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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: Proposed rule; request for public comment.

SUMMARY: The Consumer Financial Protection Bureau (CFPB) is seeking public comment on a proposed rule amending Regulation V, which implements the Fair Credit Reporting Act (FCRA), concerning medical information. The CFPB is proposing to remove a regulatory exception in Regulation V from the limitation in the FCRA on creditors obtaining or using information on medical debts for credit eligibility determinations. The proposed rule would also provide 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: Comments must be received on or before August 12, 2024.

ADDRESSES: You may submit comments, identified by Docket No. CFPB-2024-0023 or RIN 3170-AA54, by any of the following methods:

- *Federal eRulemaking Portal*: *https://www.regulations.gov*. Follow the instructions for submitting comments. A brief summary of this document will be available at *https://www.regulations.gov/docket/CFPB-2024-0023*.

- *Email*: *2024-NPRM-MEDICAL-DEBT@cfpb.gov*. Include Docket No. CFPB-2024-2023 or RIN 3170-AA54 in the subject line of the message.
- *Mail/Hand Delivery/Courier*: Comment Intake—2024 NPRM FCRA Medical Debt Information, c/o Legal Division Docket Manager, Consumer Financial Protection Bureau, 1700 G Street NW, Washington, DC 20552.

Instructions: The CFPB encourages the early submission of comments. All submissions should include the agency name and docket number or Regulatory Information Number (RIN) for this rulemaking. Because paper mail is subject to delay, commenters are encouraged to submit comments electronically. In general, all comments received will be posted without change to *https://www.regulations.gov*.

All submissions, including attachments and other supporting materials, will become part of the public record and subject to public disclosure. Proprietary information or sensitive personal information, such as account numbers or Social Security numbers, or names of other individuals, should not be included. Submissions will not be edited to remove any identifying or contact information.

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. Background

A. Rulemaking Goals

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.[1] Congress did so in order to "establish strong privacy protections for consumers' sensitive medical information," in line with the overarching privacy protection purpose of the Fair Credit Reporting Act (FCRA).[2] As part of these protections, 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.[3] 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 consistent with the congressional intent to restrict the use of medical information for inappropriate purposes.

For tens of millions of consumers, medical debt is an unexpected and unwanted expense that can lead to financial hardships. The CFPB is proposing this rule to address concerns that information about medical debt is not necessary and appropriate for credit underwriting and, as a result, does not warrant an exception to the medical information privacy protections established by Congress.

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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] 15 U.S.C. 1681 e*t seq.*, 1681(a)(4); 149 Cong. Rec. H8122-02, H8122 (daily ed. Sept. 10, 2003) (statement of Rep. Kanjorsky).

[3] 15 U.S.C. 1681b(g)(2).

Due to the complexity of medical billing, information about medical debt is often plagued with inaccuracies and errors. Third-party reimbursement processes, and debt collectors' practices for providing (or furnishing) information on consumers' debts to consumer reporting agencies, can contribute to the prevalence of errors and consumer confusion about their medical bills.[4] This can uniquely affect not just the accuracy of the information a creditor may consider about a medical debt, but also a consumer's understanding of whether, when, or in what amount, a medical bill must be paid. Many consumers do not find out about an erroneous medical bill in collections until applying for a mortgage or car loan and being denied for the loan based on their consumer report.[5]

Research has shown that medical debt has limited predictive value 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.[6] 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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[4] *See* Consumer Fin. Prot. Bureau, *Consumer credit reports: A study of medical and non-medical collections*, at 15-16, 38-49 (Dec. 2014), https://files.consumerfinance.gov/f/201412_cfpb_reports_consumer-credit-medical-and-non-medical-collections.pdf (discussing billing and collection practices for medical debt generally, in discussion of medical collections tradelines on consumer reports).

[5] This document uses the term "consumer report" which has the meaning provided in section 603(d) of the FCRA, 15 U.S.C. 1681a(d). "Consumer report" is also commonly referred to as "credit report."

[6] *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.

Because consumer reports can operate as a gatekeeper to significant life and economic decisions, medical debt can be used as leverage by debt collectors to coerce consumers to pay medical bills they may not owe.[7] In such circumstances, consumers are forced to choose between challenging inaccurate medical bills, often while recovering from a serious illness, or paying the inaccurate bill due to a frequently short review period.

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 models.[9] Similarly, some creditors have adjusted how their underwriting standards treat medical debt information.[10]

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[7] *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).

[8] *See, e.g.*, Business 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-

Based on the totality of this information, the CFPB is proposing changes to how creditors and consumer reporting agencies treat medical information concerning a consumer's medical debt to ensure the use of such information is consistent with the congressional intent to safeguard consumers' privacy and restrict the use of medical information for inappropriate purposes.

B. Summary of the Proposed Rule

Congress, through the Fair and Accurate Credit Transactions Act of 2003 (FACT Act), amended the FCRA to restrict creditors' ability to obtain or use medical information in connection with credit eligibility determinations (creditor prohibition).[11] In doing so, Congress recognized that a consumer's medical information is particularly sensitive, warranting heightened privacy protections. However, in 2005, the Federal financial agencies and the National Credit Union Administration (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.[12] And while Congress did permit the Agencies to create exceptions, Congress mandated that the Agencies determine that any exception be necessary and appropriate, and consistent with the congressional intent to restrict the use of medical information for inappropriate purposes.[13]

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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).

[11] Pub. L. 108-159, 117 Stat. 1952 (2003).

[12] 70 FR 70664 (Nov. 22, 2005).

[13] 15 U.S.C. 1681b(g)(5).

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.

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, has preliminarily determined that the financial information exception to the creditor prohibition is neither warranted nor consistent with the FACT Act's purpose of protecting the privacy of consumers' medical information. The CFPB is proposing targeted amendments to Regulation V as follows:

- 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
- Limit the circumstances under which consumer reporting agencies are permitted to furnish medical debt information to creditors in connection with credit eligibility determinations.

These amendments would 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)[14] (*i.e.*, certain auto dealers). The term creditor has the

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

same meaning as in section 702 of the Equal Credit Opportunity Act (ECOA).[15] The amendments would also apply to a consumer reporting agency as defined in section 603(f) of the FCRA.[16]

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.

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.

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[15] 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.

[16] 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.

C. Unique Characteristics of Medical Debt in the United States

A significant number of Americans have medical debt.[17] 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.[18]

Several characteristics of medical debt pose special risks to consumers and distinguish it from other types of debt.[19] The need for medical care can be unexpected,[20] 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.[21] Consumers are rarely informed of the costs of medical treatment in advance, and because of price opacity and an often immediate need for medical

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[17] 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.

[18] 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).

[19] *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.

[20] *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).

[21] *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).

care, consumers have little or no ability to ''shop around.''[22] Americans that live in rural communities may also experience limited choices when trying to access health care,[23] 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.[24] 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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[22] 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).

[23] *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).

[24] *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.[25] Also some health care providers and debt collectors exploit these complications and charge inflated or unearned bills.[26]

D. 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[27]—including information about a consumer's medical debt—and in providing consumer reports to other companies for employment, housing, insurance, and other decisions.[28] 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.[29]

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[25] *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.

[26] 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 May 21, 2024).

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

[28] *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.

[29] *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).[30] 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.[31] 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.[32] 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;[33] however, many collections tradelines are removed well in advance of seven years.[34]

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

[31] 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.

[32] *Id.*

[33] 15 U.S.C. 1681c(a)(4).

[34] 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.[35] 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.[36] 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.[37] 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.[38]

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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[35] 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.

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

[37] 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).

[38] 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.[39]

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.[40] Despite the protections offered by these rules, CFPB investigations indicate that some medical debt collectors may still be attempting to collect on medical debts that were not substantiated after consumers disputed the validity of the debts.[41]

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.

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[39] 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.

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

[41] *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/.

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.[42] In April 2023, the NCRAs also announced that medical collections with initial balances below $500 had been removed from consumer reports.[43]

The CFPB conducted an analysis of the impacts of the NCRAs' medical debt reporting changes through June 2023.[44] 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 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.[45] For example, Colorado[46] and New York[47] each

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[42] 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/.

[43] 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.

[44] 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.

[45] 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).

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

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

passed laws in 2023 prohibiting medical debts from appearing on consumer reports. Connecticut and Virginia followed suit earlier this year.[48] Illinois and Minnesota state legislatures have also passed similar legislation pending signature from their States' governors.[49] 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.[50] 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.[51]

E. 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 are less predictive of future defaults or serious delinquencies than the presence 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.[52] Following the CFPB's publication of its research and in recognition

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[48] 2024 Conn. Act 24-6; 2024 Va. Acts ch. 751.

[49] *See* Forest Nelson, *Medical debt may no longer negatively impact your credit in Illinois*, WIFR (May 16, 2024), https://www.wifr.com/2024/05/16/medical-debt-may-no-longer-negatively-impact-your-credit-illinois/; Off. of Minn. Att'y Gen. Keith Ellison, *Attorney General Ellison commends Senate for final passage of the Debt Fairness Act* (May 16, 2024), https://www.ag.state.mn.us/Office/Communications/2024/05/16_DebtFairnessAct.asp.

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

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

[52] 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.

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.[53] In January 2023, VantageScore implemented changes to VantageScore models 3.0 and 4.0 to ignore all medical collections tradelines.[54]

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,[55] the GSEs require creditors to provide credit scores derived from the older Classic FICO[56] for each borrower on a loan that the GSEs

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[53] *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/.

[54] *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).

[55] *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 "[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.

[56] 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.

purchase to assess eligibility for certain loan products and make certain pricing decisions.[57] 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 or do not consider medical collections, but that transition is not expected to occur until the fourth quarter of 2025.[58]

II. Statutory and Regulatory History

A. 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' main purposes in passing the FCRA was a respect for the consumer's right to privacy.[59] The law has been amended several times in the ensuing years, including by the FACT Act.[60] 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 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

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[57] *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.

[58] 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.

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

[60] 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).

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.[61] 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.[62]

The FCRA protects consumer privacy in multiple ways, including by clearly prohibiting certain uses of data. The law limits the circumstances under which consumer reporting agencies may disclose consumer information. For example, 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.[63] 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

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[61] *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").

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

[63] 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. Further, the Debt Collection Improvement Act of 1996, Pub. L. 104-134, 110 Stat. 1321, 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).

reasonable procedures designed to . . . limit the furnishing of consumer reports to the purposes listed under section 604."[64]

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.[65]

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.

B. Fair and Accurate Credit Transactions Act of 2003 and implementing regulations

Congress passed the FACT Act and it became law on December 4, 2003.[66] 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

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[64] 15 U.S.C. 1681e(a).

[65] 15 U.S.C. 1681b(f).

[66] Pub. L. 108-159, 117 Stat. 1952 (2003).

allowing consumers to exercise greater control regarding the type and amount of marketing solicitations they receive.[67]

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.[68] Congress also limited the circumstances under which consumer reporting agencies could furnish consumer reports containing medical information for credit, employment, or insurance purposes,[69] 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[70]—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."[71] 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."[72]

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

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

[68] 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).

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

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

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

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

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.[73] 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.[74]

The Agencies' final rules contain the financial information exception for creditors obtaining and using medical information in credit eligibility determinations.[75] 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

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

[74] 70 FR 70664 (Nov. 22, 2005). *See also* interim final rules published at 70 FR 33958 (June 10, 2005).

[75] 70 FR 70664, 70667 (Nov. 22, 2005).

purposes."[76] Although the Agencies explained the boundaries of their three-part test, and gave 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."[77]

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.[78] For example, a creditor may use medical information in credit eligibility determinations to comply with applicable requirements of local, State, or Federal laws.[79] 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.[80]

Congress (through the CFPA) transferred to the CFPB primary regulatory authority for the FCRA.[81] The CFPB restated the Agencies' regulations as an interim final rule, with request

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[76] 69 FR 23380, 23384 (Apr. 28, 2004).

[77] *Id.*

[78] 70 FR 70664, 70668 (Nov. 22, 2005).

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

[80] 69 FR 23380, 23382 (Apr. 28, 2004).

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

for comment, on December 21, 2011.[82] On April 28, 2016, the CFPB finalized the interim final rule without assessing or otherwise reconsidering the policy decisions and justifications that served as the basis for the regulations.[83]

III. Prior Proceedings, Stakeholder Outreach, and Consultation

A. Small Business Advisory Review Panel

Pursuant to the Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA),[84] the CFPB issued its Outline of Proposals and Alternatives under Consideration (Outline or SBREFA Outline).[85] 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 meetings on October 18 and 19, 2023.[86] 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

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[82] 76 FR 79308 (Dec. 21, 2011).

[83] 81 FR 25323 (Apr. 28, 2016).

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

[85] 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.

[86] 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.

Consideration for the Consumer Reporting Rulemaking (Panel Report or SBREFA Report).[87] 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.[88] The CFPB has 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 this proposed 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 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 consumer reporting systems.[89] In December 2014, following the CFPB's publication of its research report, *Data Point: Medical Debt and Credit Scores*,[90] 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

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[87] 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. As required under SBREFA, the CFPB considers the Panel's findings in its IRFA, as set out in part VIII.B below.

[88] *See* SBREFA Outline at 5.

[89] 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.

[90] *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.

between medical and nonmedical debt reporting.[91] 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.[92]

Prior to issuing this proposed rule and in accordance with CFPA section 1022(b)(2)(B), the CFPB consulted with staff from various Federal agencies to discuss aspects of its proposal. 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 Federal Trade Commission, the Department of Health and Human Services, Department of Housing and Urban Development, the FHFA, the Small Business Administration, the VA, and the Department of Agriculture.

