer reporting agencies, but it did not receive relevant information.

The U.S. Chamber of Commerce and an individual commenter stated that determining which debts are "medical" could be complex and that any broadening to include debts owed to third-party lenders would result in debts not connected to the provision of health care being removed from consumer reports. The CFPB is not broadening the rule to include debts owed to third-party lenders, however, and there is no indication that consumer reporting agencies currently have difficulty determining which debts are "medical."

The removal of medical collections information from consumer reports provided to creditors for the purpose of credit eligibility determinations may reduce consumer reporting agencies' costs by reducing the number of accounts that consumer reporting agencies must screen or conduct accuracy checks for, and the number of consumer disputes that they may need to resolve. Consumer reporting agencies regularly process significant amounts of data. For example, the NCRAs receive information on over 1 billion tradelines each month and must accurately compile this information for each consumer.[339] Under the FCRA, consumers have the right to dispute inaccuracies on their consumer reports, and consumer reporting agencies are obligated to investigate and resolve disputes if necessary.[340] This dispute resolution process imposes costs on consumer reporting agencies. A CFPB analysis shows that 5.7 percent of

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[339] *Key Dimensions and Processes in the U.S. Credit Reporting System: A review of how the nation's largest credit bureaus manage consumer data*, at 21 (Dec. 2012), https://files.consumerfinance.gov/f/201212_cfpb_credit-reporting-white-paper.pdf

[340] 15 U.S.C. 1681i(a)(1)(A).

reported medical collections tradelines have had a dispute flag, much higher than the rate of dispute flags for credit cards and student loans.[341] One NCRA commenter reported that their data shows that while consumers dispute medical collections tradelines more often than other collections tradelines, they do so at a similar rate to consumers disputing other delinquent non-collections tradelines.

To the extent that medical collections tradelines contribute to the number of disputes that consumer reporting agencies must address and, if possible, resolve, removing medical collections information from consumer reports may reduce consumer reporting agencies' costs associated with addressing disputes and dispute resolution. However, the CFPB does not have data to estimate the cost reduction arising from dispute management that consumer reporting agencies may experience if medical debt information is prohibited from appearing on most consumer reports provided to creditors. The CFPB requested data to quantify these potential cost-reducing benefits but did not receive relevant information.

One credit union commenter wrote that consumer reporting agencies may provide medical debt information in violation of the rule, which puts the recipient creditors at legal risk if they then rely on that information for credit eligibility determinations. The CFPB, however, has no reason to believe that consumer reporting agencies will fail to comply with their obligations under § 1022.38 to exclude medical debt information from consumer reports furnished to creditors, and assuming such compliance on the part of consumer reporting agencies, there will generally be no costs to creditors arising from litigation concerning medical information when they rely on consumer reports from consumer reporting agencies.

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[341] Consumer Fin. Prot. Bureau, *Paid and Low-Balance Medical Collections on Consumer Credit Reports* (July 27, 2022), https://www.consumerfinance.gov/data-research/research-reports/paid-and-low-balance-medical-collections-on-consumer-credit-reports/.

One credit union trade association commented that, for creditors that use information beyond consumer reports, there will be costs associated with excluding medical information. At least one credit union commenter and one credit union trade association commenter stated that financial institutions would incur significant costs to update their underwriting systems, consumer reporting systems, and practices, and that there is a risk of errors during the removal process which could lead to further complications and disputes. The SBA Office of Advocacy commented that it may be challenging for creditors to prove whether medical debt information was disclosed by consumers themselves, and making these determinations would require training and staffing attorneys.

The CFPB agrees that creditors may incur compliance costs from the rule. Creditors will need to ensure that they are not unintentionally using medical information in making lending determinations in circumstances that fall outside the exceptions to the creditor prohibition. The CFPB has determined that costs related to ensuring that no medical information is unintentionally used in lending determinations should be minor to the extent that creditors currently only utilize medical debt information provided through consumer reports. In such cases, so long as the consumer reporting agency providing the consumer report has complied with the rule, no medical debt information would be conveyed to the creditor, unless the consumer reporting agency has reason to believe the creditor intends to use the medical debt information in a manner not prohibited by the creditor prohibition. Creditors who use consumer reports may have additional costs if they utilize consumer reports from which the consumer reporting agency has not excluded medical debt information in compliance with § 1022.38. In such cases creditors would need to employ systems and staff time to identify and exclude that

information. But as explained above, the CFPB has no reason to believe that consumer reporting agencies will fail to comply with their obligations under § 1022.38.

In addition, creditors that rely on information outside of consumer reports will face compliance costs related to identifying medical information from other sources and excluding it from their underwriting (except as permitted by an exception to the creditor prohibition). The CFPB does not have data available to quantify the extent or dollar amount of any of these compliance costs, and requested comment on this issue but did not receive relevant data or estimates.

Commenters including health care providers, a researcher, debt collectors, credit unions, the U.S. Chamber of Commerce, and the SBA Office of Advocacy commented that the proposed rule would create conflicting obligations for creditors under the Truth in Lending Act (TILA) and Regulation Z, particularly with respect to the ability-to-repay provisions. They stated that it would be more difficult to respond to ability-to-repay laws under the proposed rule.

The rule, however, allows creditors to obtain and use medical information to comply with applicable requirements of local, State, or Federal laws, including ability-to-repay laws, and provides an example of how a creditor can consider consumers' self-reported medical debt information to comply with such laws. The CFPB thus concludes that creditors can comply with both the rule and the requirements of ability-to-repay laws.

One credit union commented that, by complying with the proposed rule, they would be at risk of losing a member with medical debt who receives credit from the credit union that they would not have received otherwise and who feels that they were not adequately educated or protected. The CFPB does not expect that consumers with medical debt would be provided credit they cannot afford under the rule.

One bank trade association expressed confusion about including certain types of medical payments in underwriting. They stated that transaction data includes payments to medical providers, and they were unclear if this information could be used by creditors for the purpose of credit eligibility determinations under the proposed rule. The CFPB has permitted the use of medical information that is included in the transaction information of an account by creditors for the purpose of credit eligibility determinations in the final rule.

7. Inaccurate billing

The CFPB understands that many medical collections included on consumer reports reflect incorrect billing, including debts that were already paid by either the consumer or by their insurance company, or debts that are not owed by the consumer. Nearly half of consumers who made formal complaints to the CFPB about medical debt collection in 2021 reported that they did not owe the debt, and many consumers did not know that they had outstanding medical debt until they discovered a collections tradeline on their consumer report.[342]

Numerous commenters, including individuals, debt collectors, health care providers, and health care trade associations, disputed the prevalence of inaccurate medical billing as described in the proposed rule. These commenters stated that most patient accounts are billed accurately and that the CFPB's complaint database, which was cited as evidence of inaccurate medical billing in the proposed rule, does not reflect health care provider perspectives. Multiple individuals, debt collectors, health care providers, NCRAs, and debt collection trade associations commented that most medical bills are accurate and that there is no evidence that bills are inaccurate. One debt collection trade association commented that disputes are generally the result

[342] Consumer Fin. Prot. Bureau, *Complaint Bulletin: Medical billing and collection issues described in consumer complaints* (Apr. 2022), https://files.consumerfinance.gov/f/documents/cfpb_complaint-bulletin-medical-billing_report_2022-04.pdf.

of conflicts between health insurers and consumers, so the fault for inaccurate medical billing lies with health insurers rather than with debt collectors. An NCRA commented that medical collections are disputed less frequently than other collections, and when disputed, are verified at higher rates.

One debt collector commented that consumer reporting agencies already have methods for consumers to dispute and pursue legal remedies for inaccurate data. A financial trade association noted that the proposed rule referenced a study in which, of the 43 percent of consumers that reported receiving a medical bill that they believed contained an error, 79 percent took actions to dispute the mistake with their insurer or health care provider.[343] Seventy percent of those disputes led to a successful resolution, which the commenter interpreted as evidence that there are already measures in place within the health care system to address erroneous billing.

At least one consumer advocate stated that, citing public statements from medical billing advocate groups, 60 to 80 percent of hospital medical bills have errors, with multiple individuals, research centers, consumer advocates, and law firms stating that inaccuracies in medical billing data are pervasive. At least one consumer advocate cited survey results that found most consumers have received a medical bill they believe to have errors.

The CFPB acknowledges that its complaint database is centered around consumers' negative experiences with medical debt, and the database cannot provide an estimate of the share of medical collections that result from inaccurate billing. However, even though there are existing mechanisms for consumers to dispute inaccurate medical bills with health care providers, debt collectors, and consumer reporting agencies, consumers will benefit from not

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[343] Karen Pollitz & Kaye Pestaina, Kaiser Fam. Found., *Could Consumer Assistance be Helpful to People Facing Medical Debt?* (July 14, 2022), https://www.kff.org/policy-watch/could-consumer-assistance-be-helpful-to-people-facing-medical-debt/.

needing to dispute these debts under the rule in order to avoid inaccurate negative information on their credit reports.

At baseline, consumers may pay debts they do not owe to remove them from their consumer report. The CFPB does not have information available to estimate how many medical debts are paid despite containing inaccurate information but expects that fewer of these erroneous debts will be paid under the final rule. The CFPB requested comment and submissions of data, or any other relevant information, that may be helpful in estimating this reduction in erroneous debts paid but did not receive data or evidence.

At least one debt collector commented that consumer privacy would be harmed under the proposal because many entities would need to handle sensitive information. The commenter did not explain why this would be the case. In fact, the CFPB expects that fewer entities would need to handle sensitive information under the rule because medical information would no longer be provided to creditors on consumer reports.

A researcher commenter stated that consumer privacy would be harmed by increased use of litigation under the rule, because litigation can lead to the formation of public records, unlike consumer reporting. The CFPB agrees that this is a potential cost of the rule but expects that the rule will not greatly increase the number of consumers that are subject to litigation.

8. Alternatives considered

Government officials and consumer advocate commenters recommended extending the rule to include medical credit cards, medical financing plans, and medical information on general-purpose credit cards. Under this alternative construction of the rule, consumer reporting agencies would not be permitted to provide this information to creditors, and creditors could not use this information in their credit eligibility determinations. One consumer advocate commented that, in addition, the CFPB should prohibit common features of medical payment products that

can lead to consumer harm, including deferred interest, charging for services before they are rendered, and issuing payment products to consumers whose insurance would otherwise pay or who qualify for financial assistance. One government official suggested that this alternative may be preferable in part because card issuers' merchant category code system includes categories that would be similar to those needed to label medical information as such, simplifying the process by which creditors would be required to identify medical information.

The CFPB's own research has shown that medical payment products can pose financial risk to consumers.[344] The CFPB is working with the U.S. Departments of Health and Human Services and Treasury to monitor the relationships between financial institutions and health care providers and gather relevant information.[345] The CFPB has also considered the use of medical transaction information in credit eligibility determinations but understands that most creditors do not use granular transaction data. The CFPB has determined that there is not yet substantial evidence that the inclusion of medical payment products information on consumer reports, or its use in underwriting, leads to consumer harm and has chosen not to include this information in the rule.

Government officials and consumer advocates recommended extending the rule to consumer reports used for employment and tenant screening, rather than limiting the prohibition to medical information provided on consumer reports for the purpose of credit eligibility determinations as proposed.

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[344] Consumer Fin. Prot. Bureau, *Medical Credit Cards and Financing Plans* (May 2023), https://files.consumerfinance.gov/f/documents/cfpb_medical-credit-cards-and-financing-plans_2023-05.pdf.

[345] Lorelei Salas, Consumer Fin. Prot. Bureau, *Ensuring consumers aren't pushed into medical payment products* (June 18, 2024), https://www.consumerfinance.gov/about-us/blog/ensuring-consumers-arent-pushed-into-medical-payment-products/.

The CFPB does not have insight into the use of medical information by employers or landlords, but it did study its use by creditors to deny access to credit through its CCIP, as discussed in part VII.E.5. This evidence motivates the rule's focus on consumer reports provided to creditors for the purpose of credit eligibility determinations. The CFPB has determined that while these proposals might have additional benefits for consumers, they are beyond the scope of this rulemaking.

Commenters including a debt collector trade association and multiple credit union trade associations stated that the CFPB should provide guidance to, or increase its enforcement of, relevant entities instead of issuing the final rule. The SBA Office of Advocacy commented that CFPB should consider using enforcement actions with respect to businesses that furnish inaccurate medical debt information instead of the proposed rule. A debt collector trade association commented that the CFPB should provide guidance to medical debt collectors covering the inclusion of financial assistance policies in debt collection communications under the safe harbor provisions of Regulation F. The commenter also stated that the CFPB should better enforce the FCRA consumer dispute provisions to ensure the accuracy of medical debt reporting and should work with the U.S. Department of Health and Human Services to provide information about financial assistance to consumers who may qualify. One credit union trade association commented that the CFPB should provide a safe harbor provision for credit unions that unintentionally possess medical debt information. A second credit union trade association commented that the CFPB should issue guidance to financial institutions to help them better understand the predictive value of medical debt or permit lenders to use medical debt as long as it is assigned a lower weight in credit eligibility determinations.

The CFPB has determined that these proposed alternatives may be marginal improvements toward the intended goals of the rulemaking but would not fully realize the full scope of the rule's benefits for consumers. As such, it has decided not to implement these suggestions.

Multiple commenters suggested alternatives that are beyond the jurisdiction of the CFPB. A debt collector trade association commented that it would be preferable to target health plan cost-sharing and policies that impact consumers' ability to pay large bills from any source, not just from health care. A debt collector commented that the CFPB should provide financial assistance programs, improve health insurance coverage, and simplify billing processes. A different debt collector stated that the CFPB should encourage health insurers to improve their health care coverage, so consumers incur less medical debt in the first place. A credit union trade association stated that the CFPB should require health care providers to require transparency in medical pricing and billing.

These alternatives may achieve some of the goals of the rulemaking, but the CFPB does not have the regulatory authority to implement them.

Commenters suggested that the CFPB conduct additional research before finalizing the proposed rule to evaluate whether the rule is necessary. A debt collector trade association commented that the CFPB could evaluate the benefit of the No Surprises Act after it has been fully implemented. A debt collector stated that the CFPB should not finalize the rule before it studies the impacts of the voluntary NCRA reporting changes, while another debt collector stated that the CFPB should first study how the marketplace responds to credit scoring models that reduce the weight that medical collection information receives.

The CFPB shares the commenters' interest in ensuring the rule is supported by research. The evidence in the Technical Appendix shows that the inclusion of medical information on consumer reports reduces consumer access to credit without lowering creditors' delinquency risk. As such, the CFPB does not believe that additional research is needed.

Two debt collectors commented that the CFPB should differentiate between consumers who can and cannot pay under the rule. One debt collector recommended making this differentiation by consumers that are insured versus uninsured, while the other recommended finding alternative measures to differentiate between consumers that are unwilling to pay versus those that are unable to pay.

Information about consumers' insured status or that specifically addresses consumers' ability to pay is not commonly available on consumer reports. Including insurance information on consumer reports would impose substantial costs on consumer reporting agencies and on health insurers that would presumably be responsible for furnishing health insurance information, and it would exacerbate the privacy concerns that this rule aims to address. Including information on consumer ability to pay may pose even more challenges as many consumers' incomes and financial responsibilities are not included on consumer reports, and numerous entities that do not commonly furnish to consumer reporting agencies, such as landlords and employers, would be required to begin doing so. This would also not resolve the privacy concerns that this rule aims to address. As such, the CFPB has decided not to differentiate between groups of consumers in the rule.

A debt collector commented that the CFPB should allow for positive consumer reporting of medical debts, such that consumers that make payments on medical bills would have those payments reported as positive information demonstrating an ability to pay debts.

The CFPB understands that, at baseline, most medical debts are furnished to consumer reporting agencies by debt collectors rather than by health care providers. If consumers are more likely to make on-time payments to health care providers before the debt is placed with a debt collector, this would impose costly furnishing requirements on health care providers. It would also impose furnishing costs on debt collectors that, at baseline, often only furnish medical debts a few times, as discussed above. The CFPB does not have any evidence that paid medical collection items are treated positively in any lending models, and reporting positive medical payment information also would only add to the privacy concerns that this rule seeks to address.

A commenter stated that the CFPB should allow medical debt to remain on consumer reports but require that it is given less weight than other debts.

It would be impracticable for the CFPB to dictate a precise weight that creditors may or may not give to medical debts in their underwriting or how credit scoring companies weight their algorithms. In addition, it is unclear to what debts the medical debt weights should be compared. Furthermore, reducing the weight on medical debts would not resolve the privacy concerns that this rule aims to address.

A commenter stated that the CFPB should prevent health care providers and debt collectors from reporting medical debts as long as the consumer makes minimum payments.

The CFPB understands that, at baseline, most medical debt furnishers use consumer reporting as a mechanism to induce payment. Therefore, it is unlikely that consumers making minimum payments on their medical debt would have it furnished to a consumer reporting agency. This suggested alternative to the rule would not achieve the same benefit to consumers as would the rule.

A debt collector commented that the CFPB should implement a waiting period before medical debt can be reported and remove paid medical debt from consumer reports instead of finalizing the proposed rule.

The NCRAs have implemented these changes voluntarily, so limiting the rule to these changes would not benefit consumers relative to the current baseline.

A credit union trade association commented that the CFPB should require medical debt furnishers to ensure the accuracy of the information they provide to consumer reporting agencies.

The CFPB agrees with this comment and issued similar guidance to medical debt collectors in October 2024.[346]

F. Specific Impacts on Consumers in Rural Areas

The costs and benefits to consumers of the rule will likely be the same, on average, for consumers regardless of where they reside. However, consumers who have outstanding medical debt may be more likely to be affected by the rule. Research by the CFPB and others shows that medical collections on consumer reports are more common for consumers who reside in rural areas, compared to those who reside in non-rural areas.[347] Therefore, in the aggregate, the rule may have a disproportionate impact on consumers in rural areas. Additionally, to the extent that the rule will lead to consumers being denied services by a health care provider, that cost could be greater for consumers in rural areas, where there are often fewer options for medical care.

Several commenters, including numerous debt collectors, multiple health care providers, at least one health care administration trade association, at least one debt collector trade

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[346] Consumer Fin. Prot. Bureau, *CFPB Takes Aim at Double Billing and Inflated Charges in Medical Debt Collection* (Oct. 1, 2024), https://www.consumerfinance.gov/about-us/newsroom/cfpb-takes-aim-at-double-billing-and-inflated-charges-in-medical-debt-collection/.

[347] *See, e.g.*, Matthew Liu et al., Consumer Fin. Prot. Bureau, *Consumer Finances in Rural Appalachia* (Sept. 2022), https://www.consumerfinance.gov/data-research/research-reports/consumer-finances-in-rural-appalachia/.

association, and at least one individual, stated that the proposed rule may decrease access to health care in rural settings. At least one health care provider trade association commenter and at least one individual commenter stated that small rural health care providers are at a disadvantage at baseline and would face more challenges under the proposed rule. Commenters including multiple health care providers, at least one health care administration trade association, several debt collectors, at least one debt collector trade association, and at least one researcher, stated that the proposed rule may lead to increased closures among providers in rural areas and may result in patients needing to travel longer distances for treatment, or may force them to use emergency rooms for non-emergency care. At least one individual commenter, at least one debt collector trade association commenter, and at least one health care provider commenter cited that over 700 rural hospitals are already at risk of closure, and more than half of the 700 face an immediate risk of closure.[348] More than one health care provider commenter stated that hospital closures in rural areas will lead to worse health outcomes or more deaths. At least one consumer advocate commenter stated that closures of health care facilities lead to longer travel distances for consumers in rural areas, and that for some consumers, longer travel times can increase unpaid time off from work and paying for childcare, in addition to the cost of health care received.

The CFPB does not expect that the rule will result in increased closures of rural health care providers. The CFPB expects that rural health care providers would only close if their revenue decreases significantly. As discussed above, the rule is unlikely to substantially impact revenue for health care providers in the aggregate, as most health care revenue does not consist

[348] Molly Gamble, *703 hospitals at risk of closure, state by state*, Becker's Hosp. Rev. (Aug. 5, 2024), https://www.beckershospitalreview.com/finance/703-hospitals-at-risk-of-closure-state-by-state.html?utm_medium=email&utm_content=newsletter.

of consumers paying their bills after receiving treatment and the CFPB does not expect that there will be significantly reduced incentive to pay medical debts as a result of the rule. Additionally, the CFPB does not expect rural providers' revenue to be differentially impacted by the rule. Therefore, the CFPB does not expect increased closures of rural health care providers and significant changes to access to health care in rural settings.

G. Specific Impacts on Depository Institutions with $10 Billion or Less in Assets

The CFPB does not expect that the rule will have significantly different impacts on depository institutions with $10 billion or less in assets, compared to larger institutions. The CFPB concludes that the costs to creditors, described above, would apply equally to these smaller institutions.

Several commenters, including at least one credit union trade association and at least one bank trade association, highlighted that small institutions, including some credit unions, lack the same risk mitigation resources as larger institutions. These commenters stated that the proposed rule would have a disparate negative impact on smaller institutions in terms of risk mitigation. At least one credit union trade association commenter stated that the proposal would likely lead to a scenario where small lenders decide the risk is too great and leave the lending market. At least one bank trade association commenter predicted that community banks would need to reduce their lending the most, leading to competitive losses and operational and compliance costs under the proposed rule. The commenter did not provide evidence for why community banks would be disproportionately impacted by the proposed rule.