IV. 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."[93] The term

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[91] 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.

[92] 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.

[93] 12 U.S.C. 5512(b)(1).

"Federal consumer financial laws" includes the "enumerated consumer laws," which include the FCRA.[94]

Section 1022(b)(2) of the CFPA prescribes certain standards for rulemaking that the CFPB must follow in exercising its authority under section 1022(b)(1).[95] For a discussion of the CFPB's standards for rulemaking under CFPA section 1022(b)(2), see part VII below.

B. FCRA Sections 621(e) and 604(g)(5)

Effective July 21, 2011, section 1088 of the CFPA made conforming amendments to the FCRA transferring rulemaking authority under much of the FCRA, except those regulations applicable 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."[96]

FCRA section 604(g)(5) specifically 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, but only if the CFPB determines 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.[97] Because the CFPB has preliminarily determined that a regulatory exception for certain financial information is not necessary and

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

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

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

[97] 15 U.S.C. 1681b(g)(5).

appropriate to protect legitimate operational, transactional, risk, consumer, and other needs (including administrative verification purposes), the CFPB is proposing to remove the exception. This would ensure 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.

V. Discussion of the Proposed Rule

A. Removal of the Financial Information Exception to the Creditor Prohibition On Obtaining or Using Medical Information

Current § 1022.30(b) incorporates the creditor prohibition in section 604(g)(2) of the FCRA.[98] The creditor prohibition 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. There are exceptions to this prohibition in current § 1022.30(d) and (e). The CFPB proposes to remove the exception at § 1022.30(d) (the financial information exception) to the creditor prohibition. As explained in part V.A.3, *Medical information related to income, benefits, or the purpose of the loan*, the CFPB proposes to retain 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). The CFPB also proposes conforming amendments to § 1022.30(c) to remove the reference to the § 1022.30(d) financial information exception.

Congress 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).[99]

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

[99] 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).

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."[100]

Consistent with the general creditor prohibition in FCRA section 604(g)(2), current § 1022.30(b)(1) provides that "[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." 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 § 1022.30(d) (the financial information exception) and (e) (listing specific exceptions).

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 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

[100] 15 U.S.C. 1681b(g)(5).

health, condition or history, type of treatment, or prognosis into account as part of the credit eligibility determination.[101]

The predecessor Agencies explained 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.[102] However, the Agencies did not cite evidence or provide analysis in support of this statement of their conclusion.

1. Medical Information Related to Debts

The financial information exception 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.[103] 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"[104] 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"[105] (collectively referred to herein as financial information). By proposing to eliminate the financial information exception, the CFPB would prohibit creditors from

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[101] 12 CFR 1022.30(d)(1).

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

[103] 12 CFR 1022.30(d)(1)(i).

[104] 12 CFR 1022.30(d)(2)(i)(A).

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

considering, in connection with credit eligibility determinations, such financial information related to consumers' medical debts, unless one of the specific exceptions in proposed § 1022.30(e) applies.

Owes or Owed to a Health Care Provider

The FCRA section 603(i) 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."

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 has preliminarily interpreted 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.[106] Specifically, 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." The CFPB has 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

[106] The CFPB uses the word "owed" to refer to the characterization of the debt by the health care provider or its agent or assignee. As discussed in part I.C, *Unique characteristics of medical debt in the United States*, the American medical billing system is byzantine and consumers frequently find errors with their medical bills and with medical collections tradeline information on their consumer reports. Accordingly, in some instances consumers may not truly "owe" the debt in question.

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's interpretation also 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. It would also include 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.[107] 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 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).

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. Such loans are new debt obligations used to pay the medical debt obligation owed to a health care provider. The CFPB also preliminarily concludes that debts owed to such

[107] *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).

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 seeks comment on its approach and also seeks comment on whether, in the alternative, 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. And, the CFPB also seeks 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.

FCRA section 603(i) specifies that medical information must relate to the payment for the provision of health care to "an individual." The CFPB has preliminarily interpreted the FCRA definition for medical information to mean that for information about a debt to be considered medical information, the debt must arise from the provision of health care to a human being.[108] And, as a result, information relating to debts arising from veterinary care would not be considered medical information under the CFPB's preliminary interpretation.

Generally, much of what Americans consider to be medical debt is owed directly to health care providers such as hospitals or doctors' or dentists' offices, even though, as noted previously, medical debt furnishing to consumer reporting agencies is usually done by third-party debt collectors.[109] The CFPB believes that such directly owed debt is likely the type of debt

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[108] *See Mohamad v. Palestinian Auth.*, 566 U.S. 449, 454-55 (2012) (explaining that "individual" usually refers to a "natural person" when used in a statute).

[109] *See, e.g.*, Michael Karpman, Urban Inst., *Most Adults with Past-Due Medical Debt Owe Money to Hospitals* (Mar. 2023), https://www.urban.org/sites/default/files/2023-03/Most%20Adults%20with%20Past-Due%20Medical%20Debt%20Owe%20Money%20to%20Hospitals.pdf (survey results indicate that 72.9 percent of adults with past-due medical debt owe at least some of that debt to hospitals, including 27.9 percent to hospitals only and 45.1 percent to both hospitals and other providers).

a consumer would clearly consider medical debt. Furnishers of information about these types of debt obligations are required to notify consumer reporting agencies of their status as medical information furnishers and thus debts are likely to be clearly marked as medical debts in consumer reports and in consumer reporting agency databases.[110] Therefore, the CFPB anticipates that a consumer reporting agency should also be able to easily identify or determine if information concerning a specific debt is medical debt information, which will make compliance with the proposed rule less burdensome.

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

Accordingly, the CFPB proposes to add a definition for medical debt information at § 1022.3(j) to facilitate compliance with various aspects of the proposed rule, including by clarifying the types of medical debts that a creditor would be prohibited from considering in connection with a credit eligibility determination if the financial information exception is removed and that a consumer reporting agency would be limited from including information about on consumer reports under proposed § 1022.38 (which uses the proposed defined term).[111] Medical debt information would be 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 (*e.g.*, a medical or health care provider), or to the person's agent or assignee, for the provision of such medical services, products, or devices. The definition would also clarify that medical debt information includes, but is not limited to, medical bills that are not past due or that have been paid.

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

[111] See part V.B, *Limits on consumer reporting agency's disclosure of medical debt information*.

The CFPB intends 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 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.[112] 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 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 would be required under proposed § 1022.38.

The proposed definition for medical debt information would also clarify that the term includes information about a debt owed to a health care provider's agent or assignee. By including agents and assignees in the medical debt information definition, the CFPB intends to include medical debt that has been purchased by a debt buyer or that is being collected by a third-party debt collector. As explained above, the CFPB considers medical debt that has been sold to a debt buyer or otherwise assigned to a third-party debt collector to be debt arising from a payment obligation that the consumer owes (or owed, for debt that has been paid or sold) directly to the health care provider that provided the health care at issue. The CFPB seeks comment on

[112] 15 U.S.C. 1681s-2(a)(9) (requiring a medical information furnisher to notify a consumer reporting agency of its status as a medical information furnisher).

whether this aspect of the proposed definition should be modified, such as to ensure it accommodates circumstances where the medical debt has been sold and then resold, as well as on its proposed definition for medical debt information generally.

In the course of the SBREFA process for this rulemaking, a few small entity representatives asked the CFPB to define medical debt and asked whether debts arising from certain health-related expenses would be included within the scope of the CFPB's creditor prohibition proposal.[113] The CFPB seeks comment on whether the proposed definition provides the clarity needed for consumers, creditors, and consumer reporting agencies to implement the proposed rule if finalized.

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

Under the FCRA, the CFPB has authority to permit an exception 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.[114] Upon further review of predecessor Agencies' rationale for the financial information exception, it appears that while the Agencies addressed specific comments on the parameters of their proposal for the financial information exception (which they substantially finalized as proposed), the Agencies did not provide evidence or analysis to support their determination.[115]

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[113] SBREFA Report at 35 (noting small entity representatives' questions about whether gym memberships, counseling or therapy sessions, veterinarian services, and dental care, or medical expenses charged to credit cards would be covered).

[114] FCRA section 605(g)(5) (15 U.S.C. 1681b(g)(5)).

[115] 70 FR 33958, 33966-67 (June 10, 2005). *See also* part II.B, *Fair and Accurate Credit Transactions Act of 2003 and implementing regulations*.

The CFPB understands that the financial information exception is the primary regulatory exception by which creditors are able to obtain and use financial information relating to a consumer's medical debts. However, since the predecessor Agencies enacted their rule, 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. These developments, which provide a more nuanced picture that raises questions about the necessity and appropriateness of creditors' use of medical debt information in credit underwriting, show that a broad exception for creditors to consider information on a consumer's medical debt is not necessary and appropriate, consistent with the intent of the creditor prohibition to protect consumers' sensitive medical information.

First, recent research has demonstrated that unlike other types of debt, medical debt often results from an event such as an accident or sudden illness.[116] In these circumstances, 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.

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. Third-party surveys and complaints received by the CFPB have shown that medical bills commonly contain errors and are frequently disputed by consumers.[117] Further, the complexity of medical

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[116] 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).

[117] *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).

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.[118]

Third, the CFPB's work shows that medical debt information has relatively limited predictive value. Research by the CFPB in 2014 found that medical debt collections tradelines (also referred to as medical collections) are less predictive of future consumer credit performance than nonmedical collections.[119] The CFPB's 2014 analysis showed that individuals with more medical than nonmedical collections and individuals with more paid than unpaid medical collections were less likely to be delinquent than other individuals with the same credit score.[120]

Other recent CFPB research also supports that medical debt information, in the form of medical collections, has limited value for credit underwriting. As described in part XI, *Technical Appendix*, CFPB researchers reviewed de-identified consumer report data after the NCRAs implemented changes pursuant to a 2015 settlement with over thirty State attorneys general requiring the NCRAs to prevent the reporting and display of medical debt furnished by debt collection agencies when the date of first delinquency is less than 180 days prior to the date the

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[118] *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).

[119] 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.

[120] *Id.* at 4-5, 13-16, 17-19.

debt is reported by the debt collector.[121] After this reporting change, the NCRAs had data on consumers' medical debts that were less than 180 days past due, but creditors making credit eligibility determinations did not receive them in consumer reports provided by the NCRAs. The CFPB researchers compared the performance of credit accounts originated just before a medical collection was added to a consumer report to the performance of credit accounts originated just after a medical collection was added to a consumer report. Under the assumption that consumer delinquency risk is similar in both scenarios, the only difference in these originated accounts is the inclusion of the medical collection on the consumer's report when the consumer applied for the credit account. The CFPB researchers noted that if medical collection reporting is useful in creditor underwriting to reduce delinquency risk, the CFPB would have generally expected a credit account originated for a consumer with unreported medical collections at the time the creditor was making the credit eligibility determination to have a higher delinquency risk than a credit account originated for a consumer that had medical collection information on their consumer report. However, the CFPB researchers found that, on average, new credit accounts of consumers whose medical collections were not included on their consumer reports at the time of their credit applications were no more likely to be seriously delinquent within two years of a credit account's origination than the new credit accounts of consumers whose medical collections were included on their consumer reports at the time of their credit applications. This research suggests that not only can creditors 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. Under the assumption

[121] 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.

that two-year serious delinquency is a good proxy for the overall risk of a credit account, the CFPB's research described the *Technical Appendix* implies that information about consumers' medical debts distorts underwriting decisions, impairs creditors' ability to make safe and low-risk credit approvals, and thus reduces credit approval volumes within creditors' risk-tolerances.

Further confirming the limited value of medical debt information for ensuring that credit decisions are based on whether a consumer will repay a loan, in the time since the CFPB's 2014 study, two major credit score providers adjusted their newer models to reduce or eliminate the weight of medical debt collections.[122] Nonetheless, some widely used models still weigh medical and nonmedical collections equally.[123] This means that consumers with medical debt may still be negatively affected if creditors use older scoring models that overweigh medical debt.

Fourth, the inconsistent nature of medical collection furnishing and medical debt collection practices likely limits the value of such information for credit underwriting. Data suggests that medical debt collections are disproportionately represented on consumer reports compared to, for example, collections for credit card and other financial debt.[124] The vast majority of such medical debt reporting is done by third-party debt collectors,[125] who use

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[122] *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).

[123] 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.

[124] *Id.* at 5.

[125] 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*

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.[126] But, 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.[127] These issues suggest that even consumers with similar amounts amount of medical debt may face markedly different outcomes in the credit market based on whether their medical debt is furnished or not.

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.[128] And, as already noted, large credit scoring companies are moving to models that completely or partially exclude medical collections.[129] In addition, the CFPB learned from several small entity representatives during the

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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).

[126] *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).

[127] 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.

[128] Business 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.

[129] 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.

SBREFA process that some creditors have stopped considering medical collections in their underwriting.[130]

Sixth, some States and some Federal agencies have also acted to limit creditors' access to, or ability to consider, certain medical debt information. For example, several States have prohibited, or are considering prohibiting, the inclusion of consumer medical debt on consumer reports.[131] Although such efforts are in their early stages, the CFPB is not aware of evidence that such actions have affected creditors' underwriting standards or that creditors have materially curtailed access to credit or tightened credit terms in those States. Some Federal government agencies have 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.[132] These changes by the States and by the Federal government indicate a growing

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[130] *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).

[131] *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. The Illinois and Minnesota State legislatures have also passed legislation that would prevent medical debt from being on consumer reports, which will become law upon each State's respective governor's signature. *See* Forest Nelson, *Medical debt may no longer negatively impact your credit in Illinois*, WIFR (May 16, 2024), https://www.wifr.com/2024/05/16/medical-debt-may-no-longer-negatively-impact-your-credit-illinois/; Off. of Minn. Att'y Gen. Keith Ellison, *Attorney General Ellison commends Senate for final passage of the Debt Fairness Act* (May 16, 2024), https://www.ag.state.mn.us/Office/Communications/2024/05/16_DebtFairnessAct.asp. Similar legislation is under consideration in California, Maine, New Jersey, Virginia, and Rhode Island. *See* SB-1061(Cal. 2024), https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB1061; Libby Palanza, *Maine Lawmakers Consider Insulating Medical Debt from Credit Score Calculation, Interest Accumulation, and Legal Action*, Maine Wire (Mar. 20, 2024), https://www.themainewire.com/2024/03/maine-lawmakers-consider-insulating-medical-debt-from-credit-score-calculation-interest-accumulation-and-legal-action/; Robert Walker, *New Jersey Seeks to Ban Medical Debt Collectors from Credit Agency Reporting*, Shore News Network (Mar. 21, 2024), https://www.shorenewsnetwork.com/2024/03/21/new-jersey-seeks-to-ban-medical-debt-collectors-from-credit-agency-reporting/; HB 1265 (Va. 2024), https://lis.virginia.gov/cgi-bin/legp604.exe?241+ful+HB1265+pdf; RI H7103 (R.I. 2024), https://webserver.rilegislature.gov/BillText24/HouseText24/H7103.pdf.

[132] *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-

awareness that medical debt information may have limited value for credit underwriting purposes. 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 broad basis. Removing the financial information exception in Regulation V would create a uniform nationwide baseline consistent with these advancements.

Given these developments, the CFPB has preliminarily concluded that a creditor's consideration of sensitive financial information concerning a consumer's medical debt under the broad financial information exception in existing § 1022.30(d) is not "necessary and appropriate" to protect legitimate operational, transactional, risk, or consumer needs. 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). The CFPB seeks comment on this preliminary conclusion regarding medical debt information, as well as on whether any adjustments to the proposed rule would be "necessary and appropriate to protect legitimate operational, transactional, risk, consumer, and other needs (and which shall include permitting actions necessary for administrative verification purposes)."[133]

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

In addition to debts, the financial information exception permits a creditor to consider 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. By proposing to eliminate the financial information exception, the CFPB would prohibit a creditor from obtaining

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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/.

[133] 15 U.S.C. 1681b(g)(5).

and using sensitive medical information relating to expenses, assets, or collateral in making a determination of the consumer's credit eligibility, unless a specific exception in § 1022.30(e) applies.

Medical expenses and medical debts are closely related. Unpaid medical expenses may become medical debts that a creditor would be prohibited from considering in making a credit eligibility determination under the CFPB's proposal discussed in part V.A.1, *Medical information related to debts*. Because of the similarities between medical expenses and medical debts, the CFPB is proposing to treat these categories of medical information the same. The CFPB has preliminarily determined that the financial information exception for a creditor to consider medical information relating to a consumer's expenses is also not "necessary and appropriate" 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).

The CFPB has also considered the existing financial information exception for medical information relating to a consumer's assets and collateral and, upon further review, has preliminarily determined that the financial information exception for assets and collateral is not warranted. 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. However, such medical equipment is often necessary and potentially lifesaving. Given the importance of medical assets and collateral to a consumer's well-being, the CFPB has preliminarily determined that it is not "necessary and appropriate . . . to protect legitimate operational, transactional, risk, consumer, and other needs" as required under FCRA section

604(g)(5) to continue to have the financial information exception to the creditor prohibition apply to information about medical assets and collateral.

The CFPB seeks comment on its proposed approach to removing the financial information exception at existing § 1022.30(d) for expenses, assets, and collateral. In particular, the CFPB is interested in feedback from creditors and their representatives about whether they take medical devices as collateral or into consideration as assets that may be used by consumers to pay a future debt obligation, and if so, the business justification for doing so.

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

The financial information exception also permits creditors to consider medical information related to income, benefits, and the purpose of the loan, including the use of the loan proceeds. Although the CFPB is proposing to remove the financial information exception, the CFPB intends to retain elements of the exception relating to income, benefits, and the purpose of the loan by moving relevant material to the list of specific exceptions in § 1022.30(e), as outlined below.

Proposed § 1022.30(e)(1)(x) generally retains the financial information exception's test for medical financial information. However, given the proposed narrow scope of the exception (applying only to income, benefits, or the purpose of the loan, including the use of proceeds), it is not necessary to retain § 1022.30(d)(1)(i), which requires the medical information creditors may consider under the exception to be information routinely used in making credit eligibility determinations. Instead, proposed § 1022.30(e)(1)(x)(A) would provide that the exception only applies to medical information relating to income, benefits, or the purpose of the loan, including the use of proceeds. Proposed § 1022.30(e)(1)(x)(A) also provides examples of the types of financial information related to income and benefits relied upon as a source of repayment by restating the examples of financial information in existing § 1022.30(d)(2)(i)(C). Proposed

§ 1022.30(e)(1)(x)(B) and (C) would also provide, as currently required, that the creditor must use the information 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.

The CFPB believes 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. For example, 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.[134] 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.

The CFPB proposes to move an existing example illustrating a use of medical information related to long-term disability income from § 1022.30(d)(2)(ii)(B) to proposed § 1022.30(e)(7). The CFPB does not propose incorporating certain examples from existing § 1022.30(d)(2)(iii) because they do not relate to a consumer's income, benefits, or the purpose of a loan, including the use of proceeds. Some examples describe the creditor's consideration of the consumer's health condition in each instance in denying credit. In light of the CFPB's preliminary determination that certain types of medical information are not necessary and

[134] 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 Z comment 1002.2(z)-3.

appropriate for use in credit determinations, the CFPB believes that these examples do not need to be restated.[135]

The CFPB seeks comment on its approach to the exception in proposed § 1022.30(e)(1)(x) and the accompanying example at proposed § 1022.30(e)(7). The CFPB also seeks comment on whether each of the other, existing specific exceptions are necessary and appropriate and whether the CFPB should amend any of the other existing exceptions and examples in the list of specific exceptions at § 1022.30(e).

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

The CFPB is proposing 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 permit 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 is not prohibited from obtaining or using the medical debt information under § 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.

FCRA section 604, entitled *Permissible purposes of consumer reports*, identifies an exclusive list of permissible purposes for which consumer reporting agencies may provide

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[135] *See* 12 CFR 1022.30(d)(iii)(B) (regarding a consumer's conversation with a loan officer about the consumer's potentially terminal disease), (C) (regarding a loan officer's observation of a consumer's apparent medical condition).

consumer reports.[136] The statute states that a consumer reporting agency may furnish consumer reports under these circumstances "and no other."[137] 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).[138] But, FCRA section 604(g)(2) imposes a specific 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 for credit, for which there are limited exceptions.

The CFPB preliminarily interprets the FCRA section 604(a)(3)(A) credit permissible purpose limitation and the FCRA section 604(g)(2) limitation on the ability of creditors to obtain or use medical information in connection with credit eligibility determinations together to mean that a creditor does not have a credit permissible purpose to obtain or use a consumer report containing medical information that the creditor is prohibited from obtaining or using. Under this interpretation, if the CFPB removes the financial information exception in § 1022.30(d) as proposed, a creditor would 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 the general prohibition in § 1022.30(b), unless a specific exception for

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[136] 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").

[137] *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. 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).

[138] 15 U.S.C. 1681b(a)(3)(A).

obtaining and using medical information in § 1022.30(e) applies to the medical debt information; therefore, absent a specific exception, the creditor would not have a credit permissible purpose for a consumer report containing the medical debt information. Because a consumer reporting agency may only furnish a consumer report to a person if it has reason to believe the person has a permissible purpose for the information, it follows that a consumer reporting agency may not furnish to a creditor a consumer report containing medical debt information if it has reason to believe the creditor is prohibited from using the medical debt information. This limitation is clarified in proposed § 1022.38(b)(1).

The CFPB has also preliminarily determined that the proposed limits on a consumer reporting agency's disclosure to a creditor of a consumer's sensitive medical debt 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.[139] These limitations on consumer reporting agencies would markedly facilitate compliance. 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. Doing so may be cumbersome, especially for creditors that use automated underwriting processes. On the other hand, consumer reporting agencies could more easily implement automatic processes that remove 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.[140] The CFPB has also preliminarily determined that this proposed

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

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

limitation 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."[141] 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.

Proposed § 1022.38(b)(2) would incorporate other limitations on consumer reporting agencies' furnishing of consumer reports containing medical debt information to make clear that proposed § 1022.38 does not override any other prohibition regarding the furnishing of consumer reports. For example, State legislatures and Federal agencies have enacted policies that limit the inclusion of medical debts on consumer reports. The CFPB commends the work of States to proactively protect consumers against the harms of medical debt reporting. In 2022, the CFPB issued an interpretive rule explaining that, with limited exceptions, States are permitted to enact State-level laws that provide consumer protections involving consumer reporting, including regarding the content of information contained in consumer reports, in addition to those provided by the Federal FCRA.[142] The CFPB intends for the proposed intervention to operate alongside Federal and State-level efforts to increase consumer protections around medical debt consumer reporting.

The CFPB is also proposing a related amendment to remove the example in § 1022.30(c)(3)(iii), which describes a creditor receiving medical information on a consumer

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

[142] Consumer Fin. Prot. Bureau, *The Fair Credit Reporting Act's Limited Preemption of State Laws* (June 2022), https://files.consumerfinance.gov/f/documents/cfpb_fcra-preemption_interpretive-rule_2022-06.pdf.

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 proposes to remove the example.

SBREFA panelists raised concerns about the consequences of prohibiting the inclusion of medical debts on consumer reports used for credit underwriting. The CFPB is not proposing to impose a blanket prohibition on the consumer reporting of medical debt information. Proposed § 1022.38 addresses how a consumer reporting agency's responsibilities, with respect to medical debt information, would be impacted by the proposal to remove the financial information exception discussed in part V.A, *Removal of the financial information exception to the creditor prohibition on obtaining or using medical information*.

The CFPB has considered alternatives to this approach. For example, as discussed in the SBREFA Outline, 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.[143] This approach would have been similar to the voluntary changes that the NCRAs implemented in 2022 and 2023 that stopped the reporting of some, but not all, medical debt on a consumer report. SBREFA panelists questioned whether the proposals under consideration were necessary, given recent market changes regarding medical debt consumer reporting.[144]

The CFPB acknowledges the value of these voluntary consumer reporting changes by the three NCRAs, but has preliminarily determined that these types of changes do not do enough to

[143] SBREFA Outline at 19.

[144] *See generally* SBREFA Report.

protect the privacy of consumers' medical data during the credit underwriting process. 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.D, *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. In addition, as discussed in part V.A.1, *Medical information related to debts*, the CFPB has preliminarily determined that a creditor's consideration of sensitive financial information concerning a consumer's medical debt is not warranted.

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.[145] However, consumer reporting agencies are already subject to accuracy and dispute resolution requirements. Therefore, the CFPB has preliminarily determined that its rulemaking goals are best achieved through the proposed approach.

The CFPB seeks comment on all aspects of proposed § 1022.38.

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

During the SBREFA process, several financial institutions, furnisher small entity representatives, and debt collectors expressed concern about how the proposal under consideration to remove the financial information exception in § 1022.30(d) and prohibit consumer reporting agencies from including medical debt collections tradelines on consumer

[145] SBREFA Outline at 19.

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.[146] 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 stating what creditors should tell consumers regarding whether medical debt information should be disclosed on applications for credit, and any limitations on financial institutions' use of consumer-provided information for underwriting.

For the reasons discussed above, the CFPB preliminarily finds it is generally not necessary and appropriate for creditors to obtain or use information about a consumer's medical debt in determining a consumer's credit eligibility. However, the CFPB has preliminarily determined to not repeal other exceptions, including one for medical information is necessary to comply with applicable local, State, or Federal laws. In response to comments during the SBREFA process, the CFPB is proposing an example in new § 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, 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.

[146] SBREFA Report at 36.

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, the creditor would be permitted to use this limited category of 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 provides 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 this limited category of medical information disclosed by the consumer on their application as an ongoing payment obligation.

Proposed § 1022.30(e)(6) explains 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. The CFPB has 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 unsolicited medical information; therefore, it would not be necessary or appropriate for a creditor or card issuer to use medical information contained in a consumer report or request a consumer report in an attempt to obtain medical information in order to comply with the applicable laws. As explained in part V.B, *Limits on consumer reporting agency's disclosure of medical debt information*, the CFPB also believes 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, the limited amount of medical debt information that would be relevant to ability-to-repay or ability-to-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 above, the CFPB preliminarily finds 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 and ability-to-pay rules, and is necessary and appropriate and will prevent evasions and facilitate compliance with the FCRA.

The CFPB does not believe that creditors would need to begin obtaining medical information from consumers under the proposed rule if they do not already do so. For example, the CFPB does not intend this proposal 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.[147]

The CFPB requests feedback on this aspect of the proposed rule and whether the proposal under consideration would assist a creditor or card issuer in making its repayment ability determination under TILA/Regulation Z. The CFPB also seeks 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.

[147] *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.")

VI. Proposed Effective Date

The Administrative Procedure Act generally requires that rules be published not less than 30 days before their effective dates.[148] The CFPB proposes that, once issued, the final rule for this proposed rule would be effective 60 days after it is published in the *Federal Register*. The CFPB preliminarily concludes that 60 days should be enough time for implementation. 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. The CFPB requests comment on this proposed effective date.