The CFPB finds in the Technical Appendix that the use of medical collections information in underwriting does not reduce the delinquency risk of accounts originated to consumers with reported medical collections relative to consumers with unreported medical collections, and therefore expects that removing medical collection information from consumer

reports will not reduce the ability of institutions to assess delinquency risk. The CFPB does not expect the impact to vary by the size of institution. Thus, the CFPB does not expect significantly different impacts on depository institutions with $10 billion or less in assets.

H. Specific Impacts on Access to Credit

The CFPB discusses impacts on access to credit in detail above. In brief, the CFPB expects that some consumers will lose their credit score, although it is unclear whether this will decrease these consumers' access to credit relative to only having medical collections tradelines. Other consumers will likely see increased access to credit due in part to increased credit scores.

VIII. Regulatory Flexibility Act Analysis

The Regulatory Flexibility Act (RFA) generally requires the CFPB to conduct an initial regulatory flexibility analysis (IRFA) and a final regulatory flexibility analysis (FRFA) and convene a panel to consult with small entity representatives before proposing a rule subject to notice-and-comment requirements,[349] unless it certifies that the rule will not have a significant economic impact on a substantial number of small entities.[350] The CFPB provided its analysis to "describe the impact of the rule on small entities" in the NPRM and requested public comment.[351]

In the NPRM, the CFPB Director certified that the proposed rule would not have a significant economic impact on a substantial number of small entities within the meaning of the RFA. Thus, neither an IRFA nor a Small Business Advisory Review Panel (SBREFA Panel) was required. Nonetheless, the CFPB decided in an abundance of caution to include the proposed rule

[349] 5 U.S.C. 603, 609(b), (d)(2).

[350] 5 U.S.C. 605(b).

[351] 5 U.S.C. 603(a).

in the SBREFA Panel convened to address a number of topics under the FCRA on October 18 and 19, 2023, and to provide an analysis consistent with the requirements of an IRFA. In response to the NPRM, the CFPB received comments relevant to the IRFA, which are reflected in the FRFA set forth in part VIII.B.

The Small Business Review Panel for this rule is discussed in part VIII.A. Among other things, the FRFA contains a statement of the significant issues raised by the public comments in response to the IRFA, a statement of the assessment of the agency of such issues, a statement of any changes made in the proposed rule as a result of such comments, the response of the CFPB to comments filed by the Chief Counsel for Advocacy of the Small Business Administration in response to the proposed rule, and estimates of the number of small entities that may be subject to the rule and descriptions of the impact on those entities. The FRFA for this rule is set forth in part VIII.B.

A. Small Business Review Panel

Under section 609(b) of the RFA, as amended by SBREFA and the CFPA, the CFPB must seek, prior to publishing the IRFA, information from representatives of small entities that may potentially be affected by its proposed rule to assess the potential impacts of that rule on such small entities. The CFPB complied with this requirement when it included the proposed rule in the Small Business Review Panel convened on October 18 and 19, 2023.

B. Final Regulatory Flexibility Analysis

1. Statement of the need for, and objectives of, the rule

The creditor prohibition in section 604(g)(2) of the FCRA reflects Congress's intention to protect the privacy of sensitive medical information.[352] The creditor prohibition generally

[352] FCRA section 604(g)(2) (15 U.S.C. 1681b(g)(2)).

prevents creditors from considering medical information pertaining to a consumer in determining the consumer's eligibility, or continued eligibility, for credit. As described in more detail in part IV.B, Congress allowed certain Agencies, and later the CFPB, to make exceptions to this prohibition, consistent with the congressional intent "to restrict the use of medical information for inappropriate purposes."[353] In 2005, the Federal financial agencies and the National Credit Union Administration promulgated the financial information exception, restated in the CFPB's regulations at § 1022.30(d), which allows a creditor to consider certain medical information, including medical debt information and information relating to expenses, assets, and collateral, pertaining to a consumer in crediting decisions, provided the conditions of a three-part test are met.[354] The CFPB has determined that an exception for creditors to consider this type of medical information for credit eligibility determinations is not "necessary and appropriate" to protect legitimate operational, transactional, risk, consumer, or other needs, nor is an exception consistent with the intent of the creditor prohibition to restrict the use of medical information for inappropriate purposes as required for an exception under FCRA section 604(g)(5). The CFPB has also determined that an exception for creditors to consider medical information relating to a consumer's expenses, assets, and collateral would not meet the requirements for an exception under FCRA section 604(g)(5). As a result, the CFPB is removing the financial information exception and limiting the circumstances under which consumer reporting agencies can include medical collections information in consumer reports provided to creditors. Further details may be found in parts I.B and IV.

[353] FCRA section 604(g)(5) (15 U.S.C. 1681b(g)(5)).

[354] This background and the three-part test are discussed in part III.B.

The primary objectives of this rule are to enhance consumer privacy with respect to sensitive medical information and enable creditors to make appropriate credit decisions based on accurate information, in line with the purposes of the FCRA. The CFPB is authorized under section 604(g)(5) of the FCRA to promulgate exceptions to the creditor prohibition "that are determined to be necessary and appropriate to protect legitimate operational, transactional, risk, consumer, and other needs . . . consistent with the intent of [the prohibition] to restrict the use of medical information for inappropriate purposes." The CFPB also has authority under section 621(e) of the FCRA to issue regulations to carry out the purposes and objectives of, and to prevent evasions of or to facilitate compliance with, the FCRA. A discussion of the background leading to the rule may be found in part I, and a discussion of the legal authority relevant to this rule may be found in part III.

2. Significant issues raised by public comments in response to the IRFA, a statement of the assessment of the agency of such issues, and a statement of any changes made in the proposed rule as a result of such comments

The CFPB received few comments that were explicitly in response to the IRFA of the proposed rule. Commenters, including small entity representatives in the SBREFA process and debt collectors, stated that the SBREFA process was rushed and that they did not have enough information to provide input on the proposed rule. Commenters also stated that some types of entities that would be affected by the proposed rule were not considered in the IRFA, such as nonbank lenders, health care providers, and payors. A debt collector trade organization stated that initial compliance costs would be about $100,000 for each of its member debt collectors, most of which, according to the commenter, are small entities. Several commenters, including debt collectors and a debt collector trade association, stated that the CFPB should consider some exemptions or longer implementation timelines.

In response to these comments, the CFPB respectfully disagrees that the SBREFA process was rushed or that participants needed more information—the proposal relevant to this rulemaking was straightforward, the CFPB gave participants an outline summary of the proposal one month in advance of hosting the panel and gave participants an opportunity to provide written feedback three weeks after the panel. Additionally, with respect to the IRFA, the CFPB has revised its estimate of the number of small entities that may be affected by the rule to include debt collectors and health care providers in addition to the consumer reporting agencies and creditors listed in the IRFA. In its discussion of projected reporting, recordkeeping and compliance costs, the CFPB includes estimates provided by commenters. The CFPB also includes a discussion of the alternatives proposed by commenters in its description of significant alternatives to the rule.

3. Response of the agency to any comments filed by the Chief Counsel for Advocacy of the Small Business Administration in response to the proposed rule, and a detailed statement of any change made to the proposed rule in the final rule as a result of the comments

The Chief Counsel for Advocacy of the Small Business Association (Advocacy) provided comments on several aspects of the proposal, which generally echoed comments received from both small and large industry entities. Advocacy stated that the rule will significantly impact small entities involved in debt collection and that the CFPB has underestimated the number of small entities that may be impacted. Advocacy stated that the CFPB did not provide sufficient information to meet the requirements of a certification of no significant economic impact on a substantial number of small entities, and that the IRFA did not contain economic information on the projected reporting, recordkeeping, and other compliance costs. Advocacy also commented that the rule will increase litigation, causing harm to small entities and consumers because litigation is costly. Advocacy stated that the rule will lead to conflicts with other laws, including TILA and Regulation Z, as well as applicable State

laws. Furthermore, Advocacy stated that the rule is redundant in light of changes to industry practices and State laws. In their comment, Advocacy stated that the CFPB should issue clarifications on which laws are controlling so as to mitigate litigation risks for small entities, including creditors who have ability-to-repay requirements under TILA and Regulation Z, and debt collectors who operate in states with their own medical debt collection laws. Advocacy also stated, based on feedback from small entity representatives during the SBREFA Panel, that the cost of credit for small entities may be affected by the rule because removing medical collections from consumer reports may increase credit scores and cause creditors to increase their underwriting standards.[355] Finally, Advocacy suggests that the CFPB provide guidance to small entities for complying with the rule, and develop a mechanism to ensure that small entities are not penalized for not including medical debt in their ability-to-repay determinations.

In this FRFA, the CFPB has considered indirect impacts to small entities that are health care providers and debt collectors, in addition to the direct impacts to consumer reporting agencies and creditors considered in the IRFA.[356] By examining all credit inquiries made between July 2023 and December 2023 contained in the CCIP, the CFPB determined that most small creditors receive few applications from consumers with medical collections that appear on their consumer reports. In order for the rule to create a significant reduction in revenue,

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[355] Advocacy also commented that the cost of credit for small entities will increase because of the "written instructions" provision. The "written instructions" provision would specify what is needed to establish a permissible purpose for an entity to obtain a consumer report pursuant to the written instructions of the consumer. While the "written instructions" provision was included in the topics under the FCRA that were discussed during at the SBREFA Panel convened, it is not included in this rulemaking.

[356] By considering impacts on small entities not directly regulated by the rule, the CFPB has gone beyond the statutory requirements for a FRFA. *See* 5 U.S.C. 604(a)(4)-(5) (calling for analysis focused on "small entities *to which the rule will apply*" and "small entities *which will be subject to the requirement[s]*" of the rule) (emphasis added); *see also Mid-Tex Elec. Coop., Inc. v. FERC*, 773 F.2d 327, 342 (D.C. Cir. 1985) ("Congress envisioned that the relevant 'economic impact' [under the Regulatory Flexibility Act] was the impact of compliance with the proposed rule on regulated small entities.").

consumers with medical collections would have to experience unreasonably high default rates. Thus, the CFPB has determined that the rule will not have a significant economic impact on a substantial number of small entities directly impacted by the rule, specifically, consumer reporting agencies and creditors. The rule will not directly impact the behavior of medical debt holders such as health care providers and debt collectors since the rule will not affect their ability to furnish medical debt information to consumer reporting agencies. However, to the extent that furnishing becomes a less effective means of inducing payment, health care providers and debt collectors may incur costs associated with their use of other collection mechanisms as well as potential reductions in revenue. For these reasons, the CFPB acknowledges the possibility of indirect economic impacts on small entities that are health care providers or debt collectors. In some parts of the FRFA, the CFPB references the impact analysis part of this rule and presents quantitative estimates when available, including estimates provided by commenters in response to the proposed rule. In addition, the CFPB has revised its estimates of the number of small entities that are creditors that will be affected by the rule.

With regard to the harm to consumers and small entities from litigation, the CFPB has considered the extent to which litigation might increase as a means of inducing payment of medical debt under the rule. As discussed in part VII.E.4, debt collection litigation is already a collection mechanism used at baseline, and the rule might increase debt collection litigation. Increased debt collection litigation may be most likely to occur in States that have not already passed laws prohibiting medical collections from appearing in consumer reports, and also for small entities collecting on medical debts that are over $500.

In the proposed rule, the CFPB included an example in proposed § 1022.30(e)(6) to direct creditors and card issuers that are creditors regarding how they may use medical

information provided by the consumer in compliance with TILA and Regulation Z, as set forth in § 1022.30(e)(1)(ii), for purposes of compliance with the ability-to-repay rule under § 1026.43(c) for closed-end mortgages, the repayment ability rule under § 1026.34(a)(4) for open-end, high-cost mortgages, and the ability-to-pay rule under § 1026.51(a) for open-end (not home-secured) credit card accounts. With respect to Advocacy's comment that the rule is redundant in light of changes to State laws and industry practices, the CFPB's expectation is that the rule will provide clarity and uniformity in the treatment of medical collections on consumer reports across the US. The rule will also complement the voluntary NCRA changes that removed medical collections from consumer reports under $500 as well as paid medical collections, which are industry practices that apply only to medical collections furnished to the NCRAs and can be reversed at any time.

The CFPB acknowledges that it is possible that underwriting standards might tighten if the rule causes credit scores to increase for a substantial fraction of the population. However, the CFPB's recent research shows that only 5 percent of consumers still have medical debt on their consumer reports at baseline.[357] The CFPB expects that any increase in credit scores may represent a more accurate reflection of credit risk, and that it is unlikely that creditors will raise underwriting standards sufficiently to cause a significant impact on the cost of credit for small entities.

[357] Ryan Sandler & Zachary Blizard, Consumer Fin. Prot. Bureau, *Recent Changes in Medical Collections on Consumer Credit Records Data Point*, at 3 (Mar. 2024), https://files.consumerfinance.gov/f/documents/cfpb_recent-changes-medical-collections-on-consumer-credit-reports_2024-03.pdf.

4. Description and, Where Feasible, Provision of an Estimate of the Number of Small Entities to which the Rule Will Apply

The rule will directly affect small entities that participate as creditors as that term is defined in section 702 of the ECOA, except for small entities excluded from coverage by section 1029 of the CFPA, because it will prohibit them from considering certain medical information in their underwriting decisions. This information has been available to creditors under the financial information exception. In limiting the circumstances under which medical debt information can be included on consumer reports, the rule will also directly affect some small consumer reporting agencies. Specifically, consumer reporting agencies that currently provide medical debt information to creditors for credit eligibility determinations will generally no longer be able to do so.

For the purposes of assessing the impacts of the rule on small entities, "small entities" are defined in the RFA to include small businesses, small nonprofit organizations, and small government jurisdictions.[358] A "small business" is determined by application of Small Business Administration (SBA) regulations in reference to the North American Industry Classification System (NAICS) classification and size standards.[359]

There are several NAICS industries with small entities that may be subject to this rule. Consumer reporting agencies receive and assemble various types of consumer information and provide consumer reports to third parties for various purposes. Consumer reporting agencies are mostly contained within the NAICS industry "credit bureaus" (561450). However, not all entities

[358] 5 U.S.C. 601(6)

[359] *See* U.S. Small Bus. Admin., *Table of size standards*, https://www.sba.gov/document/support-table-size-standards (last visited May 13, 2024).

within this NAICS code are consumer reporting agencies.[360] Additionally, some consumer reporting agencies specialize in providing consumer reports to facilitate other operations, such as employment screening, check and bank account screening, and insurance, and not for credit purposes.[361] Many small consumer reporting agencies will not be affected by the rule, either because they do not currently furnish consumer reports containing medical debt information or because, under the rule, consumer reports containing medical debt information may continue to be provided for purposes other than credit eligibility, such as employment screening or insurance.

Creditors potentially directly affected by the rule are contained in multiple NAICS categories. These include depository institutions, such as commercial banks and credit unions, and non-depository institutions, such as mortgage and non-mortgage loan brokers, as well as firms that are primarily engaged in sales lending, consumer lending, or real estate credit. Creditors that currently use medical information related to debts, expenses, assets, and collateral in connection with a determination of a consumer's eligibility, or continued eligibility, for credit will be directly affected by the rule.

Medical debt holders, which include health care providers and debt buyers, may also be indirectly affected by the rule. The rule will not affect these entities' ability to furnish information to consumer reporting agencies. However, because consumer reporting agencies will generally not be able to include medical debt on consumer reports provided to creditors for credit

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[360] NAICS 561450 also includes mercantile credit reporting bureaus. There may also be a small number of consumer reporting agencies classified under Investigation and Personal Background Check Services (NAICS 561611).

[361] An overview of the types of consumer reporting agencies may be found at: Consumer Fin. Prot. Bureau, *List of consumer reporting companies*, https://www.consumerfinance.gov/consumer-tools/credit-reports-and-scores/consumer-reporting-companies/ (last visited Apr. 15, 2024). This list is not intended to be all-inclusive and does not cover every company in the industry.

eligibility determinations, the rule may reduce the effectiveness of furnishing as a collection mechanism. Health care providers are broadly contained in the NAICS subsector 62. Debt collectors are contained in several NAICS categories, and include small entities such as debt buyers, collection agencies, and collection law firms.

The SBA size standards use asset thresholds for depository institutions and revenue thresholds for non-depository institutions. Depository institutions are small if they have less than $850 million in assets. Consumer reporting agencies are small if they receive less than $47 million in annual revenues. Non-depository institutions in many industries are small if they receive less than $47 million in annual revenues, but the threshold is lower for some NAICS categories of non-depository institutions. The revenue thresholds for health care providers and debt collectors differ depending on the NAICS industry they belong to, ranging between $9 million in annual revenues and $47 million in annual revenues.

Table 3 shows the number of small businesses within NAICS categories that may be subject to the rule according to the December 2023 NCUA and FFIEC Call Report data and the 2017 Economic Census data from the U.S. Census Bureau, which are the most recent sources of data available to the CFPB.

Table 3: Number of Entities within NAICS Industry Codes that May be Subject to the Rule

NAICS Codes	NAICS Description	Total Number of Entities	Total Number of Small Entities	SBA Size Standard
522110	Commercial Banking	4248	3170	< $850M (assets)
522130	Credit Unions	4702	4202	< $850M (assets)
522180	Savings Institutions and Other Depository	322	239	< $850M (assets)

NAICS Codes	NAICS Description	Total Number of Entities	Total Number of Small Entities	SBA Size Standard
	Credit Intermediation			
522210	Credit Card Issuing	6	1	< $850M (assets)
522220	Sales Financing	2367	2124	< $47M
522291	Consumer Lending	3037	2915	< $47M
522292	Real Estate Credit	3289	2904	< $47M
522298	International, Secondary Market, and All Other Non-depository Credit Intermediation	5422	128	< $47M
522310	Mortgage and Nonmortgage Loan Brokers	6809	6684	< $15M
522320	Financial Transactions Processing, Reserve, and Clearinghouse Activities	3068	2928	< $47M
522390	Other Activities Related to Credit Intermediation	3772	3621	< $28.5M
541110	Offices of Lawyers	163725	833	< $15.5M
561440	Collection Agencies	3224	3050	< $19.5M
561450	Credit Bureaus	307	279	< $41M
621111	Offices of Physicians (except Mental Health Specialists)	161286	158262	< $16M
621112	Offices of Physicians,	10561	10407	< $13.5M

NAICS Codes	NAICS Description	Total Number of Entities	Total Number of Small Entities	SBA Size Standard
	Mental Health Specialists			
621210	Offices of Dentists	125329	124787	< $9M
621310	Offices of Chiropractors	38695	38665	< $9M
621320	Offices of Optometrists	19627	19492	< $9M
621330	Offices of Mental Health Practitioners (except Physicians)	24236	23958	< $9M
621340	Offices of Physical, Occupational and Speech Therapists and Audiologists	26722	26217	< $12.5M
621391	Offices of Podiatrists	7304	7241	< $9M
621399	Offices of All Other Miscellaneous Health Practitioners	19442	19170	< $10M
621410	Family Planning Centers	1472	1398	< $19M
621420	Outpatient Mental Health and Substance Abuse Centers	6523	5879	< $19M
621491	HMO Medical Centers	27	3	< $44.5M
621492	Kidney Dialysis Centers	431	374	< $47M
621493	Freestanding Ambulatory Surgical and Emergency Centers	4385	3888	< $19M

NAICS Codes	NAICS Description	Total Number of Entities	Total Number of Small Entities	SBA Size Standard
621498	All Other Outpatient Care Centers	6630	5845	< $25.5M
621511	Medical Laboratories	3365	3106	< $41.5M
621512	Diagnostic Imaging Centers	4272	3898	< $19M
621610	Home Health Care Services	23801	22840	< $19M
621910	Ambulance Services	3071	2940	< $22.5M
621999	All Other Miscellaneous Ambulatory Health Care Services	3557	3332	< $20.5M
622110	General Medical and Surgical Hospitals	2560	1130	< $47M
622210	Psychiatric and Substance Abuse Hospitals	396	213	< $47M
622310	Specialty (except Psychiatric and Substance Abuse) Hospitals	332	131	< $47M
623110	Nursing Care Facilities (Skilled Nursing Facilities)	9137	8374	< $34M
623210	Residential Intellectual and Developmental Disability Facilities	6885	6322	< $19M

NAICS Codes	NAICS Description	Total Number of Entities	Total Number of Small Entities	SBA Size Standard
623220	Residential Mental Health and Substance Abuse Facilities	4165	3674	< $19M
623311	Continuing Care Retirement Communities	3874	3533	< $34M
623312	Assisted Living Facilities for the Elderly	14338	13885	< $23.5M
623990	Other Residential Care Facilities	3194	2931	< $16M
Total		739915	554973	

Table 4 provides the estimated number of small entities within the categories of credit bureaus, depository institutions, and non-depository institutions, debt collectors (including debt buyers), and health care providers as well as the NAICS codes these entities may fall within. Under the rule, small consumer reporting agencies will no longer be able to provide to creditors consumer reports that contain medical debt information under the financial information exception. The CFPB is not able to precisely estimate the number of small consumer reporting agencies whose activities will be affected by the rule. As discussed above, many consumer reporting agencies currently specialize in providing consumer reports for purposes that will not be affected by the rule. Additionally, consumer credit markets currently rely heavily on consumer reports from consumer reporting agencies which are not small entities.[362] For these reasons, the CFPB estimates that only a small fraction of the small consumer reporting agencies

[362] Impacts to consumer reporting agencies are also described within part VII.E.

identified in Table 4 will be affected by the rule. The CFPB requested data to more precisely quantify the number of small consumer reporting agencies that will be affected by the rule, but did not receive relevant comments.