[148] 5 U.S.C. 553(d).

VII. CFPA Section 1022(b) Analysis

The CFPB is considering the potential benefits, costs, and impacts of the proposed rule. The CFPB requests comment on the analysis presented below, as well as submissions of additional data that could inform its consideration of the impacts of the proposed rule. This section contains an analysis of the benefits and costs of the proposed 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 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 proposed rule would 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.[149] Reflecting this prevalence, medical collections have recently comprised the majority of credit collection tradelines found on consumer reports.[150] 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 medical services at the time those services are incurred, and may receive medical bills that they are uncertain they actually owe.[151] Some consumers are unable to pay these bills on time, and some of these past-due medical bills eventually become medical collections.

Another factor that potentially makes medical collections an imprecise signal is that they are unevenly reported. Some 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

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[149] 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/.

[150] 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/.

[151] *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/.

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.[152]

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

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[152] 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/.

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 XI, *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.

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.[153]

The proposed rule would generally prohibit creditors from considering medical debt information from consumer reports (among other sources) in underwriting decisions.

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[153] 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.

Consequently, the incentive for medical debt holders and collectors to furnish to consumer reporting agencies would decrease. As a result, the proposed 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 outcomes. While the proposed 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 would reduce the need for dispute resolution, potentially saving both consumers and consumer reporting agencies time and resources.

B. Data and Evidence

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 proposed rule were part of the broader Consumer Reporting Rulemaking, the CFPB convened a Small Business Review 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 nationwide consumer reporting agencies (NCRAs). The data allowed the CFPB to conduct analyses of the predictive value of medical collections information in the context of whether a consumer's application for credit was successful (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 proposed rule's potential impacts to consumers and creditors. While the CCIP is nationally representative, it only contains information for consumers who have consumer reports. In addition, 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. The CFPB requests additional data that can be used to expand the impact analysis.

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.[154] The CFPB requests additional data from health care providers and debt collectors that can be used to quantify potential impacts on entities other than hospitals.

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

C. Coverage of the Proposed Rule

Part VIII.B.3 provides a discussion of the estimated number and types of entities potentially affected by the proposed rule.

D. Baseline for Consideration of Costs and Benefits

The impact analysis compares the proposed 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 voluntary changes in the consumer reporting of medical debt. In September 2017, the NCRAs implemented a 180-day

[154] 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.

waiting period before including furnished medical collections on consumer reports.[155] In July 2022, the NCRAs 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 removed both paid and unpaid medical collections under $500 from consumer reports.[156]

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: 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 proposed rule by switching to 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 proposed rule, affecting the baseline. The voluntary changes recently implemented by the NCRAs could be reversed at any time, and such reversals would tend to amplify the impacts of the proposed 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

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[155] Nat'l Pub. Radio, *Credit Agencies To Ease Up On Medical Debt Reporting* (July 11, 2017), https://www.npr.org/sections/health-shots/2017/07/11/536501809/credit-agencies-to-ease-up-on-medical-debt-reporting.

[156] 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.

included on consumer reports.[157] The only medical collections that the NCRAs include in their consumer reports are those that: (1) are more than one year past due, (2) are for collection amounts greater than $500, (3) are unpaid, and (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.[158] The proposed rule would remove these remaining medical collections from, and generally prohibit future medical collections from being included in, consumer reports provided to creditors.

E. Potential Benefits and Costs to Consumers and Covered Persons

1. Costs to Consumer Reporting Agencies

The proposed rule would generally prohibit consumer reporting agencies from including medical collections information on consumer reports provided to creditors. Consumer reporting agencies may lose revenue if, due to the proposed rule, debt collectors perceive consumer reports as less informative for guiding collection activities. This prohibition may also decrease the incentive for health care providers and debt collectors to furnish medical collections to consumer reporting agencies, although consumer reporting agencies would still be able to include medical collections information on the reports that they provide for non-credit eligibility determination purposes such as with regard to employment or insurance, or to consumers seeking a copy of their own consumer reports. This means that health care providers and debt collectors may still

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[157] *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.

[158] 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.

see some value in reporting medical collections to consumer reporting agencies, including to the three NCRAs. However, it is possible that in response to the proposed rule, consumer reporting agencies would remove medical collections from consumer reports under all circumstances. Consumer reporting agencies may also incur fixed operational and compliance costs to conform to the proposed rule.

Creditors May Be Less Willing to Pay 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 decisions would reduce the information they contain relative to the case today or, in other words, 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. While this is not a view shared by the CFPB, one NCRA commenter who submitted views to the CFPB during the SBREFA process stated that it considers medical collections as predictive of a consumer's willingness and repayment ability and believes that the complete removal of medical collections from consumer reporting would "degrade the accuracy of consumer reporting." 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 proposed rule. The CFPB requests comment on this issue, as well as data that can be used to quantify creditors' demand for consumer reports.

CFPB research finds that the use of medical collections information from consumer reports provided by the NCRAs to creditors seems to vary by creditor type. Medical collections

information appears to be most used by credit card providers, with a credit card inquiry being less successful when it is made after (rather than before) a medical collection appears on a consumer report of a consumer that previously had no nonmedical collections tradelines. To a lesser extent, mortgage providers also appear to use medical collections information.[159] However, the CFPB has no information on the extent to which consumer reporting agencies' revenues from consumer reports generally are driven by sales to these creditor types. The CFPB requests further information to quantify its analysis of the potential revenue losses due to different creditors' decreased demand for consumer reports.

Debt Collectors May Be Less Willing to Pay for Consumer Reports

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, 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.[160] Should medical debt holders and their assignees (*e.g.*, debt collectors or debt buyers) cease furnishing medical collections information to consumer reporting agencies as a result of this proposed rule, debt collectors would no longer have access to medical collections information previously included in consumer reports to assess whether a consumer will repay a specific medical debt in collections. While the remaining information on consumer reports may still be useful to guide their decisions, the loss of medical collections information may reduce debt collectors' willingness to pay for consumer reports from consumer reporting agencies. The CFPB requests data from debt collectors to assess

[159] *See* part XI, *Technical Appendix*, to this proposed rule.

[160] SBREFA Report at 36.

the usefulness of medical collections information for debt collectors' collection practices, as well as data from the NCRAs and other consumer reporting agencies, to quantify the potential revenue losses from reduced sales of consumer reports to debt collectors.

One-Time Operational and Compliance Costs

Consumer reporting agencies may incur one-time costs to comply with the proposed rule. Consumer reporting agencies may need to modify their reporting systems and databases and revise the guidance documents they provide to furnishers. Consumer reporting agencies may also need to reorganize their 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 proposed rule may have already been incurred to some degree to comply with certain States' laws. The CFPB does not have information on the reporting systems and databases used by most consumer reporting agencies at baseline and requests data that can be used to quantify costs that may be incurred or have already been incurred by consumer reporting agencies.

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 data format to furnishers, called Metro 2, and have organized their databases to process and screen data furnished in this format.[161] At baseline, the three NCRAs 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

[161] 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.

parties. The use of the Metro 2 format constitutes an ongoing compliance cost for the NCRAs. It is likely that they already have systems in place to screen out any furnished medical collections that may violate these conditions. It is possible that the NCRAs' and Innovis's screening process may have to be expanded such that they do not accidentally include medical collections submitted by furnishers on consumer reports provided to creditors. However, the Metro 2 format that the NCRAs and Innovis currently provide to furnishers may help facilitate compliance, because tradeline information submitted by furnishers is already required to include codes that specify when a debt is a medical debt.[162] In addition, complying with the proposed rule may only require an extension of the changes the NCRAs and Innovis have made or plan to make to account for laws passed in several states, including New York, Colorado, Connecticut, and Virginia.[163] 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. 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. The compliance costs for consumer reporting agencies could be greater if medical information furnishers do not comply with their FCRA section 623(a)(9) obligation to notify consumer reporting agencies of their status,[164] though the CFPB does not have any indication that medical information furnishers are not complying with that notification

[162] *Id.* at 16-19.

[163] *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.

[164] 15 U.S.C. 1681s-2(a)(9).

requirement. Consumer reporting agencies may incur costs to screen medical information provided by such furnishers, or for which there is no medical information furnisher within the meaning of FCRA section 623(a)(9), from consumer reports provided to creditors for credit eligibility determinations. The CFPB requests comment and information on this potential compliance cost. The CFPB also requests data to quantify general operational and compliance costs that may be incurred by consumer reporting agencies, as well as information on other possible one-time costs.

2. Benefits to Consumer Reporting Agencies

The removal of medical collections information from consumer reports provided to creditors may also reduce consumer reporting agencies' costs by potentially 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.[165] Under the FCRA, consumers have the right to dispute inaccuracies on their consumer report, and consumer reporting agencies are obligated to investigate and resolve them if necessary.[166] This dispute resolution process imposes costs on consumer reporting agencies. A CFPB analysis shows that 5.7 percent of medical collections tradelines had a dispute flag at one point, much higher than the rate of dispute flags for credit cards and student loans.[167] One NCRA

[165] *Id.* at 23.

[166] 15 U.S.C. 1681i(a)(1)(A).

[167] 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/.

commenter reported that their data shows that while consumers dispute medical collections tradelines more often than other tradelines, they do so at a similar rate to consumers disputing delinquent tradelines. To the extent that medical collections tradelines contribute to the number of disputes that consumer reporting agencies resolve, removing medical collections information from consumer reports may reduce consumer reporting agencies' costs associated with dispute resolution. However, the CFPB does not have data to estimate the cost reduction in 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 requests data to quantify these potential cost-reducing benefits.

3. Costs to Health Care Providers

As discussed above, the CFPB understands that some health care providers and their debt collectors currently use furnishing of medical debt information as a means of inducing payment on post-service billed amounts owed by the patient, although this is not one of the purposes of credit reporting as stated in the FCRA.[168] Because medical debt information generally would no longer be included on consumer reports provided for credit eligibility determinations, the proposed rule may reduce the effectiveness of this means of inducing payment on post-service billed amounts owed by the patient. However, post-service billed amounts paid out of pocket by patients is a small fraction of overall health care revenue and thus the overall impact on revenue is likely to be limited. In addition, the effect on health care providers that incur additional costs from pursuing debt collection lawsuits to mitigate non-payment would be marginal given that, at baseline, recovery rates associated with furnished medical collections are already low and health

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

care providers already use litigation to pursue some debts.[169] As discussed in *Costs to Medical Debt Collectors*, debt buyers that also engage in debt collection may be less willing to pay for medical debt if furnishing becomes a less effective way of inducing payment from consumers. This may further reduce the revenues of health care providers that sell medical debt to debt buyers. The CFPB requests comment on these issues, as well as data that can be used to quantify potential impacts to health care revenues and costs from potential non-payment of post-service bills, increases in debt collection litigation, and reduction in sales of medical debt to debt buyers who also engage in debt collection. These impacts are discussed in detail below.

Potential Reduction in Revenues from Post-Service Bills Sent to Patients

The vast majority of health care providers' revenues comes from insurance (*e.g.*, Medicare, Medicaid, private insurance) and other third-party payers. Out-of-pocket spending by consumers only accounts for about 11 percent of national health expenditures.[170] Of that 11 percent, a significant proportion is paid at point of service at a pharmacy or doctor's office.[171] 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

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[169] It is possible for debt collectors to furnish to consumer reporting agencies and pursue debt litigation for the same account. As discussed in *Costs to Medical Debt Collectors*, only 2.5 percent of medical collections on consumer reports 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/.

[170] 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 Dec. 12, 2023). Several SBREFA commenters claimed that the voluntary reporting changes implemented by the NCRAs would result in an 11 percent decrease in their revenues, which likely is an outlier or perhaps a misstatement given the overall share of out-of-pocket spending.

[171] In addition, 55 percent of patients with health insurance paid their out-of-pocket bill in 2021. *See* Crowe, *Hospital collection rates for self-pay patient accounts*, at 8 (Aug. 2022), https://www.crowe.com/insights/asset/h/hospital-collection-rates-for-self-pay-patient-accounts-report.

(CMS) indicates that 72 percent of hospitals had non-Medicare bad debt expenses in 2021.[172] These bad debt expenses on average represent about 6 percent of total costs in 2021 for hospitals that had non-Medicare bad debt. At baseline, industry expectations of bad debt recovery are low, with a 25 percent recovery rate used as a benchmark.[173] Assuming that health care providers achieve a 25 percent recovery rate at baseline, the CFPB estimates that bad debt expenses may rise to at most 7.5 percent of total costs on average. However, this rise assumes that bad debt recovery rates decrease to zero. This may be unlikely given health care providers' use of other collection practices, such as patient outreach and debt collection litigation.[174] The CFPB requests comment on this issue, as well as data that may be used to quantify potential increases in non-Medicare bad debt.

Given the state of health care industry billing practices and business models at baseline, it is unlikely that the proposed rule would change industry practices with respect to billing. In theory, to mitigate potential revenue losses, health care providers could implement operational changes including adding upfront payment options for patients and refusing non-emergency services if patients have an overdue account. However, the CFPB notes that it is illegal to refuse to provide some health care services in certain emergency contexts and that emergency services

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[172] 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.

[173] *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).