Small creditors that will be directly affected by the rule are included in several NAICS categories that can be broadly divided into depository and non-depository institutions. Small creditors will be generally prohibited from considering medical information from consumer reports (and other sources) in credit eligibility determinations under the rule, unless a specific exception applies. However, some small creditors currently do not consider medical information that will be prohibited under the rule, and others only consider medical debt information if consumers disclose that they have made monthly payment arrangements with medical debt holders.[363]

While all small creditors will be subject to the rule, the CFPB lacks the data to precisely quantify how many small creditors currently make credit decisions in ways that will be affected by the rule. Small creditors who are currently in compliance, whether in whole or in part, with the rule might not be impacted as much as small creditors who currently consider medical debt information (and certain other categories of medical information) from consumer reports or other sources. The CFPB requested data to precisely quantify the number of small creditors that may be directly affected by the rule, but did not receive relevant comments.

[363] Two small entity representatives provided this context in their comment letters. Written Submission of Evelyn Schroeder, Vice President, First Security Bank and Trust, to the CFPB, "Re: CFPB's Outline of Proposals and Alternatives Under Consideration, Small Business Advisory Review Panel for Consumer Reporting Rulemaking" at 7 (Nov. 6, 2023). Written Submission of Jeff Jacobson, Vice President, New Market Bank, to the CFPB, "RE: SER response to SBREFA Outline for Consumer Reporting Rulemaking" at 5 (Nov. 6, 2023).

Table 4: Estimated Number of Small Entities by Category[364]

	NAICS Code(s)	Estimated Number of Small Entities
Consumer Reporting Agencies	561450	281
Depository Institutions	522110, 522130, 522180, 522210	7612
Non-depository Institutions	522220, 522291, 522292, 522310, 522320, 522390	14454
Debt Collectors	522298, 541110, 561440	4011
Healthcare Providers	621111, 621112, 621210, 621310, 621320, 621330, 621340, 621391, 621399, 621410, 621420, 621491, 621492, 621493, 621498, 621511, 621512, 621610, 621910, 621999, 622110, 622210, 622310, 623110, 623210, 623220, 623311, 623312, 623990	521895

[364] The estimated number of small entities is calculated by taking the sum of the number of entities whose assets held or annual revenues fall below the relevant SBA thresholds for each NAICS code under the three categories, using the data presented in Table 3. When entity counts for a NAICS category in Table 3 are reported for two revenue limits (an upper and a lower bound), the average of the two entity counts is taken to estimate the number of small entities in that NAICS category.

5. Projected Reporting, Recordkeeping, and Other Compliance Requirements of the Rule, Including an Estimate of the Classes of Small Entities which will be Subject to the Requirement and the Type of Professional Skills Necessary for the Preparation of the Report

The rule may impose reporting, recordkeeping, and other compliance requirements on small entities subject to the rule. These requirements generally differ for entities in two classes: credit bureaus that function as consumer reporting agencies, and depository or non-depository institutions that function as creditors. Based on Table 4, these requirements will be imposed on, at most, an estimated 281 small consumer reporting agencies and 22,006 small creditors. The CFPB does not expect that debt collectors and health care providers listed in Table 4 will have reporting, record keeping and other compliance requirements.

Requirements for Consumer Reporting Agencies

Under the rule, consumer reporting agencies will only be able to provide to creditors (in connection with credit eligibility determinations) consumer reports that contain medical debt information if they have reason to believe that the creditor intends to use the medical debt information in a manner that is not prohibited. Thus, if consumer reporting agencies continue to receive and record medical debt information from furnishers, consumer reporting agencies may need to devise policies and procedures to ensure that they appropriately restrict the provision of medical debt information to creditors. However, these compliance costs may only apply to consumer reporting agencies who, at baseline, provide consumer reports containing medical debt information to creditors based on the existing financial information exception. It is the CFPB's understanding that this task is mostly performed by the NCRAs (none of which are small entities), and the CFPB is not aware of any small consumer reporting agencies that provide consumer reports containing medical debt information to creditors at baseline. Compliance for affected small consumer reporting agencies will generally require professional skills related to

software development, legal expertise, compliance, and customer support. The CFPB does not have the data to estimate the costs of reporting, recordkeeping, and other compliance requirements for small consumer reporting agencies, and requested but did not receive data to quantify these costs.

Requirements for Creditors

The rule will generally prohibit creditors from using information related to medical debt (among other categories of medical information) in credit eligibility decisions. The CFPB's final rule prohibits CRAs from furnishing medical debt information to creditors pulling a general report in order to underwrite a loan, which means small creditors would not have to incur the compliance costs associated with updating their underwriting procedures to exclude medical debt information. However, creditors using their own proprietary credit score may choose to change their underwriting procedures in response. Currently, many creditors use medical debt information from consumer reporting agencies that will no longer be included in consumer reports under the rule. The rule will 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 response to questions in credit applications that do not specifically request medical information to satisfy ability-to-repay requirements. The rule may cause creditors to modify their underwriting procedures to rely more heavily on consumer information that they obtain from credit applications. These changes will generally require professional skills related to compliance, underwriting, and legal expertise. The CFPB requested data and evidence to estimate these costs, but did not receive relevant comments.

Requirements for Debt Collectors

One debt collector trade association commented that initial compliance costs will be at least $100,000 per debt collector. This estimate included costs such as updating software, hiring attorneys to ensure compliance with the rule, renegotiating contracts with vendors, and updating their business practices. However, the rule will not prohibit debt collectors from furnishing medical debt information to consumer reporting agencies or directly impose any other reporting, recordkeeping, or other compliance burdens on them. As discussed in part VII.E.4, the rule may make furnishing a less effective means of inducing payment of medical debts. This may reduce debt collectors' revenue; however, reductions in revenue will not be due to reporting, recordkeeping or compliance requirements that the rule imposes on debt collectors.

Requirements for Health Care Providers

The CFPB understands that at baseline, health care providers do not generally furnish medical debt information to consumer reporting agencies. But even if they do furnish debt collection information to consumer reporting agencies, as described above, the rule does not impose any requirements on furnishers, nor does the rule impose other requirements on health care providers. Accordingly, the CFPB has determined that the rule will not impose reporting, recordkeeping, and other compliance costs on health care providers. However, as discussed in part VII.E.4, the rule may make furnishing a less effective means of inducing payment of medical debts. This may impose costs on health care providers if they turn to other collection mechanisms that may be more costly or less effective than furnishing, such as debt collection litigation, or if the rule causes them to renegotiate contracts with medical debt buyers or debt collectors, but these costs will not be due to reporting, record keeping, or compliance requirements that the rule imposes on health care providers.

6. Description of the steps the agency has taken to minimize the significant economic impact on small entities consistent with the stated objectives of applicable statutes, including a statement of the factual, policy, and legal reasons for selecting the alternative adopted in the final rule and why each one of the other significant alternatives to the rule considered by the agency which affect the impact on small entities was rejected.

When developing the proposal, the CFPB decided to include a prohibition on consumer reporting agencies furnishing medical debt information to creditors who did not have a permissible purpose by virtue of the fact that this rule (or other laws) prohibit them from considering the information in credit underwriting. This provision was in large part proposed, and is now finalized, in order to minimize the economic impact on small entities. In the absence of such a prohibition, consumer reporting agencies might continue to include medical debt information on credit reports, in which case creditors would have to update underwriting models and credit scores to avoid giving it any weight. By prohibiting consumer reporting agencies from sending the data, creditors are able to forgo that substantial compliance cost.

The CFPB considered exempting small entities from the rule, in whole or in part. Several commenters, including debt collectors, stated that the CFPB should consider limiting the scope of the rule to apply only to some forms of data, or to certain medical debts, such as those originating from emergency medical services. Another commenter stated that the CFPB should consider exempting small businesses below a certain size threshold. However, the CFPB has determined that such exemptions will not achieve the objective of FCRA section 604(g)(2) and the rule to protect consumer privacy with respect to sensitive medical information.

The CFPB also considered several other alternatives to the rule that would possibly result in lower costs for small entities. These alternatives include: (1) alternative compliance timelines, (2) allowing creditors to consider specific types of medical information, (3) codifying and broadening the voluntary changes in medical collections reporting implemented by the NCRAs in 2022 and 2023, (4) requiring consumer reporting agencies to independently investigate the

accuracy of furnished medical debt collections, and (5) defining when a furnisher must investigate the accuracy of furnished medical collections information.

The CFPB considered making the rule effective more than 60 days after the issuance of a final rule. During the SBREFA process, several small creditors stated that they would need time to comply with the proposals discussed at the panel. One small creditor stated that their compliance department is already working at full capacity to comply with recently issued rules, and that they and others in the financial industry would need additional time to comply with further rules. A debt collector trade association stated in a comment that an implementation period of 60 days is too short for small businesses to comply with the rule, while Advocacy stated that stakeholders believe it will take 18 to 20 months to comply with the rule. The CFPB has determined that compliance with the rule would not impose significant compliance costs on small entities, and as a result the CFPB does not believe additional time for compliance is necessary. Further, allowing additional time for compliance would extend the period during which sensitive medical information may continue to be used for credit eligibility determinations.

As described in the SBREFA Outline, the CFPB considered removing the financial information exception only with respect to medical information relating to debts, while continuing to allow creditors to consider medical information relating to expenses, assets, collateral, income, benefits, and the purpose of the loan. The CFPB has determined that a creditor's consideration of medical information relating to expenses, assets, and collateral is not warranted, and is therefore removing the financial information exception with respect to these additional categories of medical information.

The final three alternatives considered may not achieve some of the objectives of the rule. These alternatives were included in the discussions with small entity representatives and the SBREFA Panel. As discussed in part VII.B, the NCRAs voluntarily implemented changes in the consumer reporting of medical debt. Because their changes were voluntary, codifying and broadening the changes may protect consumers from the possibility that NCRAs might choose to reverse their policies in the future. The last two alternatives would serve to increase the accuracy of medical collections information on credit reports. The CFPB has determined that these three alternatives would not achieve the objective of protecting consumer privacy with respect to sensitive medical information.

After considering these significant alternatives, the CFPB declines to adopt them because none of the alternatives would achieve the objective of FCRA section 604(g)(2) to protect consumer privacy with respect to sensitive medical information, and thus are not appropriate methods for reducing the economic impact on small entities in the context of this rule.

7. Description of the steps the agency has taken to minimize any additional cost of credit for small entities

Because the rule will only affect how small consumer reporting agencies report and small creditors obtain or use consumers' medical information, the CFPB does not expect that the rule will affect the business lending market. The CFPB concludes that the costs of credit for small creditors and small consumer reporting agencies will not be impacted by the rule. Commenters, including the small entity representatives cited by Advocacy in its comment, stated the possibility of credit score creep increasing underwriting standards more broadly. To the extent that this happens, the cost of credit may rise for small business owners who rely on personal credit. However, because the share of consumers with medical collections on their consumer reports is only 5 percent at baseline, the CFPB views this possibility as unlikely.

IX. Paperwork Reduction Act

The CFPB has determined that the final rule would not impose any new information collections or revise any existing recordkeeping, reporting, or disclosure requirements on covered entities or members of the public that would be collections of information requiring approval by the Office of Management and Budget under the Paperwork Reduction Act.[365] The existing information collections contained in Regulation V, which implements the FCRA, are approved by OMB under OMB Control Number 3170-0002 which currently has an expiration date of October 31, 2025.

X. Congressional Review Act

Pursuant to the Congressional Review Act (5 U.S.C. 801 *et seq.*), the CFPB will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States at least 60 days prior to the rule's published effective date. The Office of Information and Regulatory Affairs has designated this rule as a "major rule" as defined by 5 U.S.C. 804(2).

XI. Severability

The CFPB intends that, if the consumer reporting agency prohibition on furnishing medical debt information finalized in § 1022.38 (or any provision or application of that section) is stayed or determined to be invalid, the amendments to § 1022.30 are severable and shall continue in effect. The CFPB also intends that if the amendments to § 1022.30 (or any provisions or applications of those amendments) were stayed or determined to be invalid, § 1022.38(b)(1) would not take (or continue in) effect, because it relies on the amendments to § 1022.30, but

[365] 44 U.S.C. 3501.

§ 1022.38(b)(2) is severable and shall continue in effect. Furthermore, if the result of a stay or judicial determination is that creditors are generally able to obtain or use medical information in connection with determinations of consumers' eligibility, or continued eligibility, for credit, the CFPB intends the prior version of § 1022.30(d) to continue in effect.

XII. Technical Appendix

This appendix describes the technical details of the CFPB's analysis that aims to estimate how medical collection consumer reporting affects consumer access to credit, considering an "equilibrium" in which all medical collection tradelines are removed from consumer reports, as under the rule. The analysis also compares the performance of new credit accounts that can be traced to creditors' inquiries for consumers that have medical collections. The analysis exploits a change in consumer reporting practices that occurred in 2017 that has prevented medical collections that are less than 180 days past their date of first delinquency from appearing on consumer reports obtained from the nationwide consumer reporting agencies (NCRAs).[366] As a result of this change, when consumers applied for credit in the 180 days before a medical collection tradeline was added to their consumer report, they had an outstanding medical debt that was in collections, but creditors would not have seen evidence of those medical collections on consumer reports when making determinations about whether to extend credit to the consumers.[367]

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[366] Assurance of Voluntary Compliance/Assurance of Voluntary Discontinuance (May 20, 2015), *In re Equifax Info. Servs.*, https://www.ohioattorneygeneral.gov/Files/Briefing-Room/News-Releases/Consumer-Protection/2015-05-20-CRAs-AVC.aspx.

[367] This practice continued through June 2022, when the 180-day period was extended to one year. PR Newswire, *Equifax, Experian and TransUnion Remove Medical Collections Debt Under $500 From U.S. Credit Reports* (Apr. 11, 2023), https://www.prnewswire.com/news-releases/equifax-experian-and-transunion-remove-medical-collections-debt-under-500-from-us-credit-reports-301793769.html.

1. Data Used

The data for this analysis are derived from the CFPB's Consumer Credit Information Panel (CCIP), a 1-in-50 de-identified nationally representative sample of credit records from one of the three NCRAs. The data include information on consumers' credit accounts, collections, public records, credit scores, and inquiries, which are creditor requests for consumer reports. Each credit account is described by a "tradeline," which includes the account's product type, balance amount, initial credit limit or loan principal, date of origination, anonymized firm identifier, and delinquency status.[368] Collections are also described by tradelines, which include the collection's balance amount, the original creditor's industry classification, and the date that the collection was added to the consumer report. Each inquiry includes the product type for which the consumer applied and the date that the inquiry was made. The sample used in the analysis includes all inquiries made by creditors within 180 days of a medical collection tradeline's addition to a consumer report. In other words, the sample includes inquiries made within 180 days of the time each medical collection became visible to creditors.

The CFPB created two datasets to estimate the effect of medical collection reporting on access to credit and credit account performance. The first dataset includes all inquiries made in the 180 days before and after each medical collection's addition to a consumer report (inquiry dataset). The second dataset includes the two-year performance of all credit account tradelines that can be traced back to an inquiry in the inquiry dataset (performance dataset).[369] Both datasets only include inquiries made and credit account tradelines opened in response to credit

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[368] Credit record data are described in detail by Christa Gibbs et al., *Consumer Credit Reporting Data* (forthcoming), J. Econ. Literature, https://www.aeaweb.org/articles?id=10.1257/jel.20241737&&from=f.

[369] The CFPB considered two-year delinquency as an outcome because it is the standard used in credit scoring models. VantageScore, *Credit Score Basics, Part 1: What's Behind Credit Scores?* (Nov. 2011), https://www.transunion.com/docs/rev/business/financialservices/VantageScore_CreditScoreBasics-Part1.pdf.

applications from consumers with medical collections. The analysis is limited to inquiries associated with medical collections first reported at least six months after the final implementation of the NCAP in September 2017, which ensured that all medical collections were identifiable as such and that all consumers with reported medical collections had a past-due medical bill for at least 180 days prior to the medical collection's appearance on their consumer report.[370] Given these constraints, the dataset includes inquiries associated with medical collections that were furnished to the NCRA that provides the CFPB's CCIP between March 2018 and July 2023.[371]

Each dataset in the primary sample includes a subsample of inquiries and tradelines that were associated with medical collection tradelines having initial balances over $500 and that were made when any other medical collection tradelines on the consumer report had initial balances over $500. This specification is referred to as the "over-$500" sample and mimics the current reporting environment in which medical collections under $500 are not included on

[370] Prior to NCAP, the field in credit record data indicating the original creditor type of a collections tradeline was optional and was left blank by the furnisher for around a quarter of all collections tradelines in the CCIP. Some of these tradelines with unreported original creditor type were likely medical collections tradelines. One component of the NCAP was to make the original creditor type a mandatory field, such that all medical collections reported after September 2017 can be identified as such.

[371] The sample is limited to inquiries associated with medical collections added to consumer reports between March 2018 and July 2023 because the dataset needs to include all inquiries made within a 361-day window of each medical collection. A medical collection reported before March 2018 may have an associated inquiry that was made before the September 2017 reporting change, while a medical collection reported after July 2023 may have an associated inquiry that was made after the final date of the CFPB's CCIP at the time of the research analysis, January 2024. The sample includes inquiries made in the 180 days before a medical collection is reported because all consumers have an outstanding medical collection during that period, and includes inquiries made in the 180 days after a medical collection is reported in order to have a balanced window. Additionally, note that the sample may omit some inquiries associated with medical collections. Some collections may not have been reported to all three NCRAs, so the CFPB may not observe all consumers' medical collections.

consumer reports.[372] The CFPB also created versions of the inquiry and performance datasets that do not make any restrictions on the dollar amount of medical collection tradelines and presents results for this "full sample" in parallel with those for the "over-$500 sample."

Creditors only observe the consumer reports of consumers that apply for credit, so the analysis is inherently limited to consumers that actively seek credit. The CFPB found in the proposed rule, and included in part VII.E.5, that there was a near-zero change in consumers' propensity to demand credit when medical collections under $500 were removed from consumer reports. The CFPB expects that the composition of consumers actively seeking credit will not be affected by the rule.

When a consumer has multiple medical collection tradelines, the data contain duplicates of the inquiries and credit account tradelines if they occur within 180 days of different medical collection tradelines. For example, suppose a consumer has two medical collection tradelines that are first reported on May 1 and on September 1. Suppose a creditor makes an inquiry on August 1. This inquiry will appear in the inquiry dataset twice: once for the May 1 collection, and once for the September 1 collection. Inquiries and credit account tradelines are also duplicated when consumers have multiple medical collection tradelines reported on the same day.

Three reporting changes occurred during the sample period that removed certain types of medical collections from consumer reports.[373] However, because the analysis exploits the date

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[372] The NCRAs removed medical collections with balances below $500 from consumer reports in April 2023. The datasets include inquiries made through January 2024, and so a small portion of the inquiries in the datasets were subject to this removal. All of these inquiries are included in the "over-$500" sample of the results. *See* PR Newswire, *Equifax, Experian and TransUnion Remove Medical Collections Debt Under $500 From U.S. Credit Reports* (Apr. 11, 2023), https://www.prnewswire.com/news-releases/equifax-experian-and-transunion-remove-medical-collections-debt-under-500-from-us-credit-reports-301793769.html.

[373] PR Newswire, *Equifax, Experian and TransUnion Remove Medical Collections Debt Under $500 From U.S. Credit Reports* (Apr. 11, 2023), https://www.prnewswire.com/news-releases/equifax-experian-and-transunion-remove-medical-collections-debt-under-500-from-us-credit-reports-301793769.html.

that a medical collection was added to a consumer report instead of the date it was removed from a consumer report, these changes do not undermine the general methodology of the analysis. The reporting changes do affect the types of medical collections that were on consumer reports when inquiries were made.[374] The CFPB first describes each of these three changes and their impact, before addressing the consequences for the analysis. First, all paid medical collections were removed from consumer reports in June 2022. Fewer than 2.5 percent of medical collections reported between January 2017 and March 2022 were ever marked as paid.[375] Second, medical collections that were between 180 days and 365 days past due were removed from consumer reports in June 2022, and the delay before medical collections could be added to consumer reports was permanently extended to one year. The CFPB does not have an estimate of how many medical collections were affected by this change, as the number of days that the medical debt is past due is not provided in the CCIP. Finally, all medical collections under $500 were removed from the NCRAs' consumer reports in April 2023. Combined, these reporting changes contributed to a large decline in the number of consumers with medical collection tradelines on their consumer report, from 14 percent of consumers in March 2022 to 5 percent of consumers in June 2023.[376]

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[374] Furthermore, the reporting changes may impact how creditors used medical collections in their credit eligibility determinations. For example, suppose creditors weighted medical collections more heavily in their determinations after the April 2023 reporting change. Then inquiries made with reported medical collections after April 2023 may have a lower success rate than inquiries made prior to the change. The estimated coefficient provides an average impact of medical collection reporting on inquiry success and cannot identify these potential changes in creditor behavior.

[375] Lucas Nathe & Ryan Sandler, Consumer Fin. Prot. Bureau, *Paid and Low-Balance Medical Collections on Consumer Credit Reports* (July 2022), https://www.consumerfinance.gov/data-research/research-reports/paid-and-low-balance-medical-collections-on-consumer-credit-reports/.

[376] Ryan Sandler & Zachary Blizard, Consumer Fin. Prot. Bureau, *Recent Changes in Medical Collections on Consumer Credit Records Data Point*, at 3-4, 17 (Mar. 2024), https://files.consumerfinance.gov/f/documents/cfpb_recent-changes-medical-collections-on-consumer-credit-reports_2024-03.pdf.

Because of these reporting changes for some inquiries that were made after a medical collection tradeline was first reported, the medical collection may not have been present on the consumer report by the date of the inquiry. For example, if a consumer had a medical collection with an initial balance less than $500 first reported in February 2023, and an inquiry in May 2023, the inquiry would be classified as occurring about three months after the collection but would not in fact have that collection tradeline included on the consumer report at the time of the inquiry. The CFPB expects this to attenuate the results, as inquiries made "with medical collection reporting" would have outcomes more similar to inquiries with the medical collection not yet reported. Medical collections reported before January 2022 would not have associated inquiries affected by any of these reporting changes.

The analysis of the performance dataset is not affected by the recent reporting changes. Because the focus is on two-year performance, the performance analysis only included tradelines opened before January 2022, as they require sufficient time to measure two-year performance. Therefore, the performance regressions are not impacted by these medical collection removals.

Commenters including a bank trade association commenter and a researcher stated that the time period considered in the proposal was not reflective of the current market because it was marked with instability in the medical debt collection environment, including pandemic-era changes and State policy changes. The CFPB acknowledges this limitation but finds it infeasible to study two-year delinquency risk without using accounts that were originated at least two years ago. Furthermore, because relatively few medical collections are included on consumer reports at baseline, the analysis needs to incorporate older data to have sufficient statistical power to

identify statistically significant effects.[377] The CFPB expects that any differences in consumer behavior as a result of these changes, compared to the current baseline, may affect the magnitude of the results but not the direction. For example, if mortgage forbearance caused fewer consumers with medical collections to become delinquent on their mortgages, the estimated difference in mortgage performance between consumers with reported medical collections and consumers with unreported medical collections may be smaller than at the current baseline. However, there should be no difference in the coefficient's sign if consumers with unreported collections are more likely, in any time period, to be seriously delinquent than consumers with reported medical collections because creditors use medical collection information to avoid bad debt risks.

Other commenters, including at least one researcher and at least one debt collector, stated that the analysis in the Technical Appendix to the proposed rule is subject to self-selection bias because only consumers actively seeking credit are included in the dataset. The inquiry and performance datasets are structured at the inquiry or credit account tradeline level, and not at the consumer or medical collection level. This means the analysis can be interpreted as modeling credit decisions and outcomes from creditors' perspective, rather than modeling the decisions of consumers or debt collectors.

Commenters, including at least one debt collector, health care provider, researcher, and individual, stated that the results of the Technical Appendix were skewed or too narrow because they were limited to medical collections with initial balances over $500. As described above, the

[377] Mary-Alice Doyle & Laura Feeney, *Quick Guide to Power Calculations*, Abdul Latif Jameel Poverty Action Lab, https://www.povertyactionlab.org/resource/quick-guide-power-calculations (last updated Mar. 2021).

CFPB also presents results for the full sample, regardless of medical collection balance amount. The results from this sample are similar to those in the primary sample, as described below.

Multiple researcher commenters stated that the results of the CFPB's analysis could not be validated or fully evaluated with the information included in the Notice of Proposed Rulemaking. Releasing the data would be a violation of the CFPB's contract with the NCRA that provides its CCIP, however, and courts have held that an agency can rely on confidential information in its rulemaking so long as the agency discloses information to allow interested parties to comment on the methodology and general data.[378] Here, the CFPB discussed its data set, provided information about its methodologies, and invited interested parties to comment. The CFPB considered the comments that addressed the analysis and has determined that the available evidence supports the choices made in the final rule. While some commenters also suggested that the CFPB erred in not obtaining peer review of its analysis, they did not articulate why peer review would be required in this rulemaking.

2. Construction of the Inquiry Dataset

Because inquiries in the dataset are made in the 180 days before and after a medical collection is reported, the inquiries in the dataset occurred between September 2017 and January 2024. The dataset includes the number and type of medical and nonmedical collection tradelines that were included on the consumer report at the time each inquiry was made.

Identifying unique medical collections over time in the CCIP may be imprecise; the CFPB assumes that unique medical collections are characterized by their dollar amounts, dates of medical collection account opening (usually the date the medical collection was assigned to the

[378] *See NRDC v. Thomas*, 805 F.2d 410, 418 n.13 (D.C. Cir. 1986); *see also Riverkeeper Inc. v. EPA*, 475 F.3d 83, 112 (2d Cir. 2007), *rev'd on other grounds*, 556 U.S. 208 (2009).

debt collector or other furnisher), and dates of the account's addition to the consumer report. Medical collections are rarely consistently reported for the full seven-year period for reporting adverse information permitted by the Fair Credit Reporting Act.[379] This poses challenges in tracking the same medical debt over time, as debts can disappear and reappear. Medical debts in collections are often transferred between debt collectors (*e.g.*, reassigned to a different collector by the health care provider or sold to a debt buyer), and when this happens the dates and dollar amounts associated with the medical collection tradelines may change, making it difficult to link these records. While these may be experienced as unique collections by the consumer as a new debt collector attempts to make contact, they may not be representative of the number of unique medical debts that each consumer has, as many of the debts are reflected by multiple subsequent collections.[380]

The inquiry dataset is used to estimate the impact of medical collection reporting on consumers' access to credit, as measured by inquiry success. The CFPB classifies an inquiry as "successful" if the inquiry leads to an open tradeline. This definition of "success" does not necessarily mean that the specific credit application that generated the inquiry was being approved. The CFPB cannot directly observe whether the specific credit application that generated the inquiry in question was approved, and it is challenging to infer approval for a specific inquiry for several reasons. First, the CCIP does not include inquiries made to other NCRAs, and creditors do not always make inquiries to all three NCRAs. The CCIP therefore

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[379] Consumer Fin. Prot. Bureau, *Paid and Low-Balance Medical Collections on Consumer Credit Reports* (July 27, 2022), https://www.consumerfinance.gov/data-research/research-reports/paid-and-low-balance-medical-collections-on-consumer-credit-reports/.

[380] A challenge in studying the impact of medical collections tradelines is that a shock to consumers' health, such as an injury or illness that results in hospitalization, may affect credit outcomes independently. Given this challenge, one benefit of these collection debt transfers is that it means that the medical expense that resulted in the medical collections tradeline is relatively more likely to have occurred long before the medical collection appeared.

includes credit account tradelines that cannot be matched to an inquiry. These tradelines cannot be included in the CFPB's analysis because the empirical strategy requires that one know the date of each tradeline's associated inquiry. Second, the CCIP does not include creditor names, but instead has an anonymized company identifier; however, a particular creditor often has a different identifier for inquiries and for opened credit account tradelines. Thus, even if the consumer opened a tradeline with the same creditor that pulled their consumer report, it may not be identifiable as such in the data. Therefore, the CFPB cannot be certain that the observed inquiry is associated with a specific opened tradeline. The CFPB instead follows approaches used in academic research and the CFPB's Consumer Credit Trends credit tightness series and assumes that a credit account is associated with an inquiry if it is opened within a certain number of days after the observed inquiry and is of the same credit account type.[381] The number of days varies for different account types because of differences in the typical length of time between an account application and origination.[382] Finally, when consumers shop for credit, multiple inquiries may be made in a narrow window of time, even though the consumer only intends to open one account. The CFPB assumes that multiple inquiries for one consumer within a certain shopping window indicate the consumer's shopping behavior, and therefore only the last of these inquiries is included in the datasets, where each credit account type's window length

[381] *See* Charles Romeo & Ryan Sandler, Off. of Rsch., Consumer Fin. Prot. Bureau, *The effect of debt collection laws on access to credit*, 195 J. Econ. (2021), https://ssrn.com/abstract=3124954; Consumer Fin. Prot. Bureau, *Credit Trends: Market dashboards* (Dec. 10, 2019), https://www.consumerfinance.gov/data-research/consumer-credit-trends/.

[382] The inquiries are considered to be within a shopping window if they are within 14 days for credit cards and auto loans, 120 days for mortgages, and 30 days for all other loan types, following approaches used in academic research and the CFPB's Consumer Credit Trends credit tightness series, both of which use data similar to the CCIP. *See* Charles Romeo & Ryan Sandler, Off. of Rsch., Consumer Fin. Prot. Bureau, *The effect of debt collection laws on access to credit*, 195 J. Econ. (2021), https://ssrn.com/abstract=3124954; Consumer Fin. Prot. Bureau, *Credit Trends: Market dashboards* (Dec. 10, 2019), https://www.consumerfinance.gov/data-research/consumer-credit-trends/.

is equivalent to its maximum time-to-origination.[383] For example, if a consumer had inquiries from mortgage lenders on April 1 and May 1, these would be treated as one observation, dated May 1, and it would be counted as a successful inquiry if a mortgage account was opened by August 29.

A researcher commenter restated the limitations described above, which were also described in the proposal, but characterized this discussion as indicating that the CFPB did not have a "clean standard" to identify inquiry success in the Technical Appendix to the proposed rule. As described above and in the rule, the CFPB's construction of inquiry success is the best available measure and has been used in academic research and the CFPB's policy research.

3. Construction of the Performance Dataset

The performance dataset includes all originated credit account tradelines that are associated with successful inquiries in the inquiry dataset. The match between credit account tradelines and inquiries is one-to-one: each tradeline is matched to one inquiry, and each inquiry is matched to, at most, one tradeline.[384] The CFPB calculated the two-year performance for each originated credit account tradeline, with performance success measured by whether the tradeline was ever 90 or more days delinquent (seriously delinquent) within the first two years of its origination date.[385] Because the CFPB focuses on two-year performance, credit account

[383] This follows approaches used in academic research and the CFPB's Consumer Credit Trends credit tightness series, both of which use data similar to the CCIP. *See* Charles Romeo & Ryan Sandler, Off. of Rsch., Consumer Fin. Prot. Bureau, *The effect of debt collection laws on access to credit*, 195 J. Econ. (2021), https://ssrn.com/abstract=3124954; Consumer Fin. Prot. Bureau, *Credit Trends: Market dashboards* (Dec. 10, 2019), https://www.consumerfinance.gov/data-research/consumer-credit-trends/.

[384] When multiple credit account tradelines within a time 14, 30, or 120 days of an inquiry (as appropriate for the type of credit) are observed, the tradeline with the earliest origination date is kept.

[385] Credit account tradelines are matched over time either using the tradeline's account number or the tradeline's date of account opening and loan type. Tradelines are matched on origination date and loan type when there is no match on account number because account numbers can change when an account is lost or transferred, *e.g.*, if a consumer loses their credit card and has a new card issued.

tradelines opened after January 2022 are not included in the analysis as the CFPB cannot observe a full two years after origination. The CFPB was able to identify the two-year performance of over 94 percent of the credit account tradelines opened before January 2022. The exceptions are accounts that stopped being reported by the furnisher before the end of two years.

4. Inquiry Summary Statistics

Table 5: Inquiry Summary Statistics[386]

	(1) Credit cards	(2) Mortgages	(3) Other Inq. Type
Panel A: Unsuccessful, Over $500 Sample			
Shopping window (days)	0.47	16.87	0.89
No. open mortgages	0.03	0.11	0.04
No. open credit cards	0.73	1.18	0.68
No. open other trades	0.61	0.82	0.64
Any D90+ trades	0.30	0.29	0.29
Credit score	563.89	613.81	566.76
Obs. (Unique Inquiries)	259532	44524	218127
Panel B: Successful, Over $500 Sample			
Shopping window (days)	1.00	42.74	1.11
No. open mortgages	0.07	0.23	0.07
No. open credit cards	1.36	1.85	1.11
No. open other trades	0.71	0.99	1.08

[386] Each panel in the table includes one observation per inquiry. All values are means. Panels A and B limit the sample to consumers with at least one inquiry that is associated with a medical collection over $500 and includes no medical collections on the consumer report under $500 when the inquiry is made. Panels C and D include the full sample. Panels A and C includes all inquiries that do not correspond to a tradeline opened within the inquiry type's origination window. Panels B and D includes all inquiries that can be matched to an originated tradeline. "Shopping window (days)" provides the length of the shopping window for each inquiry, where the shopping window is equal to zero if all inquiries are made on the same day. Variables providing the number of open accounts for a given credit account type, "No. open", describe the number of accounts of a given type that appeared on the consumer report in the month before the inquiry. "Any D90+ trades" is equal to one if the consumer had at least one tradeline (open or closed) that had been at least 90+ days delinquent in the last seven years included on their consumer report in the month before the inquiry. "Credit score" is equal to the credit score in the month before the inquiry. "Credit amount", "Two-year D90+", and "Past due amount" describe tradelines that opened in response to the inquiry, where "Credit amount" provides the credit limit of revolving accounts or credit account principal of installment accounts, "Two-year D90+" is equal to one if the account is at least 90 days delinquent within two years of its origination date, and "Past due amount" is the dollar amount past due on the account after two years. These variables cannot be included in Panels A and C because no account was opened in response to unsuccessful inquiries.

	(1) Credit cards	(2) Mortgages	(3) Other Inq. Type
Any D90+ delinquent trades	0.26	0.20	0.29
Credit score	624.44	673.12	602.45
Credit amount	1645.96	244846.31	5374.88
Two-year D90+	0.21	0.03	0.25
Past due amount	145.19	304.43	661.84
Obs. (Unique Inquiries)	117147	11188	13160
Panel C: Unsuccessful, Full Sample			
Shopping window (days)	0.46	16.09	0.86
No. open mortgages	0.03	0.12	0.04
No. open credit cards	0.69	1.15	0.64
No. open other trades	0.56	0.80	0.60
Any D90+ trades	0.30	0.30	0.30
Credit score	562.12	607.76	563.39
Obs. (Unique Inquiries)	892295	171704	761275
Panel D: Successful, Full Sample			
Shopping window (days)	0.97	40.69	1.06
No. open mortgages	0.08	0.26	0.06
No. open credit cards	1.32	1.84	0.98
No. open other trades	0.70	0.96	1.04
Any D90+ trades	0.27	0.20	0.30
Credit score	621.08	670.13	597.12
Credit amount	1582.59	238199.13	5597.18
Two-year D90+	0.20	0.03	0.23
Past due amount	125.17	201.84	598.32
Obs. (Unique Inquiries)	409209	42138	52669

Table 5 provides summary statistics for the unique inquiries in the data. The summary statistics are provided separately for "unsuccessful" inquiries that do not result in originated credit account tradelines, which are provided in Panels A and C, and for "successful" inquiries that can be associated to originated tradelines, which are provided in Panels B and D. Panels A and B are limited to the over-$500 sample, while Panels C and D provide summary statistics for the full sample. Table 5 shows that successful inquiries are associated with stronger credit profiles for every inquiry type and for both considered samples. The average successful credit

applicant has more open pre-existing credit account tradelines, fewer seriously delinquent pre-existing credit account tradelines, and a higher credit score in the month or quarter before inquiry was made than the average unsuccessful credit applicant.[387] The table also shows that successful credit applicants shop for longer than unsuccessful credit applicants in the sample. Panels B and D further include the average characteristics of credit accounts opened in response to successful inquiries, measuring the credit limit at time of origination, the past due amount, and serious delinquency status two years after origination, showing that credit cards are much more likely than mortgages to be seriously delinquent within two years from opening, perhaps in part because credit cards are unsecured. However, the average past due amount is lower for credit cards, perhaps because average credit card monthly minimum payments are much lower than mortgage monthly payment amounts.

5. Consumer Summary Statistics

Table 6: Consumer Summary Statistics[388]

	(1) Mean	(2) Median	(3) Obs. (Unique Consumers)
Panel A: Over $500 Sample			

[387] These characteristics are considered as of the month or quarter before the inquiry because they can be affected by the outcome of the inquiry. The month before the inquiry is used when data is available, but only quarterly data are available prior to 2020 for some variables.

[388] Each panel in the table includes one observation per consumer. All values are means. Panel A limits the sample to consumers with at least one inquiry that is associated with a medical collection over $500 and includes no medical collections under $500 on the consumer report when the inquiry is made. Panel B includes the full sample. "No. medical collections" provides the number of unique medical collections in the sample for each consumer. Because each observation in the analysis dataset corresponds to an inquiry, consumers may have additional medical collections that are not represented in the sample if there were no inquiries made in the 180 days before or after those medical collections were first reported. "Months between date of last med. coll. and date of first med. coll." provides the number of months between each consumer's medical collections, for those medical collections that are represented in the sample. The "No. inquiries" variables only include inquiries made in the 180 days before or after a medical collection was first reported; consumers may have other inquiries that are not included in the data if they

	(1) Mean	(2) Median	(3) Obs. (Unique Consumers)
No. medical collections	2.24	1.00	266147
Months between date of last med. coll. and date of first med. coll.	20.47	0.00	266147
No. credit card inquiries	1.42	1.00	266147
No. mortgage inquiries	0.21	0.00	266147
No. other inquiries	1.11	1.00	266147
Credit score at first inquiry	594.52	588.00	214485
Missing credit score at first inquiry	0.19	0.00	266147
Consumer age at first inquiry	40.29	38.00	261488
Northeastern share at first inquiry	0.08	0.00	266147
Midwestern share at first inquiry	0.15	0.00	266147
Southern share at first inquiry	0.61	1.00	266147
Western share at first inquiry	0.14	0.00	266147
Panel B: Full sample			
No. medical collections	4.08	2.00	688682
Months between date of last med. coll. and date of first med. coll.	35.77	10.92	688682
No. credit card inquiries	1.89	1.00	688682
No. mortgage inquiries	0.31	0.00	688682
No. other inquiries	1.52	1.00	688682
Credit score at first inquiry	596.10	590.00	558362
Missing credit score at first inquiry	0.19	0.00	688682
Consumer age at first inquiry	41.89	40.00	676075
Northeastern share at first inquiry	0.10	0.00	688682
Midwestern share at first inquiry	0.19	0.00	688682
Southern share at first inquiry	0.54	1.00	688682
Western share at first inquiry	0.16	0.00	688682

Table 6 provides summary statistics at the consumer level, using the first observation for each consumer observed in the inquiry dataset. On average, a consumer in the over-$500 sample experiences 2.24 medical collections that appear within 180 days of an inquiry. These medical

did not fall within these 361-day windows. Variables "at first inquiry" are provided for each consumer's earliest inclusion in the sample, as they may change within consumers over time. There are fewer consumer observations corresponding to average credit scores than for the other statistics in both panels because average credit score is only calculated using data from consumers whose credit scores are non-missing. There are also some consumers with missing birth year that are not included in the calculation of average age. State regional shares were calculated using Census Regions; *see* U.S. Census Bureau, *Geographic Levels*, https://www.census.gov/programs-surveys/economic-census/guidance-geographies/levels.html (last revised Oct. 8, 2021).

collections are, on average, approximately 20 months apart from the earliest to the latest reported. Nineteen percent of the consumers in the sample do not have a credit score in the month before their first inclusion in the sample; for consumers who do have a credit score, it is most often subprime.[389] More than 60 percent of consumers in the sample are located in Southern States, reflecting the disproportionate share of consumers with medical debt in the South documented in prior research.[390] These summary statistics support the generalizability of the results, as the sample of consumers is generally similar to the overall population of consumers with medical collections during this time period.[391]

One debt collector commenter stated that the CFPB should have instead considered all inquiries associated with medical collections over $500 instead of making the restriction, in the proposed rule, that these inquiries are not made when a medical collection under $500 is included on the consumer report. The CFPB chose not to change its construction of the over-$500 subsample because the relevant question is how inquiries would be evaluated under the rule, relative to the baseline, in which no medical collections under $500 are included on consumer reports. The over-$500 sample, as initially constructed, is the closest approximation for estimating the effects of the rule. Results are included for the full sample to show that the estimated effects are broadly similar for all inquiries associated with medical collections of any size. Furthermore, the summary statistics for consumers in the full sample are similar to those for

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[389] Consumer Fin. Prot. Bureau, *Borrower risk profiles*, https://www.consumerfinance.gov/data-research/consumer-credit-trends/student-loans/borrower-risk-profiles/ (last visited May 9, 2024).

[390] U.S. Census Bureau, *19% of U.S. Households Could Not Afford to Pay for Medical Care Right Away* (Apr. 7, 2021), https://www.census.gov/library/stories/2021/04/who-had-medical-debt-in-united-states.html.