[174] In practice, the bad debt recovery rate may be even lower than the industry benchmark, further limiting the potential rise in non-Medicare bad debt that may result from the proposed rule. Using a 2018 survey, the recovery rate for collection accounts generally was estimated to be 11 percent. *See* ACA Int'l, *Kaulkin Ginsberg 2020 State of the Industry Report* (Sept. 21, 2020), https://policymakers.acainternational.org/whitepapers/2020/09/21/2018-state-of-the-industry-report/.

represent a significant share of health care spending.[175] At baseline, there is already a substantial economic incentive to require upfront payment or deny service to patients with overdue accounts given that recovery rates on billed expenses to patients are already low.[176] The proposed rule may only marginally increase the incentive to require prepayment or upfront payment. Upfront payment is already a uniform practice in pharmacies, and prepayment or point-of-service payment for out-of-pocket expenses is commonplace for providers of health care services as well.[177] The CFPB expects that it is unlikely that a decrease in the recovery rates of furnished medical collections would cause health care providers to substantially change their operational and billing procedures in light of already existing incentives. The CFPB requests comment on these issues and requests information on health care providers' billing practices and provision of health care services that can be used to quantify the magnitude of potential revenue losses and consequences.

The CFPB understands that many health care providers sell medical debt to debt buyers. 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

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[175] *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/.

[176] According to a Healthcare Financial Management Association (HFMA) report, the industry expectation is health care providers will 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/. In addition, collecting post-service bills is time consuming, with 75 percent of health care providers needing more than one statement to collect a patient balance. *See* J.P. Morgan Healthcare Payments, *Trends in Healthcare Payments* (Mar. 26, 2024), https://www.jpmorgan.com/insights/payments/payment-trends/healthcare-payment-trends.

[177] 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/.

from health care providers at a price that is a fraction of the nominal value of the medical bills.[178] Because the proposed 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 further reduce the revenues of the affected health care providers. Depending on the magnitude of the decrease in price, health care providers may consider collecting the debt themselves or writing the debt off. However, the revenues of health care providers that at baseline do not allow debt collectors to furnish medical collections information would not be affected in this way. 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 collectors to furnish medical collections information to consumer reporting agencies. The CFPB requests data from health care providers to help quantify their potential reduction in revenues from the sale of medical debt bundles to debt buyers.

Potential Increased Use of Litigation to Collect Medical Debt

The potential for revenue losses described above may affect the rate at which health care providers or the debt collectors they work with choose to file debt collection lawsuits against consumers.[179] Should this happen, it may impose additional costs on health care providers, since pursuing litigation entails some fixed and variable costs. However, repayment rates for medical debt in collections have been historically quite low, and pursuing additional lawsuits as a result

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[178] 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.

[179] 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/.

of the proposed rule is not likely to result in an increase in marginal recovery rates.[180] At baseline, health care providers can already pursue debt collection litigation in conjunction with other collection practices. Accordingly, the CFPB expects that any increase in overall litigation frequency would be limited. The CFPB requests comment on this issue and requests data that may help quantify this potential increase.

Medical debt collection lawsuits tend to be filed in small claims courts and to involve amounts of less than $10,000, with most lawsuits ending in default judgment in favor of plaintiffs.[181] Health care providers may contract with debt collectors to file debt collection lawsuits on their behalf.[182] Depending on whether health care providers sell or assign medical debt to debt collectors, it can be difficult to assess who decides to bring and incur the costs associated with debt collection lawsuits. Health care providers may sell medical debt to debt buyers who also engage in debt collection, thereby transferring ownership for the debt.[183] 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 deciding 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

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[180] 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/.

[181] The Pew Charitable Trusts, *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.

[182] John Ingold & Chris Vanderveen, *UCHealth sues thousands of patients every year. But you won't find its name on the lawsuits*, Colorado Sun (Feb. 19, 2024), https://coloradosun.com/2024/02/19/uchealth-debt-collectors/.

[183] 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.

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 recently reported to have filed 15,710 lawsuits from 2019 through 2023.[184] 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.

Health care providers themselves can also file debt collection lawsuits on their own behalf.[185] Health care providers may incur a mix of fixed costs and variable litigation costs. 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.[186]

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

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[184] 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/.

[185] 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.

[186] 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/.

amounts, making it difficult to estimate costs that hospitals may face.[187] Attorneys can be paid on an hourly basis or on a contingency fee basis. However, if health care providers already employ in-house attorneys, 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 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.[188] The CFPB does not have data to quantify these costs of debt collection litigation that health care providers may incur and requests information from health care providers who currently pursue debt collection lawsuits.

Because health care providers already have the option to pursue debt collection lawsuits 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 proposed rule. The proposed rule would affect the consumer reporting of medical collections above $500, because medical debts under $500 are already removed from consumer reports from the NCRAs at baseline. Since debt collection lawsuits are filed and recorded in State or lower-level courts, the CFPB does not have data to quantify the additional debt collection lawsuits that health care providers may pursue after the proposed rule is implemented.[189] The CFPB requests information from health care providers on the amounts involved in current debt collection litigation.

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[187] *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).

[188] 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.

[189] Blake N. Shultz et al., *Hospital Debt Collection Practices Require Urgent Reform*, Health Affairs (May 2, 2022), https://www.healthaffairs.org/content/forefront/hospital-debt-collection-practices-require-urgent-reform.

4. Costs to Medical Debt Collectors and Debt Buyers

Debt collectors (including debt buyers who also engage in debt collection) generally use three types of collection practices. Debt collectors may use means of communication such as mail and phone calls to locate consumers, inform them of the stated collection amount, and negotiate payment. They may also furnish medical collections information to consumer reporting agencies (generally, one or more of the NCRAs) to induce payment from consumers. Finally, debt collectors can file debt collection lawsuits against consumers.

Debt collectors may switch to the other two types of collection practices 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 proposed rule may reduce their profits if the other collection practices that are not restricted under the proposed rule are costlier or less effective. 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.[190] At baseline, it is possible for debt collectors to furnish to the NCRAs and pursue debt litigation for the same account. 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 requests comment on this issue and data to quantify changes in litigation costs. Debt collectors may have to incur both fixed and variable costs to

[190] SBREFA Report at 38.

increase their use of collection practices other than medical collections furnishing if the proposed rule is finalized. If collecting medical debt becomes more difficult, debt buyers, including those that also engage in debt collection, may also attempt to negotiate a lower price when they purchase medical debt from health care providers. This lower price might reduce health care providers' willingness to sell medical debt to debt buyers.

Given the reporting changes implemented by the NCRAs in recent years, 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. However, the CFPB does not have data to assess the relative prevalence, costs, and effectiveness of the various collection practices that debt collectors use at baseline. The CFPB requests data to quantify the impacts on debt collectors.

Increased Use of Traditional Methods of Debt Collection

Because many debt collectors rely on furnishing medical collections information at baseline, they may have to incur costs from having to increase their use of the collection practices that would not be restricted under the proposed rule. Relative to furnishing medical collections information, contacting consumers through traditional methods of debt collection that include mail, phone, or other means may be more time-intensive and expensive. Some debt collector small entity representatives expect to have to increase staffing by 10 percent as a result. This potential staffing increase may create new jobs. Increased staffing may also impose additional labor costs on debt collectors. 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.[191] The CFPB requests additional information on the costs that debt collectors incur when using traditional methods of communication with consumers, and the effectiveness of these methods for recovering the collection amounts.

Increased Use of Debt Collection Litigation

Debt collectors may also respond to the proposed 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 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.

Debt collectors may incur a mix of fixed costs and variable costs when they increase their use of 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. However, the CFPB does not have information on the current prevalence of debt collection lawsuits relative to other collection practices used by debt collectors.

Debt collectors may also incur variable costs that increase with the number and complexity of debt collection lawsuits. Court filing fees vary depending on the jurisdiction and the collection amounts, making it difficult to estimate the increase in costs that debt collectors

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[191] *Id.*

may incur.[192] Attorneys can be paid on an hourly basis or on a contingency fee basis. However, 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. The CFPB does not have data to quantify these costs of debt collection litigation, and requests further information on the debt collection litigation activities of debt collectors.

The CFPB expects that the increase in total costs associated with debt collection litigation would depend on the number of additional debt collection lawsuits that debt collectors pursue if the proposed rule is finalized. At baseline, medical collections information is included in the consumer reports from the NCRAs if the medical collections are for amounts above $500. Debt collectors appear to use debt collection litigation for both small and large collection amounts, but some research indicates that most debt collection lawsuits are pursued for collection amounts larger than $500.[193] Without comprehensive data on the distribution of stated medical collection amounts, the CFPB cannot provide an estimate of the number of additional debt collection lawsuits that debt collectors may pursue.

Potentially Decreased Recovery Rates

Based on available information, the CFPB expects that approximately 2.5 percent of medical collection accounts are recovered by debt collectors who furnish medical collections information to the NCRAs, as estimated using the share of medical collections marked as paid on

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[192] *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).

[193] 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.

consumer reports.[194] The CFPB requests comment or data submissions that may better approximate the share of medical collections that are recovered by debt collectors. If consumers are no longer concerned that unpaid medical bills will appear on their consumer report when they are seeking credit, they may have less incentive to pay the collection amount even if debt collectors seek to induce payment by using mail, text messages, or phone calls. Thus, despite the changes that debt collectors make to their collection practices, the proposed rule may lead to a further decrease in recovery rates. Decreased recovery rates would reduce debt collectors' revenues, potentially worsening the impact of the increased costs associated with other types of collection practices.

Because recovery of collection amounts is how debt buyers that also engage in debt collection (referred to here as debt collectors) profit from buying medical debt from health care providers, reduced recovery rates would reduce debt collectors' demand for medical debt. If debt collection becomes more difficult or costly, debt collectors' willingness to pay for medical debt would decrease. Depending on the relative bargaining position of debt collectors and health care providers, debt collectors may be able to pass on some of the decrease in expected revenues to health care providers by negotiating a lower price when they purchase medical debt.

The CFPB does not have data that would allow estimation of the potential reduction in recovery rates, or on transactions between debt collectors and health care providers that would allow estimation of expected reduction in the price paid by debt collectors to health care providers, and requests data that can be used to quantify these impacts.

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[194] 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/.

5. Costs and Benefits to Creditors

Under the proposed 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), which the CFPB understands is currently how creditors' primarily use medical debt information. This 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.

However, the CFPB's research in the Technical Appendix instead suggests that creditors would benefit from the removal of medical collections from consumer reports. The CFPB finds that creditors are much less likely to grant credit to consumers with reported medical collections tradelines information, despite also finding that credit accounts originated when creditors were able to observe applicants' medical collections on their consumer reports perform no better in terms of likelihood of serious delinquency, on average, than when creditors were unable to observe that information. This implies that the use of medical collections in underwriting may prevent creditors from making what would be profitable loans.

The Technical Appendix is described in detail below in part XI. Before discussing the CFPB's empirical findings and conclusions, the CFPB discusses more general economic analysis for how creditors may be affected by the proposed rule.

The CFPB understands that creditors for many types of credit products do not generally ask explicitly for medical debt information on applications for credit, 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.[195] The CFPB does not have access to credit applications and the analysis that follows assumes that creditors currently only use medical debt information that is included on consumer reports, except where stated otherwise. While the proposed rule would allow creditors to use medical debt information that consumers provide in credit applications to satisfy ability to repay requirements, the proposed rule would not change any existing law or guidance regarding the information that creditors must request from applicants, and thus would not impose additional costs in that regard. The CFPB requests evidence for how the continued ability to observe medical debt on credit applications may impact creditors and consumers.

Because most consumers with medical debt do not have medical collections on their consumer report, creditors currently provide credit accounts to many consumers who have medical debt without any knowledge of that debt. 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.[196] However, only 14 percent of consumers had a medical collection on their consumer report in 2022.[197] By June 2023, after the

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[195] *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 May 9, 2024).

[196] 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/.

[197] 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/.

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.[198]

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. Further, not all medical debts that are in collections are included on consumer reports, for a variety of reasons. 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.[199] 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.[200] 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

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[198] 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.

[199] 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.https://www.ohioattorneygeneral.gov/Files/Briefing-Room/News-Releases/Consumer-Protection/2015-05-20-CRAs-AVC.aspx

[200] 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.

than one year, and just over 10 percent were reported for at least four years.[201] Since the NCRAs' voluntary medical debt reporting changes were fully implemented in April 2023, the persistence of medical collection reporting has been substantially lower. 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. 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. Creditors may also not observe a medical collection on a consumer report if the debt collector did not report to all three NCRAs.[202] Finally, several States, including Colorado, New York, Virginia, and Connecticut, have enacted laws that significantly restrict or prohibit consumer reporting of medical debt information.[203] 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.

The discussion above presupposes that extending credit to consumers with medical debt is less profitable than extending credit to consumers without, conditional on the other information available to the creditor. It further assumes that being aware of consumers' medical debts would increase creditors' expected revenue, and removing medical debt information would lower revenue. In other words, the discussion presupposes that medical collections tradelines are

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[201] 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/.

[202] *Id.*

[203] *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.

predictive of creditor revenue, and in particular, predictive of serious delinquency.[204] But in fact, previous CFPB research showed that medical collections tradelines are less predictive of serious delinquency than nonmedical collections. This research also 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.[205] The CFPB understands that medical collections may still have some predictive value in the sense that, on average and without considering other consumer characteristics, consumers with medical collections are more likely to become seriously delinquent than consumers without medical collections. However, as explained below, 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 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. Many creditors have voluntarily minimized 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

[204] For purposes of this discussion, the term "serious delinquency" means an account that is at least 90 days past due. Commercial credit scoring models typically try to predict the probability that a new account made to a given consumer will become at least 90-days past due within two years of origination.

[205] 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.

effects on performance.[206] 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.[207]

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 the proposed rule, the CFPB expects that an ex-post analysis of the proposed rule would draw a similar conclusion as the industry analysis above. 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;[208] additionally, more than 40 percent had at least one nonmedical

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[206] *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).