[391] Consumer Fin. Prot. Bureau, *Paid and Low-Balance Medical Collections on Consumer Credit Reports* (July 27, 2022), https://www.consumerfinance.gov/data-research/research-reports/paid-and-low-balance-medical-collections-on-consumer-credit-reports/.

the over-$500 sample, but consumers in the over-$500 have nearly two fewer medical collections reported within 180 days of an inquiry in the sample. Though this at first may seem counterintuitive, this is because consumers with several medical collections often have at least one medical collection under $500 which removes them from the over-$500 subsample.

6. Empirical Strategy

The CFPB used a regression discontinuity in time (RDiT) design to estimate the effect of reported medical collections on consumers' access to credit and the performance of credit account tradelines resulting from creditors' inquiries. Regression discontinuity is a quasi-experimental design that, under certain assumptions, allows estimation of the causal effect of a treatment or intervention where a treatment is assigned by a threshold value of that variable.[392] In the present context, inquiries are "treated" when a medical collection tradeline is added to the NCRA's database. The date that a medical collection is added to a consumer report is the "threshold" that potentially creates a discontinuous effect on the studied dependent variables: inquiry success and two-year serious delinquency. Before this date, creditors cannot observe the medical collection on the consumer report at the time an inquiry is made, but the CFPB can observe using the CCIP that the consumer did have a medical debt in collections that would eventually be reported. The proximity of each inquiry to the threshold, referred to as the "running variable" in regression discontinuity terminology, is equal to the number of days between the date that the collection was first included on the consumer report and the date that the inquiry was made. When the inquiry date occurred after the medical collection reported date (or in other words, the medical collection was included on the consumer report before the inquiry

[392] Guido W. Imbens & Thomas Lemieux, *Regression discontinuity designs: A guide to practice*, 142(2) J. Econometrics, at 615-35 (Feb. 2008), https://www.sciencedirect.com/science/article/abs/pii/S0304407607001091.

was made), this running variable is greater than or equal to the "threshold" zero; for values less than or equal to zero, the medical collection was not included on the consumer report when the inquiry was made. The key assumption of a regression discontinuity analysis is that nothing is changing discontinuously across the threshold besides the treatment.

To analyze inquiry success, the CFPB estimated Equation 1 using the inquiry dataset:

$$Y_{ijk} = \alpha + \gamma D_{ijk} + \beta Z_{ijk} + \delta D_{ijk} \times Z_{ijk} + \epsilon_{ijk} \quad (1)$$

Where *i* is a consumer, *j* is an inquiry, and *k* is the medical collection associated with the inquiry. Y_{ijk} is a binary variable equal to one if the inquiry is successful, *i.e.*, if a tradeline is originated within 14 days for a credit card or auto loan, 120 days for a mortgage, or 30 days for other loans. D_{ijk} is the running variable, *i.e.*, the number of days after medical collection *k* was added to the consumer report that inquiry *j* was made. D_{ijk} is negative if the inquiry was made before the medical collection was added, and positive if the inquiry was made after. Z_{ijk} is a binary variable equal to one if the inquiry *j* was made after the date when collection *k* was reported. The coefficient of interest, β, represents the difference in the likelihood that an inquiry is successful for inquiries made after a medical collection is added, relative to inquiries made before. The intercept α allows estimation of a more flexible linear form.

The CFPB also estimated Equation 1 for the performance dataset, using the two-year performance of tradelines that can be traced to an inquiry included in the inquiry dataset as the dependent variable. The estimating equation is largely unchanged, though *j* is interpreted as a tradeline associated with an inquiry in the inquiry dataset (rather than the inquiry itself), and Y_{ijk} is a binary variable equal to one if the account is at least 90 days delinquent on the tradeline at any point within the first two years after the tradeline is originated (rather than if the inquiry is associated with a tradeline origination, as in the inquiry dataset regression).

In the results described below, the CFPB estimated six specifications to estimate impacts on inquiry success and account performance. The first specification is limited to the over-$500 sample, as defined above. The second and third specifications separate the over-$500 sample into two groups: inquiries that were made when the consumer had no nonmedical collections on their consumer report, and inquiries made when consumers had nonmedical collections on their consumer report. These specifications test whether reported medical collections affect inquiry success and better predict account performance for consumers with fewer other signals of negative information. The hypothesis is that the effects of a reported medical collection should be larger for inquiries made without nonmedical collections on the consumer report. If a consumer already has nonmedical collections, the appearance of a medical collection likely implies a smaller marginal change in expected delinquency risk. Finally, the CFPB then estimated each of these three specifications for all inquiries in the sample.

The CFPB only reports its estimates of the parameter β, which provides the effect of medical collection furnishing on inquiry success and account performance. Combined across the main results and balance tests described later, the CFPB estimated a total of 192 β coefficients, so the reported standard errors were adjusted using the Benjamini-Hochberg procedure, a method for accounting for multiple comparisons (under which it is more likely to find a statistically significant result by chance than in a one-off analysis).[393]

To justify the robustness of the main specification, the CFPB considers the potential threats to identification that can arise from RDiT specifications. RDiT varies from a standard regression discontinuity design because the running variable is not generally continuous. As

[393] *See* Yoav Benjamini & Yosef Hochberg, *Controlling the False Discovery Rate: A Practical and Powerful Approach to Multiple Testing*, 57(1) J. of the Royal Stat. Soc'y Series B (Methodological), at 289-300 (1995), http://www.jstor.org/stable/2346101.

summarized by an academic paper, RDiT designs can be biased if observations far from the threshold time period are used for identification, as there may be autoregressive properties or unobservable confounders.[394] This is often required in RDiT designs that have little cross-sectional variation, as the sample size can only grow by adding observations further from the threshold, rather than by adding additional cross-sectional units. A researcher commenter cited this concern in their critique of the CFPB's analysis. However, the data underlying the analysis discussed in this document contains ample cross-sectional variation, with 663,678 unique inquiries in the inquiry dataset and 401,027 unique tradelines in the performance dataset for the over-$500 sample. Furthermore, the analysis considers observations that are no more than 180 days from the threshold, minimizing the extent of possible autoregression.

In addition to these features of the datasets that limit the potential for bias arising from the RDiT design, the CFPB estimates the regressions using econometric best practices as implemented by a practitioner software package.[395] Standard errors are clustered by consumer to account for correlation within consumer observations over time. Additionally, the CFPB conducted several robustness checks to support the validity of the main design, described in detail after the discussion of the main results.

A researcher commenter stated that a consumer may take steps to improve their credit profile near the threshold time period, introducing bias into the model if the effects of these changes are erroneously attributed to the medical collection report. The CFPB finds it

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[394] Catherine Hausman & David S. Rapson, *Regression Discontinuity in Time: Considerations for Empirical Applications*, 10 Ann. Rev. of Res. Econ. (2018), https://www.annualreviews.org/content/journals/10.1146/annurev-resource-121517-033306.

[395] Specifically, the regressions are estimated using the Stata package rdrobust, implemented with a triangular kernel, a common mean-square-error-optimal bandwidth selector, and adjustments for mass points. Sebastian Calonico et al., *rdrobust: Software for regression-discontinuity designs*, 17:2 Stata J. (2017), https://rdpackages.github.io/references/Calonico-Cattaneo-Farrell-Titiunik_2017_Stata.pdf.

implausible that a consumer would choose to improve markers of their financial wellbeing over the short amount of time near the appearance of a medical collection on their consumer report. It estimates balance tests to test for this phenomenon in Tables 9 and 10 and finds no supporting evidence. Even if a consumer did improve their credit profile near the date that the medical collection is added to their consumer report, this would only attenuate results, as consumers with reported medical collections would look like better risks than they would absent this behavior. This would shrink the difference, from a creditor's perspective, between consumers with reported and unreported medical collections.

One researcher commenter stated that the CFPB should not have included the $D_{ijk} \times Z_{ijk}$ term in its regression equation because it is highly correlated with other variables in the regression equation, leading to multicollinearity bias. In fact this term, which is standard in RDiT equations, does not lead to multicollinearity bias and instead increases the precision of the estimated parameters. The term allows the relationship between the running variable and the outcome variable to change across the reporting threshold. Because some medical collections appear on a consumer report for fewer than 180 days, the slope between the running variable D_{ijk} and inquiry success Y_{ijk} may be positive for positive values of D_{ijk} because inquiries made farther from the medical collection report date are less likely to occur when the medical collection appears on the consumer report, likely leading to a greater likelihood of inquiry success. There is no similar expectation of a positive relationship in the 180 days before the medical collection is reported, *i.e.*, for negative values of D_{ijk}. The estimated parameter γ would conflate these two relationships if the interaction term is omitted from the regression equation.

A researcher commenter stated that the CFPB should have considered more heterogeneity between groups in the Technical Appendix of the proposed rule, such as a consumer's age, their

number of medical collections, and whether their medical collection has been disputed. While specific effects on these groups may be of general interest, the rule is not limited to certain subpopulations or types of medical collections, so the parameter of primary interest to the CFPB is the average effect taken over the entire population that has medical collections over $500, which mimics the current reporting environment.

One researcher commenter stated that the CFPB did not provide measures that can be used to assess model quality, primarily concerning a hypothetical in which consumers far from the regression discontinuity threshold receive too much weight in the analysis. The CFPB included just 180 days before and after the threshold to mitigate this concern, as well as using econometric best practices in its regression equation as described above. The commenter did not describe specific, actionable examples of the measures that would assuage their concern.

One NCRA commenter stated that the CFPB should have studied differences between consumers with medical collections and consumers without medical collections in the Technical Appendix of the proposed rule instead of limiting its focus to consumers with reported and unreported medical collections. The commenter stated that it was important to distinguish between consumers with and without medical collections because these groups have different payment performance.

The CFPB does not agree that a comparison between all consumers with medical collections and all consumers without medical collections is relevant to understanding the impacts of the rule. Although consumers with medical collections may have a different delinquency risk than consumers without medical collections, the rule will not change which consumers have outstanding medical collections. The rule instead changes whether medical collections appear on a consumer report that a creditor receives for the purpose of a credit

eligibility determination. The analysis discussed in this part considers whether creditors use medical collection information that appears on a consumer report to deny consumers with medical collections access to credit and limit their delinquency risk. This provides the closest understanding of the environment that would be created by the rule: consumers with reported medical collections are like the baseline while consumers with unreported medical collections are like the post-rule environment, and the CFPB's analysis compares them.

A researcher commenter stated that the CFPB should have used propensity score matching instead of a RDiT approach in the Technical Appendix of the proposed rule. The commenter suggested a design that would compare consumers with "hidden" medical debts, or consumers in the 180 days before their medical collection is added to their consumer report, to similar consumers without medical debt on their consumer reports.

The CFPB does not agree that a propensity score matching approach as suggested by the commenter would be appropriate. The CFPB could control for information included on consumer reports, but not unobservable variables like outstanding medical debt, as most medical debt is not included on consumer reports. Therefore, the consumers with hidden medical debt would be compared to consumers who, for the most part, do not have medical debt. Differences between these groups would not be related to the inclusion of a medical collection on consumer reports but would instead be driven by the presence of medical debt. This analysis would not be as relevant to the rule as the CFPB's analysis.

7. Results on Inquiry Success

The CFPB first uses the inquiry dataset to consider how medical collection reporting affects inquiry success. Importantly, an unsuccessful inquiry does not necessarily imply that the lender denied the credit application. Consumers may be approved for credit with worse terms than they would have received absent medical collection reporting and decline the offer of credit

as a result, or consumers may choose not to take up approved credit for idiosyncratic reasons. The CCIP does not include data on the terms of originated accounts or on credit approvals that do not lead to originated accounts. However, this is less likely to be an issue with credit cards because the CFPB understands that credit card accounts are generally issued automatically if the creditor approves an application, with little opportunity for a consumer to decline. The CFPB assumes that consumers' underlying demand for credit is unaffected by medical collection reporting, so changes in inquiry success across the reporting threshold can be attributed to creditors' denial of credit account applications or provision of worse terms, rather than changes in who applies. The CFPB justifies this assumption below.

Table 7: The Effect of Medical Collection Reporting on Inquiry Success[396]

	(1) Over $500	(2) Over $500, no NMC	(3) Over $500, NMC	(4) All	(5) No NMC	(6) NMC
Panel A: Credit cards						
RD Estimate	-0.047***	-0.072***	-0.029***	-0.033***	-0.049***	-0.022***
	(0.006)	(0.009)	(0.006)	(0.003)	(0.005)	(0.003)
	[-0.059,-0.036]	[-0.090,-0.055]	[-0.041,-0.018]	[-0.038,-0.027]	[-0.059,-0.040]	[-0.028,-0.017]
Avg. success	0.294	0.381	0.222	0.275	0.364	0.214
Observations	601230	267276	333954	3026355	1233571	1792784
Panel B: Mortgages						
RD Estimate	-0.026*	-0.040*	-0.003	-0.014	-0.013	-0.005
	(0.012)	(0.018)	(0.012)	(0.009)	(0.015)	(0.006)
	[-0.049,-0.004]	[-0.074,-0.006]	[-0.027,0.022]	[-0.031,0.004]	[-0.043,0.017]	[-0.016,0.006]
Avg. success	0.186	0.248	0.098	0.167	0.235	0.089
Observations	79372	46003	33369	439685	237413	202272
Panel C: Other credit accounts						
RD Estimate	-0.014*	-0.020*	-0.010	-0.015***	-0.024***	-0.010**
	(0.006)	(0.009)	(0.007)	(0.003)	(0.005)	(0.004)
	[-0.026,-0.003]	[-0.038,-0.002]	[-0.024,0.004]	[-0.021,-0.009]	[-0.033,-0.015]	[-0.017,-0.003]
Avg. success	0.242	0.307	0.197	0.246	0.316	0.205
Observations	469290	190942	278348	2484030	908849	1575181

Standard errors in parentheses, 95 percent confidence intervals in brackets

$* p < 0.1$, $** p < 0.05$, $*** p < 0.01$

[396] The table provides the regression discontinuity estimates for the inquiry dataset, separately by credit account type. Each coefficient (RD Estimate) estimates a percentage point effect of having an additional medical collection reported on inquiry success. These effects can be represented as percent changes by comparing to the baseline "Avg. success", which is calculated as the success rate of all inquiries made to the left of the regression discontinuity threshold (or without medical collection reporting). Column 1 limits the sample to inquiries associated with medical collection tradelines over $500 made when the consumer had no medical collection tradelines under $500 on their consumer report, which is then subset into Columns 2 and 3. Column 2 limits the sample to inquiries made when the consumer did not have a nonmedical collection tradeline (NMC) on their consumer report; Column 3, when consumers did have a nonmedical collection tradeline on their consumer report. Column 4 includes the full sample. Columns 5 and 6 are defined equivalently to Columns 2 and 3 for the full sample. Standard errors are clustered by consumer and adjusted using the Benjamini-Hochberg procedure.

Table 7 provides the results of the main regression discontinuity analysis on inquiry success. Each panel represents a different loan type, as products generally have different underwriting procedures. At a high level, several summary observations can be made. First, just over half of the inquiries in the full sample of the inquiry dataset are for credit cards. Only 7.4 percent of the inquiries in this sample are for mortgages, compared to almost 17 percent of all inquiries in the CCIP. This likely reflects the fact that most consumers in the sample have thin credit files[397] and subprime credit scores, and therefore may be less likely to apply for mortgages than for other types of credit, given the higher underwriting standards of mortgages.[398] Inquiry success rates are higher for all loan types when inquiries are made without nonmedical collection tradelines on the consumer report than when nonmedical collection tradelines are present, with differences as large as 15.9 percentage points. This is expected because consumers with less negative information on their consumer reports are more likely to be approved for credit or receive favorable terms. Perhaps less intuitively, average success rates for credit cards and mortgages are also generally higher for the subsample of inquiries made by consumers who only have medical collection tradelines over $500, if they have any. As discussed above, inquiries made by consumers with many medical collection tradelines are often excluded from the over-$500 sample because at least one of those medical collection tradelines is under $500. The average number of medical collection tradelines on a consumer report when an inquiry is made

[397] A thin credit file is a consumer report that contains fewer than five credit accounts. Jennifer White, Experian, *What is a Thin Credit File?* (May 25, 2022), https://www.experian.com/blogs/ask-experian/what-is-a-thin-credit-file-and-how-will-it-impact-your-life/.

[398] Consumers with credit scores below 500 may not be approved for a mortgage but can usually access secured credit cards. Louis DeNicola, Experian, *How to Buy a House with Bad Credit* (Oct. 7, 2023), https://www.experian.com/blogs/ask-experian/how-to-get-a-home-loan-with-bad-credit/; Consumer Fin. Prot. Bureau, *How to rebuild your credit* (July 2020), https://files.consumerfinance.gov/f/documents/cfpb_how-to-rebuild-your-credit.pdf.

in the full sample, in Column 4, across all loan types, is 5.03. Conversely, the average number of medical collection tradelines on a consumer report when an inquiry is made, for inquiries made with all medical collection tradelines greater than $500, in Column 1 is 1.08. Thus, the over-$500 sample is positively selected, *i.e.*, consumers in this sample have less negative information than consumers in the full sample, at least as measured by the number of medical collection tradelines present on their consumer reports. Despite the positive selection into the over-$500 sample, the CFPB expects these results to most closely represent the effects of removing all medical collection tradelines from consumer reports given the parallel with the NCRAs' current practice for under-$500 medical collection tradelines.

Turning to the regression estimates in Table 7, Column 1 of Panel A (credit cards) shows that a medical collection being reported causes a 4.7 percentage point decline in the likelihood of inquiry success for the over-$500 sample. This represents a 16.0 percent decline from relative to the average success rate for inquiries to the left of the regression discontinuity threshold (*i.e.*, inquiries made before the medical collection was reported). The effect is larger in absolute value for inquiries made when the consumer had no nonmedical collection tradelines on their consumer report, shown in Column 2, than when consumers had nonmedical collection tradelines on their consumer report, shown in Column 3. This supports the hypothesis that medical collection reporting has a larger effect on consumers without outstanding nonmedical collections. Columns 4 through 6 repeat the groups from Columns 1 through 3 but include the full sample. The regression result shown in Column 4 of Panel A describes a 3.3 percentage point, or 12.0 percent, decline in inquiry success for inquiries made with these larger medical collections reported relative to inquiries made without these medical collections reported. Again, effects are

larger in absolute value for inquiries made when consumers did not have nonmedical collection tradelines on their consumer report than when nonmedical collection tradelines were present.

The first three Columns of Panel B (mortgages) find relatively small and no more than marginally significant effects of medical collection reporting on mortgage inquiry success. Medical collection reporting reduces mortgage inquiry success by 2.6 percentage points, or 14.0 percent of its baseline level. The effect appears to be driven by inquiries made when there were no nonmedical collection tradelines on the consumer report, as the coefficient in Column 3 is statistically insignificant and small. However, the estimates in Columns 1 and 2 are only statistically significant at the 10 percent level.[399] All estimates for the full sample in Columns 4 through 6 are statistically insignificant. Using the 95 percent confidence interval for the coefficient in Column 4 of Panel B, it is possible to reject effects larger than a 3.1 percentage point, or 18.6 percent, decline in inquiry success for the full sample.[400]

Panel C provides results for all other types of credit accounts. The estimated effects are all smaller in magnitude than the results for credit cards and vary in statistical significance. The coefficients imply that medical collection reporting causes a 1.4 percentage point decline in the likelihood of inquiry success for non-mortgage and non-credit-card credit accounts for the over-$500 sample, or a 5.8 percent decline from the baseline inquiry success rate. Estimated effects

[399] That is, given the variability in the data, if medical collections had no effect on inquiry success, one would expect an estimate as large as those show in Columns 1 and 2 less than 10 percent of the time, but more than 5 percent of the time, through chance alone.

[400] The confidence intervals provided in brackets in the tables contain the true value of the parameter being estimated with 95 percent confidence, *i.e.*, if the CFPB had sufficient data to run this regression with 100 different samples, and estimated 100 different confidence intervals, one would expect 95 of these confidence intervals would contain the true value of the parameter. Therefore, the CFPB can reject coefficients outside of the bounds of its estimated confidence intervals as unlikely to be consistent with the true effect of medical collections reporting on inquiry success with 95 percent confidence.

are similar for the full sample. As with the effects on credit cards and mortgage inquiries, effects for both samples are larger for consumers without nonmedical collection tradelines.

8. Results on Account Performance

The estimated effects on inquiry success show that the underwriting procedures for many credit types penalize consumers for having medical collection tradelines on their consumer reports, with generally larger effects for consumers with medical collection tradelines over $500. The CFPB next considered whether this use of medical collection tradelines protects creditors from delinquency risk. If creditors use medical collection information to accurately predict whether consumers have high delinquency risk and deny their applications, then originated accounts resulting from a successful inquiry for a consumer with an unreported medical collection at the time of the inquiry would be more likely to be seriously delinquent than those resulting from a successful inquiry for a consumer with a reported medical collection. However, to the extent that creditors provide worse credit terms to consumers with reported medical collections and such worse credit terms increase the likelihood of serious delinquency, one might expect the opposite: Originated accounts resulting from an inquiry for a consumer with an unreported medical collection could be less likely to be seriously delinquent (because they received more affordable credit terms) than those resulting from an inquiry for a consumer with a reported medical collection (because they received worse credit terms). These opposing effects make it impossible to determine how the underlying delinquency risk of consumers with and without unreported medical collections varies. However, the results of this analysis are still informative as to how two-year delinquency rates are affected by medical collection reporting, net of the effects of application denials and the provision of worse terms.

Table 8: The Effect of Medical Collection Reporting on Two-Year Credit Account Performance[401]

	(1) Over $500	(2) Over $500, no NMC	(3) Over $500, NMC	(4) All	(5) No NMC	(6) NMC
Panel A: Credit cards						
RD Estimate	-0.000	0.002	-0.003	0.002	0.004	-0.005
	(0.012)	(0.014)	(0.021)	(0.006)	(0.007)	(0.008)
	[-0.023,0.023]	[-0.026,0.031]	[-0.045,0.038]	[-0.009,0.013]	[-0.010,0.018]	[-0.021,0.011]
Avg. D90+	0.231	0.190	0.293	0.223	0.171	0.284
Observations	96297	56423	39874	565680	305980	259700
Panel B: Mortgages						
RD Estimate	-0.011	-0.021	0.033	0.004	-0.006	0.034
	(0.014)	(0.014)	(0.034)	(0.007)	(0.006)	(0.019)
	[-0.039,0.017]	[-0.049,0.007]	[-0.033,0.100]	[-0.009,0.017]	[-0.018,0.007]	[-0.003,0.071]
Avg. D90+	0.035	0.025	0.069	0.038	0.029	0.065
Observations	10177	7944	2233	56976	43106	13870
Panel C: Other credit accounts						
RD Estimate	-0.012	-0.011	-0.009	-0.001	-0.002	-0.002
	(0.014)	(0.015)	(0.021)	(0.006)	(0.006)	(0.009)
	[-0.040,0.015]	[-0.041,0.019]	[-0.050,0.033]	[-0.012,0.011]	[-0.014,0.011]	[-0.019,0.016]
Avg. D90+	0.182	0.135	0.235	0.171	0.120	0.216
Observations	71760	36951	34809	459094	213481	245613

Standard errors in parentheses, 95 percent confidence intervals in brackets

$* p < 0.1$, $** p < 0.05$, $*** p < 0.01$

[401] The table provides the regression discontinuity estimates for the performance dataset, separately by credit account type. The results estimate effects on two-year 90-day delinquency rate for all accounts originated from a successful inquiry in the inquiry dataset. Each coefficient (RD Estimate) estimates a percentage point effect of having an additional medical collection reported on inquiry success. These effects can be represented as percent changes using the baseline "Avg. D90+", which is calculated as the 90-day delinquency rate of all inquiries made to the left of the regression discontinuity threshold (or without medical collection reporting). Column 1 limits the sample to inquiries associated with medical collection tradelines over $500 made when the consumer had no medical collection tradelines under $500 on their consumer report, which is then subset into Columns 2 and 3. Column 2 limits the sample to inquiries made when the consumer did not have a nonmedical collection tradeline (NMC) on their consumer report; Column 3, when consumers did have a nonmedical collection tradeline on their consumer report. Column 4 includes the full sample. Columns 5 and 6 are defined equivalently to Columns 2 and 3 for the full sample.

Table 8 shows the results of the main regression discontinuity analysis in the performance dataset. Across all loan types and subsamples, the estimated effects of medical collection reporting on serious delinquency are small and statistically insignificant. Column 1 of Panel A shows that, in the over-$500 sample, the CFPB can reject effects larger in absolute value than 2.3 percentage points, or 10.0 percent of the baseline delinquency rate, with 95 percent confidence. That is, it would be highly unlikely to find an estimate as small as what is reported in Table 8 through chance alone if having an unreported medical collection was associated with an increase in the rate of serious delinquency by 10 percent or more. The confidence interval is tighter and the central estimate more positive (*i.e.*, unreported medical collections associated with less delinquency) for inquiries made when consumers did not have nonmedical collection tradelines on their consumer report than when these collection tradelines were present. This means that the true effects for inquiries made without nonmedical collection tradelines are more likely to be positive. Further, if there is a difference in delinquency rate for consumers with unreported medical collections, these consumers are less likely to be delinquent than consumers with reported medical collections. This also holds for the full subsample in Columns 4 through 6.

These results broadly find that credit card lenders use medical collection information in underwriting, but do not reduce their two-year serious delinquency risk for originated credit account tradelines by doing so. Fewer accounts are originated to consumers with reported medical collections, but those that are originated are no less likely to be delinquent than accounts originated to consumers with unreported medical collections. This suggests that removing medical collections information from credit card underwriting would increase access to credit without negatively impacting the likelihood of serious delinquency for consumers with medical collections, all else equal.

The results in Panel B show qualitatively similar estimates for mortgages, but with less precisely estimated effects. The effects are less precise because the average serious delinquency rate is much lower for mortgages than for credit cards: only 3.5 percent of mortgages in the over-$500 sample are seriously delinquent within two years, compared to 23.1 percent of credit cards. The lower frequency in the dependent variable as well as the smaller sample size will naturally lead to wider confidence intervals. Column 1 shows that the CFPB can only reject marginal reductions in mortgage delinquency rates with reported medical collections that are larger in absolute value than 3.9 percentage points, or 111.4 percent of the baseline delinquency rate, with 95 percent confidence. For the full sample, the CFPB can reject marginal reductions larger in absolute value than 0.9 percentage points, or 23.7 percent of baseline delinquency rate. Though these results are too imprecise to allow the rejection of large effects, their statistical insignificance can be interpreted as suggestive that removing larger medical collection tradelines from mortgage underwriting would not cause increases in serious delinquency risk.

As for credit cards, the results for non-mortgage and non-credit-card accounts, shown in Table 8, are mostly statistically insignificant and small in magnitude. Again, the CFPB concludes that the use of medical collections information in underwriting does not reduce the delinquency risk of accounts originated to people with reported medical collections.

These results suggest that, absent consumer reporting of medical collections, the additional credit accounts that creditors provide to consumers whose medical collections would no longer be reported would be no more likely to be delinquent than the credit accounts creditors provide at baseline. In line with economic theory, the CFPB expects that creditors only provide credit if the account's expected profit is positive. Under this expectation, creditors would not provide accounts to consumers with unreported medical collections at baseline if they were not

profitable. However, it is possible that creditors currently provide those accounts not because they are profitable, but because they have no other mechanism for identifying and either denying the credit applications of, or changing the terms provided to, applicants with unreported medical collections. In this case, the rule would reduce profit for creditors by increasing the number of unprofitable loans in their portfolio.

The CFPB illustrates this concern with a simple example. Suppose that a creditor's applicant pool is equally divided across three nonoverlapping groups of consumers, which are identical in all attributes except for the presence of collections and delinquency risk. Assume that applicants with no collections have a delinquency risk of 1 percent and applicants with medical collections have a delinquency risk of 1.25 percent. Suppose for simplicity that a lender seeks to minimize their delinquency risk and is unwilling to provide loans if the expected delinquency rate is 1.2 percent or higher. If half of consumers with medical collections (or one-sixth of the total population) have those medical collections included on their consumer report at baseline, the lender provides loans to consumers with no collections and those with unreported medical collections, for an overall delinquency risk of 1.08 percent. If no medical collections were included on consumer reports, creditors would provide accounts to all consumers with no collections and with medical collections, for an overall delinquency risk of 1.13 percent.

Under this line of reasoning, the above results related to account performance would be unrelated to the consequences of the rule. It would be unsurprising that consumers with reported medical collections have the same underlying delinquency risk as consumers with unreported medical collections, because in the example delinquency risk is determined by the medical collection itself, and not as a consequence of consumer reporting. Instead, the relevant question

would be whether consumers with medical collections have a higher delinquency risk than consumers without medical collections, holding all else equal.

However, this example presupposes that delinquency risk is an inherent quality of consumers, rather than in part determined by the terms of credit extended to consumers. The dollar amounts and interest rates impact the likelihood of delinquency, as well as creditor revenue. These levers remain available to creditors under the rule and can be used to attenuate reductions in revenue that result from any increases in delinquency risk. Indeed, unlike in this simple example, the performance results in Table 8 show that creditors willingly provide accounts to people with reported medical collections at baseline. This requires that there exist terms for which credit accounts can be profitably, on expectation, provided to consumers with medical collections. Because creditors will not be able to differentiate between consumers with and without medical collections using information provided on consumer reports under the rule, any changes in terms of credit under the rule may impact all consumers, not just those with medical collections.

Furthermore, if the credit extended to consumers with unreported medical collections were unprofitable at the pre-rule baseline, the CFPB expects that creditors could request this information on credit applications to ensure they do not provide loans to these applicants or provide different terms. Credit applications commonly request information from consumers that may not be available on their consumer reports, such as their employment status or income. Given the relatively small share of medical debt that is included on consumer reports, creditors could request this information from consumers directly if it were a key determinant of account

profitability. At baseline, however, mortgage creditor applications, for example, ordinarily do not specifically request medical information.[402]

A researcher commenter described these results in the proposed rule, equivalent to Table 8, as showing that not having nonmedical debt, including products like student loans and auto loans, leads to higher rates of delinquency than having a product like a credit card. The commenter stated that these results suggested a problem with the CFPB's methodology for the Technical Appendix overall, as one would expect nonmedical debt to be associated with a greater rate of delinquency.

While the CFPB agrees with the general principle that counterintuitive results of any statistical analysis may warrant additional scrutiny, the commenter does not accurately characterize the analysis above, and the results are not counterintuitive in the way the commenter suggests, much less indicating a problem with the CFPB's methodology. The CFPB's analysis does not compare delinquency rates between consumers with and without nonmedical debt in general. Rather, as discussed above, the results in Table 8 include versions with the sample split by the presence or absence of nonmedical collections tradelines. Nonmedical collections are not equivalent to nonmedical forms of debt such as student loans or auto loans, as a debt only goes to collections after it is seriously delinquent. Further, comparing Columns 2 and 3 or Columns 5 and 6 shows that credit products originated to people with nonmedical collections have higher delinquency rates, on average, than credit products originated to people without nonmedical collections, as would be expected.

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[402] *E.g.*, Fannie Mae, *Uniform Residential Loan Application (Form 1003)*, https://singlefamily.fanniemae.com/delivering/uniform-mortgage-data-program/uniform-residential-loan-application (last visited Nov. 25, 2024).

The researcher commenter also stated that the results in the proposed rule equivalent to Table 8 showed that there was a near-significant impact of nonmedical debt on mortgage delinquency. Again, this is an inaccurate characterization of the analysis presented above. The CFPB did not estimate the effect of nonmedical debt on delinquency at all. Instead, the CFPB found one subsample—consumers with non-medical collections tradelines and medical collections of any dollar amount—for which the effect of having a medical collections tradeline reported on mortgage delinquency is positive and close to being statistically significant at 95 percent. This is shown in Column 6 of Panel B of Table 8. If the effect were estimated with statistical significance, it would suggest that consumers with reported medical collections in this subsample are more likely to become seriously delinquent on mortgages. Differences in the terms provided to consumers with reported and unreported medical collections could lead to these higher delinquency rates, but the CFPB expects that this result is more likely attributed to statistical noise, given the inconsistency with the results from the other subsamples studied.

The CFPB also considered whether to compare different credit scoring models, constructed with and without medical information, as a way to determine how well such models predict account performance. Such an approach, however, would call on the CFPB to design its own credit scoring models and determine what types and magnitude of differences between the results of the models were meaningful, and may depend more on the specifications of the models constructed than the actual rate of default in any studied population. The CFPB finds its regression discontinuity design and balance tests a more appropriate and reliable measure for how medical information improves creditors' ability to minimize their risk of default. The results of the CFPB's analysis of the performance of actual accounts indicate that creditors who use medical information do not reduce risk by doing so.

9. Results Related to Credit Demand and Selection

The results described in the previous two subsections suggest that creditors use medical collections information in their underwriting procedures, but this information does not enable them to originate accounts that are less likely to become seriously delinquent. This interpretation of the regression discontinuity results relies on the identifying assumption discussed above: the only difference between the inquiries made before and after a medical collection tradeline is added to a consumer report is the medical collection reporting itself, rather than that the application delinquency risk (quality) is lower for consumers with reported medical collections. This section discusses evidence supporting this identifying assumption.

Though the analysis benefits from ample observations near the threshold, as discussed above, RDiT specifications may still be affected by anticipation or selection effects if cross-sectional observations can sort themselves on either side of the threshold. In this setting, consumers may be less likely to apply for credit after a medical collection tradeline is added to their consumer report. If consumers with lower delinquency risk have more knowledge about when a medical collection tradeline will be added to their consumer report, they may be more likely to apply for credit immediately to the left of the threshold (*i.e.*, just before the medical collection tradeline is added to the consumer report). The CFPB first considered how the magnitude of credit demand changes across the reporting threshold by plotting the number of inquiries made in each week relative to the week of the medical collection tradeline's addition to the consumer report.

Figure 1: Inquiry Distribution Across Weeks[403]

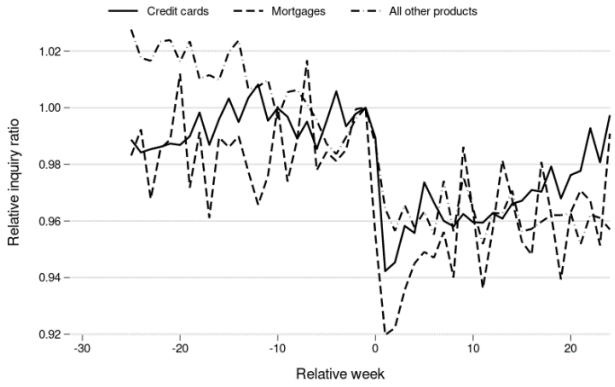

Figure 1 plots the number of inquiries made in each week relative to the week before the date a medical collection tradeline was added to a consumer report, represented as week zero. For all credit account products, credit demand is largely stable through the 25 weeks before the medical collection is reported, but there is an immediate reduction in the week that the medical collection is reported. Credit demand rebounds quickly from this initial drop but remains persistently lower for the 25 weeks after the medical collection is reported, only approaching its pre-report level by the final considered week for credit cards and mortgages. Though the reduction in credit demand is sharp around the week of the medical collection's first report, it is not large; at most, credit demand falls by 8 percent of the baseline (for mortgages).

Any reduction in credit demand corresponding to medical collection reporting may appear to threaten the identifying assumption, which requires that applications for credit made by consumers with reported medical collections only differ from those made by consumers whose medical collections were not yet reported because of the medical collection reporting itself, and

[403] This figure plots the number of inquiries made in each week within 180 days of the medical collection's first reported date. The number of inquiries is provided as a ratio, relative to the number of inquiries made in the week before the associated medical collection's first reported date. The first and last week of the 180-day window include only six days and are not plotted.

not because application quality differs. However, credit demand may fall for reasons that do not simultaneously affect credit application quality. For example, many NCRAs provide credit monitoring services that alert a consumer when a collection is added to their consumer report.[404] A consumer who planned to apply for credit may no longer do so if they are aware of a medical collection tradeline's negative effect on their credit score, which would affect their access to credit. The causality may also flow in the other direction if debt collectors track consumer reports and use "collection triggers" to focus their medical collection reporting after consumers apply for or open new credit accounts.[405] These mechanisms cannot be observed in the data but could explain the observed discontinuous decline in credit demand around medical collection reporting.

To estimate if credit application quality changes across the threshold, the CFPB estimated balance tests using Equation 1, where Y_{ijk} is equal to one of several variables that describe the consumer report at the time of the inquiry j. This estimates how inquiries made with reported medical collections differ from inquiries made with unreported medical collections. If such differences are large in absolute value and statistically significant, one might be concerned that there are underlying differences in the types of credit applications made when medical collections are reported that could be driving the regression discontinuity results, instead of the medical collection reporting itself. Finding small or imprecise coefficients would support the identifying assumption that the only difference in inquiries across the regression discontinuity threshold is the addition of a medical collection tradeline to the consumer report.

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[404] *See, e.g.*, Equifax, *Equifax Complete™*, https://www.equifax.com/personal/products/credit/monitoring-and-reports/ (last visited May 15, 2024).

[405] *See, e.g.*, Experian, *Collection Triggers℠: Monitoring your collections accounts*, https://www.experian.com/business/products/collection-triggers (last visited May 15, 2024).

Table 9: Inquiry Balance Tests[406]

	(1) Credit card	(2) Mortgage	(3) Other credit accounts
Panel A: Over $500 sample			
RD Estimate	0.117	0.257	0.118
	(0.172)	(0.464)	(0.172)
Avg. consumer age	39.295	41.430	38.637
RD Estimate	-3.208**	4.034	-0.540
	(1.192)	(3.572)	(1.255)
Avg. credit score	576.254	617.565	569.366
RD Estimate	0.012**	-0.001	0.008
	(0.005)	(0.009)	(0.005)
Avg. missing credit score	0.197	0.074	0.151
RD Estimate	0.032	0.050	0.026
	(0.035)	(0.115)	(0.039)
Avg. num. open loans	1.328	1.997	1.275
RD Estimate	-0.001	-0.010	-0.008
	(0.005)	(0.012)	(0.006)
Avg. any D90+	0.265	0.256	0.268
RD Estimate	49.549	-259.894*	29.122
	(63.234)	(149.575)	(72.823)
Avg. tot. past due am.	1131.626	1155.664	1276.969
Panel B: Full sample			
RD Estimate	0.072	-0.111	-0.077
	(0.077)	(0.235)	(0.087)
Avg. age	41.092	43.078	40.784
RD Estimate	-1.472*	1.868	-0.817
	(0.590)	(1.990)	(0.642)
Avg. credit score	569.811	606.276	561.472
RD Estimate	0.007**	0.002	0.005*
	(0.003)	(0.004)	(0.003)
Avg. missing credit score	0.171	0.073	0.134
RD Estimate	-0.010	-0.092	-0.010
	(0.020)	(0.047)	(0.018)
Avg. num. open loans	1.122	1.749	1.065

[406] The table includes balance tests for the inquiry sample. Panel A limits the sample to inquiries associated with a medical collection tradeline over $500 and no medical collection tradelines under $500 on the consumer report when the inquiry is made. Panel B includes the full sample. These balance tests estimate Equation 1 using characteristics from the consumer's consumer report in the month before the creditor makes an inquiry. "RD Estimate" provides the estimate for β when the dependent variable is the variable whose average is provided. Each column limits the sample by inquiry type. "Any D90+" describes whether any open or closed account on the consumer report is at least 90 days delinquent, and "tot. past due am." describes the total amount past due or charged off across all accounts. Standard errors are clustered by consumer and adjusted using the Benjamini-Hochberg procedure.

	(1) Credit card	(2) Mortgage	(3) Other credit accounts
RD Estimate	0.001	-0.000	0.000
	(0.003)	(0.006)	(0.004)
Avg. any D90+	0.262	0.260	0.267
RD Estimate	-33.152	-72.382	70.836
	(42.478)	(76.899)	(40.274)
Avg. tot. past due am.	1073.628	1135.919	1190.611

Standard errors in parentheses

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$

Table 10: Performance Balance Tests[407]

	(1) Credit card	(2) Mortgage	(3) Other credit accounts
Panel A: Over $500 sample			
RD Estimate	0.261	0.294	0.200
	(0.296)	(0.894)	(0.366)
Avg. consumer age	41.404	42.692	40.184
RD Estimate	-3.694	7.807	0.502
	(2.012)	(7.099)	(2.608)
Avg. credit score	618.329	668.427	601.025
RD Estimate	-0.005	0.005	0.002
	(0.006)	(0.010)	(0.007)
Avg. missing credit score	0.078	0.014	0.099
RD Estimate	0.286***	0.564*	0.089
	(0.092)	(0.340)	(0.092)
Avg. num. open loans	1.884	2.834	1.804
RD Estimate	0.017	-0.019	-0.002
	(0.009)	(0.027)	(0.013)
Avg. any D90+	0.248	0.191	0.268
RD Estimate	175.228	-332.580	16.765
	(112.690)	(302.978)	(180.777)
Avg. tot. past due am.	1034.492	673.171	1220.532
Panel B: Full sample			
RD Estimate	0.411**	0.871	0.068
	(0.154)	(0.630)	(0.200)
Avg. consumer age	43.264	44.083	42.246
RD Estimate	-1.670	-0.602	-1.194
	(0.921)	(3.340)	(1.197)
Avg. credit score	611.625	660.599	590.484
RD Estimate	-0.001	0.002	-0.000
	(0.003)	(0.005)	(0.004)
Avg. missing credit score	0.057	0.016	0.087
RD Estimate	-0.027	-0.162	0.029
	(0.042)	(0.157)	(0.045)
Avg. num. open loans	1.671	2.588	1.530
RD Estimate	0.003	-0.028	0.007
	(0.005)	(0.016)	(0.007)
Avg. any D90+	0.256	0.189	0.274
RD Estimate	82.685	-135.890	35.141
	(88.985)	(138.828)	(76.515)
Avg. tot. past due am.	1005.487	609.676	1191.860

Standard errors in parentheses

$* p < 0.1$, $** p < 0.05$, $*** p < 0.01$

Table 9 provides results for the inquiry dataset and Table 10 provides results for the performance dataset. Nearly all coefficients are not statistically significant, and where there is statistical significance, the magnitude of the coefficient is never larger than 20 percent of the mean value. This implies that credit applications submitted by consumers with reported medical collections are similar to those submitted by consumers whose medical collections are not yet on their consumer reports at the time of application, and differences in inquiry success and account performance can be attributed to the medical collection reporting itself.