[207] 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.

[208] 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).

collection and nearly 19 percent had no other tradelines.[209] Thin credit files[210] and information about nonmedical collections would remain available to creditors under the proposed rule, to the extent that creditors use these markers to assess delinquency risk.

The CFPB does not interpret its previous research findings as clear evidence that, holding all else equal, consumers with medical collections are seriously delinquent at the same rate as consumers with no medical debt. However, the finding that medical collections are less predictive of serious delinquency than nonmedical collections, and the remaining presence of other information such as nonmedical tradelines on the consumer reports of people with medical collections, suggest that the difference between these two serious delinquency rates is small, holding all else equal.

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. At the baseline, many creditors approve applications for credit without full knowledge of consumer medical debts because most medical debts are not included on 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 proposed rule may impact account performance, and therefore, creditors' profits. Ideally, this

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[209] 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.

[210] 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/.

analysis would be performed with data from consumer reports linked with the timing and presence of consumers' outstanding and unreported medical debts. However, the CFPB does not have access to such linked data and is not aware of such data being available to any researcher or entity.

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.[211] 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.[212] 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.

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[211] *See* part XI, *Technical Appendix*.

[212] 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 proposed 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.[213] 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.

[213] The data used and empirical strategy of the CFPB's analysis are described in Technical Appendix. This section describes their estimation of the effect of medical collection reporting on "inquiry success," or 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 Proposed Rule by Credit Account Type[214]

(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 proposed 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

[214] 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 proposed 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 two 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 proposed rule.

the proposed rule. The 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 proposed rule would not lead to declines in credit application quality.

To provide further evidence for how credit demand may respond to the proposed 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.[215] The CFPB found that consumers in the treated group were just 0.07 percent less likely to have an associated 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.

The CFPB assumes that creditors only make loans at baseline to people with reported medical collections if they are profitable on average. If the marginal loans that would be made under the proposed rule have similar revenue potential, the increase in the number of loans made to people with medical collections would increase creditor profits. To estimate the revenue

[215] 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.

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 effectively use medical collections information in their underwriting decisions to reduce 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's research in the Technical Appendix finds no statistically significant evidence to support this hypothesis. Instead, the CFPB's research finds that credit accounts provided to people whose medical debts were not included on their consumer reports (as medical collections tradelines) were no more likely to be seriously delinquent within two years than credit accounts made to people whose medical collections were included on their consumer reports, on average. To estimate the effects of the proposed rule, the CFPB estimates the number of delinquent loans that would be issued if medical collections were not included on consumer reports, as if the proposed rule is finalized. These ranges also incorporate the evidence from the Technical Appendix on how the number of newly originated loans would change, discussed above. 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 proposed rule by credit account type[216]

(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	0.012	17.1%	63,949	10,935	10,168

None of the estimated coefficients are statistically significantly different from zero.

The CFPB expects that, at baseline, creditors only provide credit to people with reported medical collections if they expect a positive profit. As described above and reproduced in Column 4 of Table 2, the CFPB expects that more accounts are originated under the proposed rule. If these accounts are delinquent at the same rates as accounts provided to consumers with reported medical collections, these accounts would increase creditor profits, all else equal. Instead, the CFPB's research finds that, for mortgages and other (not credit card and not

[216] 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.

mortgage) account types, accounts originated by consumers with reported medical collections have slightly higher delinquency propensity than accounts originated by consumers with unreported medical collections. These coefficients are not statistically distinguishable from zero, so the CFPB cannot conclude that the expansion of credit under the proposed rule would yield a serious delinquency rate that is lower than the serious delinquency rate currently faced by creditors for accounts they provide to consumers with reported medical collections. However, the CFPB interprets its findings as evidence against any significant increase in the serious delinquency rate as compared to the serious delinquency rate for accounts provided to consumers with reported medical collections at baseline. The CFPB notes that this claim holds if consumer demand for credit and the supply of credit do not change in response to the proposed rule.

If consumer demand for credit is affected by the proposed 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 may lead these consumers to submit credit applications, which could lead to an increase or decrease in the delinquency risk of applicant pools, depending on how affected consumers' delinquency propensity compares to that of the average applicant. The CFPB does not have information available to estimate the direction or magnitude of potential changes.

This may change the propensity for a credit application to lead to an opened credit account, as well as the performance of opened credit accounts. 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. In equilibrium, the CFPB expects that consumer demand for credit may increase without the use of medical collections information in underwriting, but the CFPB is unaware of any evidence that either those consumers' underlying delinquency risk, or creditors' ability to predict those consumers' delinquency risk, would change under the proposed rule.

Creditors may change their underwriting processes in response to the proposed rule. The CFPB's research in the Technical Appendix analyzed inquiries that were made when some medical debt information was available to creditors. 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. However, under the assumption that creditors only change their underwriting models if those changes improve model performance, creditors' model updates should only mitigate any potential for reduced account performance under the proposed rule. That is, any changes that creditors implement will improve their ability to identify accounts likely to become seriously delinquent, compared to the models used to evaluate the inquiries observed in the Technical Appendix.

Although the CFPB does not estimate that there would be a significant number of additional seriously delinquent accounts if the proposed rule were finalized, the CFPB does not have data available that would enable it to calculate the monetary cost to creditors of such additional delinquencies as may occur. The CFPB requests information on the dollar cost to creditors of an account that becomes seriously delinquent within two years of its origination. Furthermore, the profitability of a loan is not solely defined by its delinquency. 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.[217]

Under the proposed rule, the CFPB expects that creditors would provide more credit to consumers without significantly increasing average delinquency rates. The CFPB does not have data available to quantify the monetary benefit to creditors from these additional accounts. The CFPB requests comment on this issue.

Aside from the impact on delinquency risk from the change in information, creditors may incur compliance costs from the proposed 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. These costs 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 proposed 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 proposed § 1022.38. In such cases creditors would need to employ systems and staff time to identify and exclude that information. The CFPB requests comment on the compliance costs for creditors that use consumer reports with this type of information.

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[217] 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.

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 requests comment on this issue.

6. Costs and Benefits to Consumers

The proposed rule provides that information about a consumer's medical debt cannot be obtained or used by a creditor in connection with any determination of the consumer's eligibility, or continued eligibility, for credit, unless one of the narrow, specific exceptions listed in the regulation apply. This may affect consumers' access to credit in various ways.

The CFPB expects that the proposed rule would lead to significant benefits for consumers who have medical debt in collections. The CFPB additionally anticipates significant benefits for consumers whose medical debt is not in collections and requests information to estimate these effects. The use of medical debt information in lending determinations compounds the financial consequences of medical debt, even though medical debt is often incurred without a consumer having full knowledge of its costs, given the complex nature of medical billing and insurance coverage. Under the proposed rule, consumers would continue to be liable for their medical debts. Instead, the proposed rule reduces consumers' incentives to pay incorrect or erroneous medical debts and relieves the harm that outstanding medical debt causes to consumers' credit access.

As discussed in part VII.E.3, *Costs to health care providers*, some health care providers and debt buyers use furnishing of unpaid medical debt, through third-party debt collection agencies acting as their agents, as a means of inducing payment from consumers. To the extent that this practice is effective, the proposed rule would reduce those payments induced through

furnishing of unpaid medical debt to consumer reporting agencies. However, consumers with medical debt would still owe the debt, and health care providers and debt collectors would still be permitted to collect on that debt. As discussed in parts VII.E.4, *Costs to debt collectors and debt buyers* and VII.E.3, *Costs to health care providers*, some health care providers and debt collectors may use litigation to induce payment more frequently or instead. The CFPB does not view any of these scenarios as likely.

The allocation of credit may change across consumers with and without medical debt relative to the current baseline allocation if creditors change their underwriting practices. Some consumers may be more likely to be approved for credit, or receive more favorable terms for credit, if creditors cannot use medical debt information in the manner they do now. The Technical Appendix estimates meaningful expansions of credit for consumers with reported medical collections, as described in part VII.E.5, *Costs and benefits to creditors,* and again below. Finally, a small number of consumers may become credit invisible or lose their credit score if medical collections are removed from their consumer reports, though the CFPB expects that this does not lead to substantial reductions in credit access for affected consumers, as described below.

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 consumers who cannot pay upfront or have not paid their previous balances in full. However, these views

are not shared by the CFPB. The CFPB views these outcomes as unlikely given that many health care providers already require payment before treatment.[218]

The CFPB expects that the proposed 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 pay.[219]

The CFPB estimates that the impact will be minimal but does not have data or information available to estimate the exact extent to which the proposed rule would impact the availability of health care. The CFPB requests comment on this issue, in particular quantitative estimates of the expected size of these impacts and any disparate regional impact. The CFPB further requests information from health care providers describing changes in their pricing and willingness to provide care in response to the voluntary NCRA changes that have greatly reduced the share of medical debts that are included on consumer reports,[220] or in response to the removal of medical collections from consumer reports subject to restrictions under the laws of states such as New York or Colorado, or in Connecticut or Virginia after the their laws go into effect in July 2024.[221]

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[218] Melanie Evans, *Hospitals are Refusing to Do Surgeries Unless You Pay in Full First*, Wall St. J. (May 9, 2024), https://www.wsj.com/health/healthcare/hospitals-pay-before-treatment-patients-c477e2d6?mod=hp_lead_pos10. 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/.

[219] Ctrs. for Medicare & Medicaid Servs., *Emergency Room Rights*, https://www.cms.gov/priorities/your-patient-rights/emergency-room-rights (last visited May 9, 2024) (noting Emergency Medical Treatment and Active Labor Act, 42 U.S.C. 1395dd, protections).

[220] *See* part I.D, *Medical debt and consumer reporting* (describing the NCRAs' reporting changes).

[221] *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.

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. The CFPB does not share this view and expects that the proposed rule would cause very few consumers to become uninsured. 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.[222]

In summary, the evidence available to the CFPB finds that people are uninsured largely because they cannot access health insurance or find it unaffordable, and the CFPB expects that the proposed rule would be unlikely to affect either of these margins.

The CFPB does not have data to estimate if the proposed rule would reduce on-time payments for medical services. Even if some consumers were less likely to make on-time payments, it is not necessarily the case that the proposed rule would significantly reduce health care providers' revenues, and thus lead health care providers to take actions. Consumers would remain liable for their unpaid medical debts under the proposed rule. For patients with ongoing relationships with providers, health care providers would continue to require payment for past-due bills at subsequent appointments. Health care providers and debt collectors could continue to use methods other than furnishing to induce payments, including calls, text messages, letters, and

[222] 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/.

litigation. 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.[223] The CFPB expects that 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. Though the cost of litigation is much higher, so too is the expected recovery. The CFPB understands that, while consumer reporting sometimes results in the payment of overdue debt, existing research suggests that consumer debt litigation more often leads to a default judgment in favor of the plaintiff.[224] These judgments can lead to asset seizures or wage garnishment.[225] The CFPB expects that these remaining alternative mechanisms of inducing payment would ensure that consumers continue to maintain health insurance coverage, apply for financial assistance, and pay their medical debt under the proposed rule, as the consequences of litigation may be more severe than the consequences of creditors' use of medical debt information on consumer reports in underwriting.

The CFPB expects that the threat of litigation faced by consumers would mitigate potential costs to health care providers arising from consumers' failure to pay for medical services and prevent those costs from being passed on to consumers in the form of reduced care or higher prices. However, litigation is more costly than furnishing medical debt information to consumer reporting agencies for consumers, health care providers, and debt collectors. Because medical debt litigation can impose large costs on consumers, the CFPB has considered if such

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[223] SBREFA Report at 38.

[224] The Pew Charitable Trusts, *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.

[225] *Id.*

litigation would become more common under the proposed rule. In the current baseline, medical collections are removed from the NCRAs' consumer reports when paid.[226] Consumers seeking credit may pay medical collections included on their consumer reports 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 are to the threat of litigation. The CFPB understands that, at baseline, some consumers may be pressured to pay debts they do not actually owe if they have an immediate credit demand, and the removal of furnishing may reduce the likelihood that these consumers pay spurious debts.[227] For the subset of consumers who legally owe the debt, the proposed 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 consumers, as discussed in part VII.E.4 *Costs to debt collectors and debt buyers*. At least one debt collector suggested that the proposed rule may 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 not be willing to settle or will settle only for relatively high amounts during the course of litigation.[228]

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[226] Business 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.

[227] *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).

[228] 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.

The CFPB does not have data or information available to estimate the exact extent to which the proposed rule may affect the use of litigation, relative to the baseline, by debt collectors who seek to induce payment of medical debts. Because recovery rates on medical debts are already quite low, as noted above, it is unlikely that any increase in litigation would be substantial. The CFPB requests comment on this issue, particularly data or quantitative estimates of the expected changes in litigation were the rule to go into effect. The CFPB is particularly interested in data regarding any changes in litigation propensity that have occurred in response to the voluntary NCRA changes, or the removal of medical collections from consumer reports subject to restrictions under New York or Colorado law, or in Connecticut or Virginia after their laws are implemented in July 2024.[229]

During the SBREFA process, debt collectors expressed concern that creditors would be concerned about the possibility of providing credit to consumers who cannot pay their medical debt under the proposed rule. Commenters expected that this may lead creditors to raise interest rates and fees to account for anticipated increased delinquency rates. However, as described above in part VII.E.5, *Costs and benefits to creditors*, the CFPB does not expect that creditors would experience any significant decline in applicant quality or account performance under the proposed rule. Instead, the evidence available to the CFPB and described in the Technical Appendix suggests that creditors would experience an increase in profitable loan volume under the proposed 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*. Therefore, the CFPB expects that the proposed rule would enable creditors to make more loans

[229] *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.

that have similar delinquency risk to loans in their existing lending portfolio, and would not lead to higher credit costs for consumers.