If all credit accounts were equivalent in their terms, and delinquency risk was an immutable characteristic of consumers, one may instead expect creditors to require applicants with reported medical collections to have credit profiles that reflect lower risk than those without reported medical collections, because consumers with reported medical collections have an additional, potentially negative, signal on their consumer report. Consider, under these assumptions, a simple example in which a creditor only provides credit to applicants whose expected delinquency risk is less than 10 percent. Suppose also that the presence of at least one medical collection increases an applicant's true delinquency risk by 1 percentage point. In this case, creditors will provide accounts to consumers whose true delinquency risk is between 0 and 11 percent for applicants with unreported medical collections, and between 0 and 10 percent for

[407] The table includes balance tests for the performance sample. Panel A limits the sample to inquiries associated with a medical collection tradeline over $500 and no medical collection tradelines under $500 on the consumer report when the inquiry is made. Panel B includes the full sample. These balance tests estimate Equation 1 using characteristics from the consumer's consumer report in the month before the creditor makes an inquiry. "RD Estimate" provides the estimate for β when the dependent variable is the variable whose average is provided. Each column limits the sample by inquiry type. "Any D90+" describes whether any open or closed account on the consumer report is at least 90 days delinquent, and "tot. past due am." describes the total amount past due or charged off across all accounts. Standard errors are clustered by consumer and adjusted using the Benjamini-Hochberg procedure.

applicants with reported medical collections. If risk is equally distributed across the population, on average, a consumer offered credit with unreported medical collections would be 0.5 percentage points more likely to be delinquent than a consumer offered credit with reported medical collections.[408]

To the contrary, the balance tests estimated in Table 10 show that there are no sizable and statistically significant differences between the credit profiles of consumers with reported or unreported medical collections that open credit accounts, for the considered possible differentiating variables. These balance tests suggest two possible explanations:

First, some creditors could use medical collection information to deny all applicants with such information, while other creditors could disregard this information. In this case, creditors that ignore medical collections information would provide credit to the same types of consumers on either side of the regression discontinuity threshold, thus not causing a discontinuous change in the delinquency risk of approved consumers. The findings in Table 7 would be explained by creditors that deny all consumers with reported medical collections, but these creditors would not contribute to estimating the delinquency risk of consumers with reported medical collections; there is no delinquency rate to measure because these consumers did not open an account. These differences in creditors' understanding of the usefulness of medical collection information could explain the statistically insignificant differences in delinquency rates across the regression discontinuity threshold shown in Table 8.

Second, creditors could provide different terms to consumers with reported medical collections, which may impact their delinquency risk. Consumers with reported medical

[408] In this example, the average delinquency rate for credit recipients with unreported medical collections is 5.5 percent, compared to 5 percent for credit recipients with reported medical collections.

collections may appear to be better credit risks than consumers with unreported medical collections (on a differentiating variable for which the balance tests were not estimated because the CFPB does not have the relevant data), but if they are provided worse terms, those terms may increase their delinquency risk above what it would have been had they received the terms provided to consumers with unreported medical collections. Additionally, consumers with lower delinquency risk may be less likely to take up an offered loan with worse terms. If, in the example above, consumers with a delinquency risk between 0 and 1 percent choose not to take up an offered credit account when their medical collection is reported and they are provided worse terms, the average delinquency rate would be 5.5 percent for consumers with reported medical collections, as in the sample of consumers with unreported medical collections.[409]

The CFPB does not have information about the terms of credit provided to consumers with reported or unreported medical collections, or information about credit application approvals that are not taken up by consumers, and therefore cannot estimate the extent to which the delinquency results are driven by either possible explanation. Regardless of the underlying mechanism, the CFPB concludes that even when creditors, at baseline, use medical collection information, they do not reduce their underlying delinquency risk by doing so. This suggests that differences in inquiry success and account performance can be attributed to the medical collection reporting itself, rather than a change in the consumer's risk of default arising from the underlying medical debt. Therefore, removing this information under the rule will lead creditors to provide more credit accounts to consumers that are similar in delinquency risk to the credit accounts they already provide.

[409] In this example, consumers with reported medical collections that originate an account have a delinquency rate between 1 and 10 percent, and consumers with unreported medical collections that originate an account have a delinquency rate between 0 and 11 percent. The average delinquency rate for both groups is 5.5 percent.

Two researcher commenters stated that the CFPB needed to include control variables in its regressions, specifically suggesting State of residence, credit score, or credit balances. One of these commenters stated these variables may need to be controlled for if they are correlated with either inquiry success or account performance and change discontinuously around the medical collection reporting threshold date, citing academic literature.[410]

The CFPB does not agree that including controls for State of residence, credit score, or credit balances is necessary or appropriate. If these control variables were correlated with inquiry success or account performance and changed discontinuously across the threshold date, estimating balance tests on these control variables would lead to statistically significant and large effects, but Tables 9 and 10 find no evidence in support of this hypothesis. The CFPB did not estimate balance tests for State of residence but finds it implausible that sufficiently many consumers would change States in response to a medical collection (so that a consumer's State correlated with the time between the inquiry and the medical collection report) that the move would discontinuously impact either inquiry success or account performance. Instead, the CFPB interprets its coefficients as an average of effects across all states, weighted by the number of inquiries included in the sample from each State. Additionally, the CFPB included in the Notice of Proposed Rulemaking, and reproduced below, a version of its results including control variables for day-of-week effects. These are the only effects mentioned as likely needed control variables in the academic literature cited by a commenter, but they do not meaningfully change the results.[411]

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[410] Catherine Hausman & David S. Rapson, *Regression Discontinuity in Time: Considerations for Empirical Applications*, 10 Ann. Rev. of Res. Econ. (2018), https://www.annualreviews.org/content/journals/10.1146/annurev-resource-121517-033306.

[411] *Id.*

To further test for the presence of anticipation or selection effects, the CFPB estimated a "donut" regression that removes from the sample all inquiries made within seven days of their associated medical collection's addition to the consumer report. If the regression estimates are driven by anticipation or selection, the effects would be much smaller when estimated without observations near the reporting threshold, as application quality would be less selected from the threshold. In addition, medical collections may not be reported to all three NCRAs on precisely the same date. The creditors that make inquiries to the NCRA that provides the CFPB's CCIP may observe a medical collection on an inquiry they make to a different NCRA and use this information, even though it appears in the CCIP that the medical collection was not reported. Additionally, the construction of inquiry shopping windows and inherent imprecision in connecting inquiries to opened tradelines may further limit the accuracy of calculating the running variable to a precise day. This is especially important near the reporting threshold because a one-day error in assigning the date a medical collection was reported or an inquiry was made could be sufficient to erroneously categorize the medical collection reporting status of an inquiry. The CFPB further considered variation in dates within inquiry shopping windows below.

Table 11: The Effect of Medical Collection Reporting on Inquiry Success and Credit Account Performance, Using a 14-Day Donut[412]

	(1) Over $500, Success	(2) Over $500, D90+	(3) All, Success	(4) All, D90+
Panel A: Credit cards				

[412] The table provides regression discontinuity estimates for the inquiry and performance datasets, separately by credit account type, and omitting all inquiries made within seven days of the associated medical collection's reporting date, making a 14-day "donut hole" of omitted inquiries. Each coefficient (RD Estimate) estimates a percentage point effect of having an additional medical collection reported on inquiry success (in Columns 1 and 3) using the inquiry dataset or 90-day delinquency (in Columns 2 and 4) using the performance dataset. These effects can be represented as percent changes by comparing to a baseline "Avg. dep. var.", which is calculated as the success rate or 90-day delinquency rate of all inquiries made to the left of the regression discontinuity threshold (or without medical collection reporting). Columns 1 and 2 limit the sample to inquiries associated with medical

	(1) Over $500, Success	(2) Over $500, D90+	(3) All, Success	(4) All, D90+
RD Estimate	-0.060***	-0.006	-0.041***	0.008
	(0.0080	(0.015)	(0.005)	(0.008)
	[-0.075,-0.045]	[-0.036,0.024]	[-0.050,-0.032]	[-0.009,0.024]
Avg. dep. var.	0.294	0.232	0.275	0.223
Observations	578088	92708	2908047	543865
Panel B: Mortgages				
RD Estimate	-0.037**	-0.022	-0.043***	-0.003
	(0.017)	(0.025)	(0.008)	(0.011)
	[-0.071,-0.004]	[-0.071]	[-0.060,-0.027]	[-0.026,0.019]
Avg. dep. var.	0.186	0.035	0.167	0.038
Observations	76358	9797	422584	54818
Panel C: Other Credit Accounts				
RD Estimate	-0.009	-0.038	-0.010*	0.008
	(0.009)	(0.025)	(0.004)	(0.010)
	[-0.027,0.009]	[-0.087,0.012]	[-0.018,-0.002]	[-0.012,0.027]
Avg. dep. var.	0.242	0.182	0.245	0.171
Observations	451474	69159	2387333	441523

Standard errors in parentheses, 95 percent confidence intervals in brackets

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$

Table 11 provides the "donut" specification regression results. By comparing Column 1 of Table 7 to Column 1 of Table 11 and comparing Column 4 of Table 7 to Column 3 of Table 11, one can observe that effects on inquiry success are larger in absolute magnitude and more statistically significant for credit cards and mortgages in the donut specification than in the main specification. This shows that the main results using the inquiry data are not driven by selection or anticipation effects. Instead, the results in the main specification may be attenuated by fuzziness in the date that the medical collection was reported or that the inquiry was made, as discussed above.

collection tradelines over $500 made when the consumer had no medical collection tradelines under $500 on their consumer report. Columns 3 and 4 include the full sample. Standard errors are clustered by consumer and adjusted using the Benjamini-Hochberg procedure.

Despite the modest differences between Table 11 and Table 7 for the inquiry dataset, there are no meaningful differences in the magnitude or statistical significance of effects for the performance datasets, as shown by comparing Column 1 of Table 8 to Column 2 of Table 11 and comparing Column 4 of Table 8 to Column 4 of Table 11. This provides further evidence that the use of medical collection reporting in underwriting does not improve account performance.

A final concern is that it could be problematic if there is bunching at certain values of the running variable because the likelihood of a medical collection being reported, or an inquiry being made, differs across days of the week. For example, fewer than 4 percent of the medical collection tradelines associated with inquiries in the inquiry dataset were reported on a Sunday, compared to nearly 28 percent reported on a Tuesday. The distribution of inquiries in the inquiry dataset (across all inquiry product types) is more even, with a low of 8.5 percent on Sunday, just over 15 percent on Monday through Friday, and nearly 14 percent on Saturday. Combining these two features, an inquiry made on a Monday is more likely to correspond to a medical collection tradeline on the subsequent day than an inquiry made on a Saturday. If the types of inquiries made on Mondays differ from those made on Saturdays, there may be disproportionately more inquiries made on Monday for the running variable value immediately before the threshold (equal to -1), which could cause selection bias in the estimated effect. To test whether this selection biases the regression results, the CFPB estimated an additional specification that adds binary indicator variables to the main specification for the day of the week of each observation's inquiry date and date of the medical collection report.

Table 12: The Effect of Medical Collection Reporting on Inquiry Success and Credit Account Performance, Controlling for Day-of-Week Effects[413]

	(1) Over $500, Success	(2) Over $500, D90+	(3) All, Success	(4) All, D90+
Panel A: Credit cards				
RD Estimate	-0.048***	-0.002	-0.034***	0.001
	(0.006)	(0.012)	(0.003)	(0.006)
	[-0.059,-0.038]	[-0.024,0.021]	[-0.039,-0.028]	[-0.010,0.012]
Avg. dep. var.	0.294	0.231	0.275	0.223
Observations	601230	96297	3026355	565680
Panel B: Mortgages				
RD Estimate	-0.027*	-0.017	-0.014	0.005
	(0.011)	(0.015)	(0.009)	(0.007)
	[-0.049,-0.004]	[-0.045,0.012]	[-0.032,0.003]	[-0.008,0.018]
Avg. dep. var.	0.186	0.035	0.167	0.038
Observations	79372	10177	439685	56976
Panel C: Other credit accounts				
RD Estimate	-0.014*	-0.015	-0.015***	-0.002
	(0.006)	(0.014)	(0.003)	(0.006)
	[-0.026,-0.003]	[-0.042,0.013]	[-0.021,-0.010]	[-0.013,0.010]
Avg. dep. var.	0.242	0.182	0.246	0.171
Observations	469290	71760	2484030	459094

Standard errors in parentheses, 95 percent confidence intervals in brackets

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$

[413] The table provides regression discontinuity estimates for the inquiry and performance datasets, separately by credit account type, and including binary control variables for the day of the week that the inquiry was made (or the inquiry shopping window's last date) and the day of the week of the associated medical collection tradeline's addition to the consumer report. Each coefficient (RD Estimate) estimates a percentage point effect of having an additional medical collection reported on inquiry success (in Columns 1 and 3) in the inquiry dataset or 90-day delinquency (in Columns 2 and 4) in the performance dataset. These effects can be represented as percent changes by comparing to a baseline "Avg. dep. var.", which is calculated as the success rate or 90-day delinquency rate of all inquiries made to the left of the regression discontinuity threshold (or without medical collection reporting). Columns 1 and 2 limit the sample to inquiries associated with medical collections over $500 made when the consumer had no medical collection tradelines under $500 on their consumer report. Columns 3 and 4 include the full sample. Standard errors are clustered by consumer and adjusted using the Benjamini-Hochberg procedure.

Table 12 provides the regression results for a version of Equation 1 that includes day-of-the-week controls. Results are very similar to the main specification, as can be seen by comparing Column 1 of Table 7 to Column 1 of Table 12, Column 4 of Table 7 to Column 3 of Table 12, Column 1 of Table 8 to Column 2 of Table 12 and comparing Column 4 of Table 8 to Column 4 of Table 12. The CFPB concluded that the main results are not caused by bias in the distribution of inquiry or medical collection timing across days of the week.

10. Results Related to Credit Shopping

As described above, the main specification defines the running variable using the date of the last inquiry observed within the inquiry shopping window. This creates imprecision in the measurement of the inquiry date for inquiry observations that reflect shopping windows with multiple inquiries if they were not made on the same date.[414] Because this imprecision could attenuate results, the CFPB estimated Equation 1 separately for inquiry observations that reflect multi-inquiry-date shopping windows (Shopping) and for inquiry observations that reflect shopping windows that only contain one inquiry date (No Shopping). The CFPB estimated this robustness check for the inquiry dataset first, and then for the performance dataset.

Table 13: The Effect of Medical Collection Reporting on Inquiry Success, Separated by Shopping Behavior[415]

	(1) Over $500, Shopping	(2) Over $500, No shopping	(3) All, Shopping	(4) All, No shopping
Panel A: Credit cards				

[414] Note that there may be imprecision in assignment of inquiry date for all inquiries, even those associated with no other inquiries within a shopping window, because the CFPB's CCIP only contains inquiries made to one NCRA.

[415] The table provides regression discontinuity estimates for the inquiry and performance datasets, separately by credit account type, and separately by shopping behavior. Each coefficient (RD Estimate) estimates a percentage point effect of having an additional medical collection reported on inquiry success (in Columns 1 and 3) in the inquiry dataset or 90-day delinquency (in Columns 2 and 4) in the performance dataset. These effects can be represented as percent changes by comparing to a baseline "Avg. dep. var.", which is calculated as the success rate or 90-day delinquency rate of all inquiries made to the left of the regression discontinuity threshold (or without

	(1) Over $500, Shopping	(2) Over $500, No shopping	(3) All, Shopping	(4) All, No shopping
RD Estimate	-0.043	-0.050***	0.000	-0.035***
	(0.020)	(0.005)	(0.013)	(0.003)
	[-0.082,-0.003]	[-0.060,-0.039]	[-0.025,0.026]	[-0.040,-0.030]
Avg. success	0.445	0.279	0.422	0.262
Observations	51481	549749	250319	2776036
Panel B: Mortgages				
RD Estimate	-0.019	-0.022	-0.041***	-0.002
	(0.028)	(0.011)	(0.014)	(0.011)
	[-0.074,0.037]	[-0.043,-0.001]	[-0.068,-0.014]	[-0.024,0.020]
Avg. success	0.329	0.123	0.308	0.111
Observations	24266	55106	126393	313292
Panel C: Other credit accounts				
RD Estimate	0.002	-0.016*	-0.015	-0.015***
	(0.015)	(0.006)	(0.007)	(0.003)
	[-0.030,0.027]	[-0.029,-0.004]	[-0.029,-0.001]	[-0.021,-0.008]
Avg. success	0.391	0.213	0.394	0.217
Observations	77603	391687	400620	2083410

Standard errors in parentheses, 95 percent confidence intervals in brackets

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$

Table 13 shows results for inquiry success for inquiries associated with multi-date versus single-date shopping windows. For credit cards and other non-mortgage accounts, the results are only statistically significant for single-date shopping windows and are also larger in absolute magnitude. Fewer than 10 percent of credit card inquiries are associated with multi-date shopping windows, which is expected given the small average shopping windows for credit cards shown in Table 5. Alternatively, the only statistically significant result for mortgages appears for inquiries associated with multi-date shopping windows in the full sample. This limited ability to identify a precise effect is reflected in the main specification as well, as shown in Table 7. The CFPB concluded that, for non-mortgage products, the inability to observe the exact date that an

medical collection reporting). Columns 1 and 2 limit the sample to inquiries associated with medical collection tradelines over $500 made when the consumer had no medical collections under $500 on their consumer report. Columns 3 and 4 include the full sample. Columns 1 and 3 include only inquiries with shopping windows that contained inquiries made on different dates. Columns 2 and 4 include only inquiries with sole-inquiry shopping windows or inquiry shopping windows where all inquiries were made on the same date. Standard errors are clustered by consumer and adjusted using the Benjamini-Hochberg procedure.

inquiry was made may attenuate the results in the main specification, and the true effect of having a medical collection reported may be a larger decrease in inquiry success than what is reported in Table 7.

Table 14: The Effect of Medical Collection Reporting on Two-Year Credit Account Performance, Separated by Shopping Behavior[416]

	(1) Over $500, Shopping	(2) Over $500, No shopping	(3) All, Shopping	(4) All, No shopping
Panel A: Credit cards				
RD Estimate	-0.010 (0.035) [-0.079,0.059]	-0.000 (0.013) [-0.025,0.025]	0.023 (0.018) [-0.013,0.059]	-0.001 (0.006) [-0.013,0.011]
Avg. D 90+	0.320	0.218	0.313	0.210
Observations	12288	84009	70222	495458
Panel B: Mortgages				
RD Estimate	-0.005 (0.020) [-0.045,0.036]	-0.025 (0.020) [-0.063,0.014]	0.009 (0.011) [-0.012,0.030]	0.001 (0.008) [-0.015,0.018]
Avg. D 90+	0.041	0.027	0.046	0.030
Observations	5673	4504	30756	26220
Panel C: Other credit Accounts				
RD Estimate	-0.013 (0.026) [-0.065,0.039]	-0.003 (0.014) [-0.030,0.025]	-0.000 (0.012) [-0.023,0.023]	-0.001 (0.007) [-0.014,0.012]
Avg. D 90+	0.216	0.170	0.207	0.158
Observations	19879	51881	122953	336141

Standard errors in parentheses, 95 percent confidence intervals in brackets

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$

[416] The table provides regression discontinuity estimates for the performance dataset, separately by credit account type, and separating the sample by shopping behavior. Each coefficient (RD Estimate) estimates a percentage point effect of having an additional medical collection reported on inquiry success. These effects can be represented as percent changes by comparing to a baseline "Avg. D90+", which is calculated as the 90-day delinquency rate of all inquiries made to the left of the regression discontinuity threshold (or without medical collection reporting). Columns 1 and 2 limit the sample to inquiries associated with medical collection tradelines over $500 made when the consumer had no medical collections under $500 on their consumer report. Columns 3 and 4 include the full sample. Columns 1 and 3 include only inquiries with shopping windows that contained inquiries made on different dates. Columns 2 and 4 include only inquiries with sole-inquiry shopping windows or inquiry shopping windows where all inquiries were made on the same date. Standard errors are clustered by consumer and adjusted using the Benjamini-Hochberg procedure.

Table 14 provides the same robustness check as Table 13 but estimates effects on serious delinquency using the performance dataset. As in previous robustness checks, the estimated results on account performance are all statistically insignificant, and nearly all are small in comparison to the baseline average delinquency rate. The CFPB considers these results as evidence that imprecision in assigning inquiry dates does not drive the lack of statistical significance in the main specification.

Finally, the CFPB tested whether classifying the timing of an inquiry shopping window using the last inquiry makes a difference to the results. Although it makes intuitive sense to focus on the last inquiry—a consumer finishes shopping, then either gets a new account or does not—this could impact whether a consumer is considered treated or not by having a medical collection reported or not. For example, if a consumer applied for accounts that created inquiries on March 5 and March 17, had an account opened on March 19, and had a medical collections tradeline reported on March 15, in the main specification described above, they would be considered to have a medical collection at the time of the inquiry. This may be accurate, if the March 17 inquiry (or another inquiry after March 15 that was made with a different NCRA) resulted in the open account, but it also may be inaccurate, and influence the results reported above. To further test how the definition of shopping windows may affect the main results, the CFPB estimated a version of the analysis using the first date of the shopping window instead of its last date to define the running variable.