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.[230] Similarly, VantageScore requires at least one tradeline with any activity before providing a score.[231] For consumers with few tradelines, the removal of medical collections could lead them to lose their credit score. To provide some 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 estimates using consumer reports from January 2024 in CFPB's CCIP as the current 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

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[230] 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/.

[231] *Id.*

baseline credit scores of affected consumers indicate that any increase in the population without credit scores under the proposed 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.[232] The CFPB expects that any reduction in access to credit because of an increase in the population without credit scores would be very small but requests additional information.

Despite these potential negative effects, the CFPB expects that consumers with medical collections included on their consumer reports would experience increased access to credit under the proposed rule, in part caused by increases in their credit scores. 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.[233] 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.[234] However, the causes of the studied medical collection removals were unknown, and 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. Other

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[232] 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/.

[233] 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.

[234] 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.

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.[235] 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 was not representative of all consumers with medical debts, as the reported collections were much older on average than most medical collections on consumer reports.[236] 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."[237] 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 proposed rule. Higher credit scores can lead to higher loan approval rates and more favorable terms.[238] The CFPB requests information on the dollar value to consumers of higher credit scores.

As described above in the discussion of costs and benefits to creditors, creditors currently appear to use medical collections information to either deny consumers' applications for credit or

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[235] 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/.

[236] 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.

[237] VantageScore, *VantageScore Excluding Medical Debt from Credit Scores* (Aug. 12, 2022), https://www.vantagescore.com/press_releases/vantagescore-excluding-medical-debt-from-credit-scores/.

[238] 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/.

provide worse terms. Without any changes in the underlying quality of consumer credit applications or in creditor underwriting practices, consumer credit applications would be more likely to lead to originated loans if the proposed rule were in effect and creditors could not observe medical debt information. The CFPB does not have data available to estimate the dollar value of this increased access to credit, and requests information on the dollar benefit to consumers of additional lending.

Increases in access to credit through either of these channels may be short-term if credit scoring companies change their models or creditors change their underwriting practices in response to the proposed rule. Other consumer report information could receive more or less weight 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 likely substantial costs of changing these models and procedures. The results shown in the Technical Appendix suggest that medical collections reporting does not enable creditors to make fewer delinquent loans, implying that creditors would not experience any decline in revenue from the absence of this information. 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.

Furthermore, consumers facing debt collection attempts may pay or settle debts to remove the tradelines from their consumer report. Previous research from the CFPB found evidence indicating that consumers may act to remove medical collections from their consumer

reports when they plan to apply for a mortgage.[239] Additionally, 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." This suggests that furnishing is an effective tool for inducing payment of debts, though other collection mechanisms, such as litigation, would remain available under the proposed rule. Consumers with a current need for credit would benefit under the proposed rule from reduced pressure to pay medical debts before applying for credit. The CFPB does not have data available to estimate the size of this benefit.

The CFPB understands that many medical collections included on consumer reports reflect incorrect billing, debts that were already paid by either the consumer or by insurance companies, 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.[240] Consumers whose reported medical debts contain inaccurate information may dispute the information with NCRAs and debt collectors at baseline, as discussed above. Consumers would benefit from not needing to dispute these debts under the proposed rule. 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 would be paid without debt collectors' use of furnishing. The

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[239] 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.

[240] 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.

CFPB requests comment and submissions of data, or any other relevant information, that may be helpful in estimating this reduction in erroneous debts paid.

F. Specific Impacts on Consumers in Rural Areas

The potential costs and benefits to consumers of the proposed rule would 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.[241] Therefore, in the aggregate, the proposed rule may have a disproportionate impact on consumers in rural areas. Additionally, to the extent that the proposed rule would 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. The CFPB requests comment as to whether the proposed rule would have distinct impacts on rural consumers.

G. Specific Impacts on Depository Institutions with $10 Billion or Less in Assets

The CFPB does not expect that the proposed rule would have significantly different impacts on depository institutions with $10 billion or less in assets, compared to larger institutions. The CFPB preliminarily concludes that the costs to creditors, described above, would apply equally to these smaller institutions. The CFPB requests comment as to whether this conclusion is accurate, and whether there are other costs, not described above, that would apply specifically to such smaller institutions.

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[241] *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/.

H. Specific Impacts on Access to Credit

The CFPB discusses impacts on access to credit in detail above in part VII.F in reference to potential costs and benefits to consumers. In brief, the CFPB expects that some consumers would lose their credit score if the proposed rule is finalized, although it is unclear whether this would decrease these consumers' access to credit relative to only having medical collections tradelines. Other consumers would likely see increased access to credit due in part to increased credit scores.

VIII. Regulatory Flexibility Act Analysis

The Regulatory Flexibility Act (RFA) requires the CFPB to conduct an initial regulatory flexibility analysis (IRFA) and convene a panel to consult with small entity representatives before proposing a rule subject to notice-and-comment requirements,[242] unless it certifies that the rule will not have a significant economic impact on a substantial number of small entities.[243]

The CFPB Director hereby certifies that this proposed rule, if adopted, would not have a significant economic impact on a substantial number of small entities. Thus, neither an IRFA nor a Small Business Advisory Review Panel (SBREFA Panel) is required. Nonetheless, the CFPB decided for prudential reasons to include this proposed rule 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. The CFPB requests comments or any relevant data that may further inform its determination regarding whether the proposed rule would have a significant economic impact on a substantial number of small entities.

[242] 5 U.S.C. 603, 609(b), (d)(2).

[243] 5 U.S.C. 605(b).

The Small Business Review Panel for this proposed rule is discussed in part III.A. Among other things, the IRFA contains estimates of the number of small entities that may be subject to the proposed rule and describes the impact on those entities. The IRFA for this proposed rule is set forth in this part.

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 rules to assess the potential impacts of that rule on such small entities. While this requirement does not apply where, as here, the agency certifies that the proposed rule, if adopted, would not have a significant economic impact on a substantial number of 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. Details on the SBREFA Panel and SBREFA Panel Report for this proposed rule are described in part III.A.

B. Initial Regulatory Flexibility Analysis

1. Description of the Reasons Why Agency Action is Being Considered

The creditor prohibition in section 604(g)(2) of the FCRA reflects Congress' intention to protect the privacy of sensitive medical information.[244] The creditor prohibition generally 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

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

for inappropriate purposes."[245] 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.[246] The CFPB has preliminarily 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 preliminarily 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 proposing to remove the financial information exception and limit 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 V.

2. Succinct Statement of the Objectives of, and Legal Basis for, the Proposed Rule

The primary objectives of this proposed 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

[245] FCRA section 604(g)(5) (15 U.S.C. 1681b(g)(5)).

[246] This background and the three-part test are discussed in part V.A.

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 proposed rule may be found in part I, and a discussion of the legal authority relevant to this proposed rule may be found in part IV.

3. Description and, Where Feasible, Provision of an Estimate of the Number of Small Entities to which the Proposed Rule Will Apply

The proposed rule would 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 would 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 proposed rule would also affect some small consumer reporting agencies. Specifically, consumer reporting agencies that currently provide medical debt information to creditors for credit eligibility determinations would generally no longer be able to do so.

For the purposes of assessing the impacts of the proposed rule on small entities, "small entities" are defined in the RFA to include small businesses, small nonprofit organizations, and small government jurisdictions.[247] A "small business" is determined by application of Small

[247] 5 U.S.C. 601(6)

Business Administration (SBA) regulations in reference to the North American Industry Classification System (NAICS) classification and size standards. [248]

There are several NAICS categories of small entities that may be subject to this proposed 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 category "credit bureaus" (561450). However, not all entities within this NAICS code are consumer reporting agencies, and some consumer reporting agencies that may fall within this NAICS code may not identify themselves as such.[249] Some consumer reporting agencies specialize in providing consumer reports to facilitate other operations, such as employment screening, check and bank account screening, and insurance.[250] Many small consumer reporting agencies would not be affected by the proposed rule, either because they do not currently furnish consumer reports containing medical debt information or because, under the proposed 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 affected by the proposals under consideration 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,

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[248] *See* U.S. Small Bus. Admin., *Table of size standards*, https://www.sba.gov/document/support-table-size-standards (last visited May 13, 2024).

[249] 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).

[250] 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.

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 would be directly affected by the proposed rule.

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.

Table 3 shows the number of small businesses within NAICS categories that may be subject to the proposed 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. Entity counts are provided for the specific asset amount that the SBA uses to define small depository institutions. However, entity counts are not provided for the specific revenue amounts that the SBA uses to define small entities. For these entities, Table 3 includes the closest upper and lower estimates for each revenue limit (*e.g.*, a NAICS category with a maximum size of $47 million in receipts has both the count of entities with less than $50 million in revenue and the count of entities with less than $40 million in revenue).

Table 3: Number of Entities within NAICS Industry Codes that May be Subject to the Proposed Rule

	Number of Entities	**Percent of Entities**
A. Consumer Reporting Agencies		

	Number of Entities	Percent of Entities
Credit bureaus (561450)	307	
< $35M (Revenues)	279	90.9
< $75M (Revenues)	283	92.2
B. Creditors		
Depository Firms		
Commercial Banking (522110)	4248	
< $850M (Assets)	1078	25.4
Credit Unions (522130)	4702	
< $850M (Assets)	500	10.6
Savings Institutions and Other Depository Credit Intermediation (522180)	322	
< $850M (Assets)	83	25.8
Credit Card Issuing (522210)	6	
< $850M (Assets)	1	16.7
Non-Depository Firms		
Sales Financing (522220)	2367	
< $40M (Revenues)	2112	89.2
< $50M (Revenues)	2124	89.7
Consumer Lending (522291)	3037	
< 40M (Revenues)	2905	95.7
< 50M (Revenues)	2915	96.0
Real Estate Credit (522292)	3289	
< $40M (Revenues)	2872	87.3
< $50M (Revenues)	2904	88.3
Mortgage and Nonmortgage Loan Brokers (522310)	6809	
< $15M (Revenues)	6670	98.0
Financial Transactions Processing, Reserve, and Clearinghouse Activities (522320)	3068	
< $40M (Revenues)	2916	95.0
< $50M (Revenues)	2928	95.4
Other Activities Related to Credit Intermediation (522390)	3772	
< $25M (Revenues)	3610	95.7
< $30M (Revenues)	3621	96.0

Table 4 provides the estimated number of small entities within the categories of credit bureaus, depository institutions, and non-depository institutions, as well as the NAICS codes these entities may fall within. Under the proposed rule, small consumer reporting agencies would 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 would be affected by the proposed rule. As discussed above, many consumer reporting agencies currently specialize in providing consumer reports for purposes that would not be affected by the proposed rule. Additionally, consumer credit markets currently rely heavily on consumer reports from consumer reporting agencies which are not small entities.[251] For these reasons, the CFPB estimates that only a small fraction of the small consumer reporting agencies identified in Table 4 would be affected by the proposed rule. The CFPB requests data to more precisely quantify the number of small consumer reporting agencies that would be affected by the proposed rule.

Small creditors that would be affected by the proposed rule are included in several NAICS categories that can be broadly divided into depository and non-depository institutions. Small creditors would be generally prohibited from considering medical information from consumer reports (and other sources) in credit eligibility determinations under the proposed rule, unless a specific exception applies. However, some small creditors currently do not consider medical information that would be prohibited under the proposed rule, and others only consider

[251] Impacts to consumer reporting agencies are also described within part VII.E.

medical debt information if consumers disclose that they have made monthly payment arrangements with medical debt holders.[252]

While all small creditors would be subject to the proposed rule, the CFPB lacks the data to precisely quantify how many small creditors currently make credit decisions in ways that would be affected by the proposed rule. Small creditors who are currently in compliance, whether in whole or in part, with the proposed 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 requests data to precisely quantify the number of small creditors that may be directly affected by the proposed rule.

Table 4: Estimated Number of Small Entities by Category[253]

	NAICS	Small Entity Threshold	Est. Number of Small Entities
Consumer Reporting Agencies	561450	$41M in revenue (NAICS 561450)	281
Depository Institutions	522110, 522130, 522180, 522210	$850M in assets	1662
Non-depository Institutions	522220, 522291, 522292, 522310,	$15M in revenue (NAICS 522310); $28.5M in revenue (NAICS 522390)	14454

[252] 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).

[253] 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.

NAICS	Small Entity Threshold	Est. Number of Small Entities
522320, 522390	$47M in revenue (NAICS 522220, 522291, 522292, 522320)	

4. Projected Reporting, Recordkeeping, and Other Compliance Requirements of the Proposed 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 proposed rule may impose reporting, recordkeeping, and other compliance requirements on small entities subject to the proposal. 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 would be imposed on, at most, an estimated 281 small consumer reporting agencies and 16,116 small creditors.

Requirements for Consumer Reporting Agencies

Under the proposed rule, consumer reporting agencies would 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. Compliance for affected small consumer reporting agencies would 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 requests data to quantify these costs.

Requirements for Creditors

The proposed rule would generally prohibit creditors from using information related to medical debt (among other categories of medical information) in credit eligibility decisions. Creditors may have to change their underwriting procedures to ensure that they are in compliance with the proposed rule. Currently, many creditors use medical debt information from consumer reporting agencies that would no longer be available under the proposed rule. The proposed rule would not change any existing law or guidance regarding the information that creditors must request from applicants. Creditors may use (or continue to use) certain information, including information relating to medical debt, that consumers provide in credit applications to satisfy ability to repay requirements. The proposed rule may cause creditors to modify their underwriting procedures to rely more heavily on consumer information that they obtain from credit applications. These changes would generally require professional skills related to compliance, underwriting, and legal expertise. The CFPB requests data and evidence to estimate these costs.