Table 15: The Effect of Medical Collection Reporting on Inquiry Success and Credit Account Performance, Classifying Shopping Windows by First Inquiry Date[417]

	(1) Over $500, Success	(2) Over $500, D90+	(3) All, Success	(4) All, D90+
Panel A: Credit cards				
RD Estimate	-0.049***	0.002	-0.035***	0.004
	(0.004)	(0.012)	(0.003)	(0.006)
	[-0.058,-0.041]	[-0.021,0.025]	[-0.040,-0.030]	[-0.008,0.016]
Avg. dep. var.	0.294	0.231	0.275	0.222
Observations	600209	95973	3021234	563942
Panel B: Mortgages				
RD Estimate	-0.010	0.003	-0.010	0.003
	(0.012)	(0.013)	(0.008)	(0.006)
	[-0.033,0.014]	[-0.022,0.028]	[-0.026,0.006]	[-0.009,0.015]
Avg. dep. var.	0.182	0.033	0.163	0.035
Observations	74674	8836	415412	49986
Panel C: Other credit Accounts				
RD Estimate	-0.010	-0.020	-0.012***	-0.003
	(0.006)	(0.014)	(0.003)	(0.006)

[417] The table provides regression discontinuity estimates for the inquiry and performance datasets, separately by credit account type, and using the date of the first inquiry observed within an inquiry shopping window instead of the date of the last inquiry observed, as in the primary specification. The sample is limited to inquiries whose first date of the inquiry shopping window was within 180 days of the medical collection's inclusion on the consumer report. Each coefficient (RD Estimate) estimates a percentage point effect having an additional medical collection reported on inquiry success (in Columns 1 and 3) in the inquiry dataset or 90-day delinquency (in Columns 2 and 4) in the performance dataset. These effects can be represented as percent changes by comparing to a baseline "Avg. dep. var.", which is calculated as the success rate or 90-day delinquency rate of all inquiries made to the left of the regression discontinuity threshold (or without medical collection reporting). Columns 1 and 2 limit the sample to inquiries associated with medical collection tradelines over $500 made when the consumer had no medical collection tradelines under $500 on their consumer report. Columns 3 and 4 include the full sample. Standard errors are clustered by consumer and adjusted using the Benjamini-Hochberg procedure.

	(1) Over $500, Success	(2) Over $500, D90+	(3) All, Success	(4) All, D90+
	[-0.021,0.002]	[-0.048,0.008]	[-0.018,-0.006]	[-0.015,0.008]
Avg. dep. var.	0.242	0.182	0.246	0.171
Observations	467949	71401	2476494	456828

Standard errors in parentheses, 95 percent confidence intervals in brackets

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$

The results in Table 15 are very similar in size to those in the main specification, as seen by comparing Column 1 of Table 7 to Column 1 of Table 15, Column 4 of Table 7 to Column 3 of Table 15, Column 1 of Table 8 to Column 2 of Table 15 and comparing Column 4 of Table 8 to Column 4 of Table 15. The coefficients in Column 1 of Table 15, estimating the impact of medical collection reporting on inquiry success, are no longer marginally significant for mortgages and other credit accounts. This may be because the last inquiry observed within an inquiry shopping window is a better proxy for the date that the creditor observed the consumer report for these products, which is sensible if consumers continue to shop when they reject an earlier credit offer, or their application is rejected. The CFPB considers these results as evidence that, given the inherent challenges in assigning inquiry dates, the method of using the last date that an inquiry was observed within a shopping window is the best available classification.

11. Results Related to Alternative Measures of Account Performance and Inquiry Success

Moving on from statistical and data construction considerations, the CFPB returns to the applicability of the results to the considered equilibrium in which all medical collection tradelines are removed from consumer reports. Creditors may respond to reported medical collections by providing lower amounts of credit, especially for products whose applications do not typically request a certain amount of credit, such as credit cards (and unlike mortgages). The CCIP does not contain data on the dollar amount of credit that consumers were offered if

consumers decided not to open an account, but it can observe credit limits and loan principals for originated accounts. Moreover, the CFPB understands that credit card accounts are typically opened automatically if approved by the creditor, such that consumers do not have an opportunity to decline an offer of credit with a lower limit than they prefer. The CFPB estimated Equation 1 using the account's credit limit (for revolving accounts) or loan principal (for installment accounts) as the dependent variable. This regression can only be run for the performance dataset because credit limits and loan principals cannot be observed for unsuccessful inquiries.

Table 16: The Effect of Medical Collection Reporting on Credit Account Limits and Loan Principals[418]

	(1) Over 500	**(2) All**
Panel A: Credit cards		
RD Estimate	-384.312***	-247.492***
	(80.367)	(33.855)
	[-541.829,-226.795]	[-313.848,-181.137]
Avg. credit am.	1481.169	1312.252
Observations	96208	565222
Panel B: Mortgages		
RD Estimate	-12746.532	-15734.984
	(11952.690)	
	[-36173.374,10680.309]	[-33208.174,1738.206]
Avg. credit am.	232565.905	225877.236
Observations	10163	56918
Panel C: Other credit accounts		
RD Estimate	254.621	-195.017
	(398.877)	(220.971)
	[-527.164,1036.407]	[-628.113,238.078]
Avg. credit am.	20994.097	20380.048
Observations	71739	458968

[418] The table provides regression discontinuity estimates for the performance dataset, separately by credit account type, and using the credit limit or loan principal at time of origination as the dependent variable. Each coefficient (RD Estimate) estimates a percentage point effect of having an additional medical collection reported on the

Standard error in parentheses, 95 percent confidence intervals in brackets

$*$ p < 0.1, $**$ p < 0.05, $***$ p < 0.01

Table 16 provides estimates for the effect of medical collection reporting on credit limits and loan principals. The results in Panel A show that medical collection reporting leads to lower credit limits for originated credit cards, with an average reduction in provided credit limits of $384 for the over-$500 sample and $247 for the full sample. This represents a meaningful reduction in consumer access to credit, as baseline average credit limits are lower than $1,500 for both samples. As expected, the CFPB does not find statistically significant effects for mortgages or other non-credit-card account types. Consumers generally apply for a specific dollar amount of credit for installment products, and the dollar amount of credit provided is not a margin that would generally be affected by medical collection reporting.

The CFPB understands that the classification of serious delinquency is not the sole determinant of account performance. Three other measures of performance are considered in this final set of regressions, estimated on the performance dataset: whether the account is ever 30 days or more delinquent within two years of its origination, whether the account is 90 days or more delinquent at the end of its first two years after origination (instead of whether it was ever 90 days or more delinquent within that two-year period), and the dollar amount past due or charged off for accounts with nonzero past due or charged off amounts at the end of its first two years after origination. If the primary classification of serious delinquency is a good proxy for

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account's credit limit or loan principal. These effects can be represented as percent changes by comparing to a baseline "Avg. credit am.", which is calculated as the average of the credit limit or loan principal for all inquiries made to the left of the regression discontinuity threshold (or without medical collection reporting). Column 1 limits the sample to inquiries associated with medical collection tradelines over $500 made when the consumer had no medical collection tradelines under $500 on their consumer report. Column 2 includes the full sample. The dependent variable is equal to the credit limit at the time of account origination for credit cards and other revolving accounts. The dependent variable is equal to the loan principal at the time of account origination for mortgages and other installment products. Standard errors are clustered by consumer and adjusted using the Benjamini-Hochberg procedure.

account performance, then results for the first two alternative measures should be similar to their counterparts in the main performance results in direction and statistical significance. The results for past due amounts may be more nuanced, as Table 16 above shows that medical collection reporting lowers the credit limits of credit cards. This may cause lower past due amounts in response to medical collection reporting because consumers cannot borrow as much as they can absent medical collection reporting.

Table 17: The Effect of Medical Collection Reporting on Two-Year Credit Account Performance, Alternative Classifications[419]

	(1) Over $500, D30+	(2) Over $500, D90+ alt.	(3) Over $500, Past due am.	(4) All, D30+	(5) All, D90+ alt.	(6) All, Past due am.
Panel A: Credit cards						
RD Estimate	0.008	-0.006	-215.199**	0.002	-0.003	-62.830*
	(0.013)	(0.011)	(86.597)	(0.006)	(0.005)	(29.197)
	[-0.017, 0.032]	[-0.027, 0.015]	[-384.926, -45.472]	[-0.010, 0.015]	[-0.013, 0.008]	[-120.055, -5.604]

[419] The table provides regression discontinuity estimates for the performance dataset, separately by credit account type, and using alternative classifications of account performance. Each coefficient (RD Estimate) estimates a percentage point effect of having an additional medical collection reported on the account's credit limit or loan principal. These effects can be represented as percent changes by comparing to a baseline "Avg. credit am.", which is calculated as the average of the credit limit or loan principal for all inquiries made to the left of the regression discontinuity threshold (or without medical collection reporting). Columns 1 through 3 limit the sample to inquiries associated with medical collection tradelines over $500 made when the consumer had no medical collection tradelines under $500 on their consumer report. Columns 4 through 6 includes the full sample. The dependent variable in Columns 1 and 4, "D30+", is whether the account was ever at least 30 days delinquent within two years of its origination. The dependent variable in Columns 2 and 5, "D90+ alt.", is whether the account was at least 90 days delinquent exactly two years after the origination date, in contrast to the primary classification which considers whether the account was ever at least 90 days delinquent within two years of the origination date. The dependent variable in Columns 3 and 6 is the total amount past due or charged off on the account exactly two years after the account's origination date if either value is positive and non-missing. If accounts have positive and non-missing past-due amounts and charged-off amounts, the classification uses the charged-off amount. Standard errors are clustered by consumer and adjusted using the Benjamini-Hochberg procedure.

	(1) Over $500, D30+	(2) Over $500, D90+ alt.	(3) Over $500, Past due am.	(4) All, D30+	(5) All, D90+ alt.	(6) All, Past due am.
Avg. dep. var.	0.321	0.164	713.724	0.316	0.153	643.677
Observations	96297	96297	19945	565680	565680	111342
Panel B: Mortgages						
RD Estimate	-0.034	0.002	4477.430	0.012	0.001	261.686
	(0.027)	(0.010)	(2894.862)	(0.012)	(0.005)	(1682.921)
	[-0.087, 0.018]	[-0.018, 0.022]	[-1196.394, 10151.255]	[-0.012, 0.036]	[-0.009, 0012]	[-3036.779, 3560.152]
Avg. dep. var.	0.125	0.021	7511.005	0.118	0.019	6018.840
Observations	10177	10177	409	56976	56976	1954
Panel C: Other credit Accounts						
RD Estimate	-0.006	-0.002	-803.533	-0.000	0.000	-562.913
	(0.016)	(0.013)	(732.117)	(0.008)	(0.005)	(301.400)
	[-0.037, 0.025]	[-0.027, 0.023]	[-2238.455, 631390]	[-0.016. 0.015]	[-0.009, 0.010]	[-1153.647, 27.821]
Avg. dep. var.	0.322	0.156	7012.189	0.316	0.145	6510.499
Observations	71760	71760	13777	459094	459094	81546

Standard errors in parentheses, 95 percent confidence intervals in brackets

$*$ p < 0.1, $**$ p < 0.05, $***$ p < 0.01

Table 17 estimates Equation 1 on the performance dataset using alternative measures of account performance. Columns 1, 2, 4, and 5 show small and statistically significant effects of medical collection reporting on account performance, as in Columns 1 and 4 of Table 8. In Panel A, Columns 3 and 6 provide relatively small but at least marginally significant effects,

suggesting that medical collection reporting may lead to lower past-due or charged-off amounts for credit cards, when those amounts are nonzero. This may be caused by the lower credit limits provided to consumers with reported medical collections, as shown in Table 16. Though credit cards originated to consumers with unreported medical collections may be no more likely to become seriously delinquent within two years, the dollar amount past due when the account is delinquent may be higher because consumers with unreported medical collections receive higher credit limits. The results in Panels B and C show no statistically significant effects on past-due or charged-off amounts for mortgages, as expected because there were no differences in serious delinquency or in the dollar amount of credit provided.

A researcher commenter suggested that the CFPB incorporate a risk management framework in its interpretation of the results in Tables 16 and 17, where a creditor's expected loss is modeled as:

Expected Loss = Probability of Default x Exposure at Default x Loss-Given Default.

The commenter notes that the analysis in the Technical Appendix focuses on the Probability of Default, finding that this would be unchanged under the proposed rule. For credit cards, the commenter stated that the Exposure at Default, generally the entire credit limit for consumers defaulting on credit cards, may be higher under the proposed rule because credit limits and amounts past due are higher for accounts originated by consumers with unreported medical collections, as shown in Tables 16 and 17.

The CFPB agrees that may be an appropriate theoretical framework to consider expected losses. However, the CFPB does not have the information needed to evaluate this formula.[420] Additionally, the CFPB notes that what is ultimately important to creditors is profit, which includes both expected losses and expected revenue. Creditors can earn higher revenues when providing higher credit limits to consumers who revolve their balance from month-to-month and pay interest fees. Therefore, although expected loss for credit card lenders may be higher under the rule because the Exposure at Default is higher, the expected revenue may be higher, too.

The researcher commenter further stated that the Loss-Given Default, or the percent of the loss that could not be recouped by the creditor in the case of default, might be higher under the proposed rule because recoverable debt values would fall under the proposed rule.[421] The commenter did not explain why recoverable debt values would fall, but the comment seemed to be based on an assumption that medical debt will become more challenging to collect under the rule. While the CFPB does not agree with this assumption, as discussed above in part VII.E.1, this is not relevant to the analysis here, which pertains to potential losses for credit cards. The CFPB is not aware of evidence indicating that recoverable debt values would fall for types of debt other than medical debt, and the commenter did not provide any evidence suggesting as much. As such, the CFPB does not expect that Loss-Given Default will change due the rule.

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[420] The commenter incorrectly interprets Loss-Given Default as Exposure at Default in his interpretation of the formula. Loss-Given Default is the percent of Exposure at Default that the creditor would lose if the consumer defaulted on the loan. The CFPB does not have any data that would allow it to estimate Loss-Given Default.

[421] The commenter describes Loss-Given Default as the average dollar amount of loss given default, which is not generally how Loss-Given Default is calculated, per the equation provided by the commenter and described above. The CFPB interprets the comment as being about Loss-Given Default conceptually, regardless of the exact calculation.

List of Subjects in 12 CFR Part 1022

Banks, banking, Consumer protection, Credit unions, Holding companies, National banks, Privacy, Reporting and recordkeeping requirements, Savings associations.

Authority and Issuance

For the reasons set forth in the preamble, the CFPB amends Regulation V, 12 CFR part 1022, as set forth below:

PART 1022—FAIR CREDIT REPORTING (REGULATION V)

1. The authority citation for part 1022 continues to read as follows:

Authority: 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 1681t; Sec. 214, Pub. L. 108–159, 117 Stat. 1952.

Subpart A—General Provisions

2. Amend § 1022.3 by adding paragraph (j) to read as follows:

§ 1022.3 Definitions.

* * * * *

(j) *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. Medical debt information includes but is not limited to medical bills that are not past due or that have been paid.

* * * * *

Subpart D—Medical Information

3. Amend § 1022.30 by:

a. Revising paragraph (c);

b. Removing and reserving paragraph (d);

c. Revising paragraphs (e)(1)(viii) and (ix); and

d. Adding paragraphs (e)(1)(x) and (e)(6) and (7).

The revisions and additions read as follows:

§ 1022.30 Obtaining or using medical information in connection with a determination of eligibility for credit.

* * * * *

(c) *Rule of construction for obtaining and using unsolicited medical information*—(1) *In general*. A creditor does not obtain medical information in violation of the prohibition if it receives medical information pertaining to a consumer in connection with any determination of the consumer's eligibility, or continued eligibility, for credit without specifically requesting medical information.

(2) *Use of unsolicited medical information*. A creditor that receives unsolicited medical information in the manner described in paragraph (c)(1) of this section may use that information in connection with any determination of the consumer's eligibility, or continued eligibility, for credit to the extent the creditor can rely on at least one of the exceptions in paragraph (e) of this section.

(3) *Examples*. A creditor does not obtain medical information in violation of the prohibition if, for example:

(i) In response to a general question regarding a consumer's debts or expenses, the creditor receives information that the consumer owes a debt to a hospital.

(ii) In a conversation with the creditor's loan officer, the consumer informs the creditor that the consumer has a particular medical condition.

* * * * *

(e) * * *

(1) * * *

(viii) To determine the consumer's eligibility for, the triggering of, or the reactivation of a debt cancellation contract or debt suspension agreement if a medical condition or event is a triggering event for the provision of benefits under the contract or agreement;

(ix) To determine the consumer's eligibility for, the triggering of, or the reactivation of a credit insurance product if a medical condition or event is a triggering event for the provision of benefits under the product; or

(x) So long as the conditions in paragraphs (e)(1)(x)(A) through (C) of this section are met:

(A)(*1*) The medical information is included in the transaction information of an account for a consumer financial product or service described in 12 CFR 1033.111(b)(1) through (3), and accessed with the consumer's authorization; or

(*2*) The medical information relates to income, benefits, or the purpose of the loan, including the use of proceeds. Medical information relating to income and benefits includes, 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.

(B) The creditor uses the medical information in a manner and to an extent that is no less favorable than it would use comparable information that is not medical information in a credit transaction.

(C) The creditor does not take the consumer's physical, mental, or behavioral health, condition or history, type of treatment, or prognosis into account as part of the determination of the consumer's eligibility, or continued eligibility, for credit.

* * * * *

(6) *Example to comply with applicable requirements of local, State, or Federal laws.* A consumer applies for a mortgage loan subject to § 1026.43(c) or § 1026.34(a)(4) of this chapter, or an open-end (not home-secured) credit card account subject to § 1026.51(a) of this chapter. The application does not specifically request medical information, but the consumer provides unsolicited medical information on the application. The creditor or the card issuer is permitted under paragraph (e)(1)(ii) of this section to use such medical information in connection with any determination of the consumer's eligibility, or continued eligibility, for credit only to the extent required by the applicable Federal law and implementing regulation. For example, assume a consumer applies for a mortgage loan subject to § 1026.43(c) of this chapter. Assume further that the creditor has not specifically requested medical information on the application, but the consumer provides information on a current debt obligation, such as a monthly medical payment plan, that is medical information. The creditor is permitted under paragraph (e)(1)(ii) of this section to consider the existence and the amount of the medical payment plan as required in considering factors under § 1026.43(c)(2) of this chapter, such as the current debt obligations, consumer's monthly debt-to-income ratio, and residual income, in making the repayment ability determination required under § 1026.43(c)(1) of this chapter. In this circumstance, the creditor would not be required to independently verify the existence and amount of the monthly medical payment plan, as provided for under § 1026.43(c)(3)(iii) of this chapter. See also Regulation Z (12 CFR 1026.43(c)(3), comment 43(c)(3)-6), describing a situation in which a consumer

provides a creditor with information on a debt obligation that is not listed on a consumer report. Further, a creditor or card issuer is not permitted under paragraph (e)(1)(ii) of this section to obtain or use any medical information from a consumer reporting agency to comply with the ability-to-repay rule under § 1026.43(c) of this chapter for closed-end mortgages, the repayment ability rule under § 1026.34(a)(4) of this chapter for open-end, high-cost mortgages, or the ability-to-pay rule under § 1026.51(a) of this chapter for open-end (not home-secured) credit card accounts, because the creditor or card issuer can comply with those rules using information provided by the consumer. This example only relates to the exception under paragraph (e)(1)(ii) of this section. A creditor or card issuer may obtain and use medical information for purposes of Regulation Z's ability-to-repay or pay determinations pursuant to other exceptions in paragraph (e) of this section, as applicable.

(7) *Example of medical information relating to income and benefits*. A consumer indicates on an application for a $200,000 mortgage loan that she receives $15,000 in long-term disability income each year from her former employer and has no other income. Annual income of $15,000, regardless of source, would not be sufficient to support the requested amount of credit. The creditor denies the application on the basis that the projected debt-to-income ratio of the consumer does not meet the creditor's underwriting criteria. The creditor has used medical information in a manner and to an extent that is no less favorable than it would use comparable non-medical information.

4. Amend 12 CFR part 1022 by adding and reserving §§ 1022.33 through 1022.37 and by adding § 1022.38 to subpart D to read as follows:

§§ 1022.33-1022.37 [Reserved]

§ 1022.38 Duty of consumer reporting agencies regarding medical debt information.

(a) *Scope*. This section applies to any consumer reporting agency as defined in section 603(f) of the FCRA, 15 U.S.C. 1681a(f).

(b) *Limitation regarding prohibited medical debt information*. A consumer reporting agency may include medical debt information, as defined in § 1022.3(j), in a consumer report furnished to a creditor only if the consumer reporting agency:

(1) Has reason to believe the creditor intends to use the medical debt information in a manner not prohibited by § 1022.30; and

(2) Has reason to believe the creditor is not otherwise legally prohibited from obtaining or using the medical debt information, including by a State law that prohibits a creditor from obtaining or using medical debt information.

Rohit Chopra,

Director, Consumer Financial Protection Bureau.