5. Identification, to the Extent Practicable, of All Relevant Federal Rules which May Duplicate, Overlap, or Conflict with the Proposed Rule

In its SBREFA Report, which addressed proposals under consideration for other aspects of a FCRA rulemaking as well as for the instant rulemaking regarding medical debt, the Panel identified certain Federal statutes and regulations that address consumer credit eligibility, debt collection, and privacy issues related to medical or financial information, as having provisions

that may duplicate, overlap, or conflict with certain aspects of the proposals under consideration.[254] Each of the statutes and regulations identified in the SBREFA Report, as well as additional statutes and regulations that may be relevant, is discussed below.

TILA[255] 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.

ECOA[256] and the CFPB's implementing regulation, Regulation B, 12 CFR part 1002, prohibit creditors from discriminating in any aspect of a credit transaction, including a business-purpose transaction, on the basis of race, color, religion, national origin, sex, marital status, age (if the applicant is old enough to enter into a contract), receipt of income from any public assistance program, or the exercise in good faith of a right under the Consumer Credit Protection Act.

The Fair Debt Collection Practices Act (FDCPA)[257] 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

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[254] SBREFA Report at 36.

[255] 15 U.S.C. 1601 *et seq.*

[256] 15 U.S.C. 1691 *et seq.*

[257] 15 U.S.C. 1692 *et seq.*

to collect debts and require debt collectors to make certain disclosures to consumers in debt collection.

The Gramm-Leach-Bliley Act (GLBA)[258] 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.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)[259] and the Department of Health and Human Services' implementing regulations,[260] also limit or regulate the use, collection, and sharing of certain health information. Among other things, 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 Americans with Disabilities Act[261] and its implementing regulations, 28 CFR parts 35 and 36, prohibit discrimination against people with disabilities in many aspects of public life.

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[258] 15 U.S.C. 6801 *et seq.*

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

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

[261] 42 U.S.C. 12101 *et seq.*

Similarly, the Fair Housing Act prohibits unlawful discrimination in all aspects of residential real estate-related transactions.[262]

Small entity representatives also provided suggestions of other potentially related Federal statutes and regulations, such as the Patient Protection and Affordable Care Act,[263] the No Surprises Act,[264] and Medicare cost reporting rules.[265]

The CFPB requests comment to identify any additional such Federal statutes or regulations that may impose duplicative, overlapping, or conflicting requirements on financial institutions and potential changes to the proposed rules in light of such duplicative, overlapping, or conflicting requirements, if any. The CFPB further requests comment on methods to minimize such conflicts to the extent they might exist.

6. Description of Any Significant Alternatives to the Proposed Rule which Accomplish the Stated Objectives of Applicable Statutes and Minimize Any Significant Economic Impact of the Proposed Rule on Small Entities

The CFPB considered several alternatives to the proposed 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 also considered

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[262] 42 U.S.C. 3605 (prohibiting discrimination because of race, color, religion, national origin, sex, handicap, or familial status in residential real estate-related transactions); *see also* 24 CFR part 100.

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

[264] 42 U.S.C. 300gg-111 *et seq.*

[265] *See* 42 CFR ch. IV.

exemptions for small entities. However, the CFPB has preliminarily determined that such exemptions would not achieve the objective of FCRA section 604(g)(2) and the proposed rule to protect consumer privacy with respect to sensitive medical information.

The CFPB considered making the proposed 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 will need additional time to comply with further rules. The CFPB has preliminarily determined that compliance with the proposed rule would not impose a significant economic impact on a substantial number of small entities. 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 preliminarily determined that a creditor's consideration of medical information relating to expenses, assets, and collateral is not warranted, and has therefore proposed to remove 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 proposed rule. These alternatives were included in the discussions with small entity representatives and the SBREFA Panel. As discussed in part VII.D, the NCRAs voluntarily implemented changes in the credit 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 preliminarily determined that these three alternatives would not achieve the objective of protecting consumer privacy with respect to sensitive medical information.

7. Discussion of Impact on Cost of Credit for Small Entities

Because the proposed rule would only affect how small creditors and small consumer reporting agencies obtain or use consumers' medical information, the CFPB does not expect that the proposed rule would affect the business lending market. The CFPB preliminarily concludes that the costs of credit for small creditors and small consumer reporting agencies would not be impacted by the proposed rule. The CFPB requests comment as to whether this conclusion is accurate, and any information that may inform this analysis.

IX. Severability

The CFPB preliminarily intends that, if the consumer reporting agency prohibition on furnishing medical debt information proposed in § 1022.38 (or any provision or application of that section) is stayed or determined to be invalid, the proposed amendments to § 1022.30 are severable and shall continue in effect. But because proposed § 1022.38 relies on the proposed amendments to § 1022.30, if the proposed amendments to § 1022.30 (or any provisions or applications of those amendments) were stayed or determined to be invalid, the CFPB preliminarily intends that § 1022.38 would not take (or 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 current version of § 1022.30(d) to continue in effect.

X. Paperwork Reduction Act

The CFPB has determined that the proposed rule would have de minimis burden and therefore, 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.[266]

XI. 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 collections are removed from consumer reports, as under the proposed 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).[267] As a result of this change, when consumers applied for credit in the 180 days before a medical collection was added to their consumer report, they had an outstanding medical debt that was in

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[266] 44 U.S.C. 3501.

[267] 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.https://www.ohioattorneygeneral.gov/Files/Briefing-Room/News-Releases/Consumer-Protection/2015-05-20-CRAs-AVC.aspx.

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.[268]

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.[269] 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'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

[268] 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.

[269] Credit record data are described in detail by Christa Gibbs et al., Consumer Fin. Prot. Bureau, *Consumer Credit Reporting Data* (Dec. 6, 2023), https://bguttmankenney.github.io/Public/CreditDataJEL.pdf.

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).[270] Both datasets only include inquiries made and credit account tradelines opened in response to credit 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.[271] 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.[272]

Each dataset includes a subsample of inquiries and tradelines that were associated with medical collections having initial balances over $500 and that were made when any other

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[270] 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.

[271] 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.

[272] 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 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/.

medical collections 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 consumer reports.[273] This is the primary sample considered in the analysis, but results for the full sample (which includes inquiries associated with medical collections under $500 and inquiries made when medical collections under $500 appeared on the consumer report) are also provided.

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.

When a consumer has multiple medical collections, the data contain duplicates of the inquiries and credit account tradelines if they occur within 180 days of different medical collections. For example, suppose a consumer has two medical collections 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 collections reported on the same day.

[273] 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.

Three reporting changes occurred during the sample period that removed certain types of medical collections from consumer reports.[274] However, because the analysis exploits the date 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.[275] 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.[276] 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 collections on their

[274] 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.

[275] 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.

[276] 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/.

consumer report, from 14 percent of consumers in March 2022 to 5 percent of consumers in June 2023.[277]

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 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.

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

[277] 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.

2024. The dataset includes the number and type of medical and nonmedical collections 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 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.[278] 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.[279]

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

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[278] 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/.

[279] 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.

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 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.[280] The number of days varies for different account types because of differences in the typical length of time between an account application and origination.[281] Finally, when consumers shop for credit,

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[280] *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/.

[281] 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*

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 is equivalent to its maximum time-to-origination.[282] 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.

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.[283] 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

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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/.

[282] 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/.

[283] 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.

origination date.[284] Because the CFPB focuses on two-year performance, credit account 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.

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 econometric analysis can be interpreted as modeling creditor decisions and creditor outcomes, as viewed from creditors' perspectives, rather than modeling the decisions of consumers or debt collectors.

When a consumer has multiple medical collections, the data contain duplicates of the inquiries and credit account tradelines if they occur within 180 days of different medical collections. For example, suppose a consumer has two medical collections 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 collections reported on the same day.

[284] 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.

4. Inquiry Summary Statistics

Table 5: Inquiry Summary Statistics[285]

	(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
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

[285] 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
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.[286] 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[287]

	(1) Mean	(2) Median	(3) Obs. (Unique Consumers)
Panel A: Over $500 Sample			

[286] 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.

[287] 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 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).

	(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 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.[288] 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.[289] 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.[290] Furthermore, the summary statistics for consumers in the full sample are similar to those for 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 valued 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.[291] In the present context, inquiries are "treated" when a medical collection tradeline is added to the

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[288] 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).

[289] 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.

[290] 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/.

[291] 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.

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 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 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 lower 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).[292]

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 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.[293] 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. 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

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[292] *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.

[293] 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.

CFPB estimates the regressions using econometric best practices as implemented by a practitioner software package.[294] 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.

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. 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.

[294] 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.

Table 7: The Effect of Medical Collection Reporting on Inquiry Success[295]

	(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

$* p < 0.1$, $** p < 0.05$, $*** p < 0.01$

[295] 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 collections over $500 made when the consumer had no medical collections 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 (NMC) on their consumer report; Column 3, when consumers did have a nonmedical collection 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[296] 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.[297] Inquiry success rates are higher for all loan types when inquiries are made without nonmedical collections on the consumer report than when nonmedical collections 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 collections valued over $500, if they have any. As discussed above, inquiries made by consumers with many medical collections are often excluded from the over-$500 sample because at least one of those medical collections is under $500. The average number of medical collections on a consumer report when an inquiry is made in the full sample, in Column 4, across

[296] 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/.

[297] 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.

all loan types, is 5.03. Conversely, the average number of medical collections on a consumer report when an inquiry is made, for inquiries made with all medical collections 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 collections 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 collections from consumer reports given the parallel with the NCRAs' current practice for under-$500 medical collections.

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 collections on their consumer report, shown in Column 2, than when consumers had nonmedical collections 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 collections on their consumer report than when nonmedical collections 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 collections 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.[298] 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.[299]

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 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 collections.

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[298] 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.

[299] 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.

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 collections on their consumer reports, with generally larger effects for consumers with medical collections over $500. The CFPB next considered whether this use of medical collections 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[300]

	(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

$* p < 0.1$, $** p < 0.05$, $*** p < 0.01$

[300] 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 collections over $500 made when the consumer had no medical collections 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 (NMC) on their consumer report; Column 3, when consumers did have a nonmedical collection 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 collections on their consumer report than when these collections were present. This means that the true effects for inquiries made without nonmedical collections 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 collections 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.

9. Results Related to Credit Demand and Selection

The results described in the previous two subsections confirm 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 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 is added to their consumer report. If consumers with lower delinquency risk have more knowledge about when a medical collection 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 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's addition to the consumer report.

Figure 1: Inquiry Distribution Across Weeks[301]

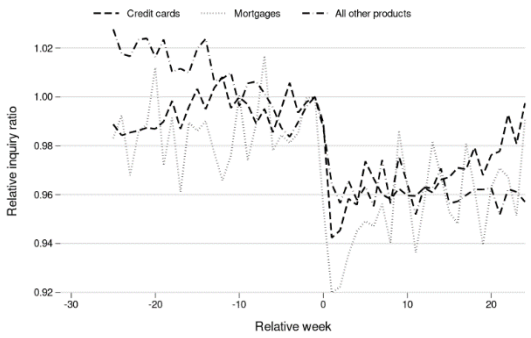

Figure 1 plots the number of inquiries made in each week relative to the week before the date a medical collection was added to a consumer report, represented as week zero. For all

[301] 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.

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 eight 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 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.[302] A consumer who planned to apply for credit may no longer do so if they are aware of a medical collection'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.[303] These mechanisms cannot be observed in the data but could explain the observed discontinuous decline in credit demand around medical collection reporting.

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[302] *See, e.g.*, Equifax, *Equifax Complete™*, https://www.equifax.com/personal/products/credit/monitoring-and-reports/ (last visited May 15, 2024).

[303] *See, e.g.*, Experian, *Collection Triggers℠: Monitoring your collections accounts*, https://www.experian.com/business/products/collection-triggers (last visited May 15, 2024).

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 to the consumer report.

Table 9: Inquiry Balance Tests[304]

	(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

[304] The table includes balance tests for the inquiry sample. Panel A limits the sample to inquiries associated with a medical collection over $500 and no medical collections 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	-0.010	-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
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[305]

	(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.

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 NCRA 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

[305] The table includes balance tests for the performance sample. Panel A limits the sample to inquiries associated with a medical collection over $500 and no medical collections 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.

connecting inquiries to opened tradelines may further limit the accuracy of calculating the running variable. 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[306]

	(1) Over $500, Success	(2) Over $500, D90+	(3) All, Success	(4) All, D90+
Panel A: Credit cards				
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

[306] 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 collections over $500 made when the consumer had no medical collections 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+
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.

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 a hidden effect to the number of days between the first date a medical collection tradeline is reported and the date of an inquiry as the running variable. The potential issue is that there may be bunching at certain values of the running variable if the likelihood of a medical collection being reported, or an inquiry being made, differs across days of the week. For example, fewer than four percent of the medical collections 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 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 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[307]

	(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

[307] 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'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 collections 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+
	(0.011)	(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

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$

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.[308] 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

[308] 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.

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[309]

	(1) Over $500, Shopping	(2) Over $500, No shopping	(3) All, Shopping	(4) All, No shopping
Panel A: Credit cards				
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

[309] 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 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 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.

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 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[310]

	(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]

[310] 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 collections 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.

	(1) Over $500, Shopping	(2) Over $500, No shopping	(3) All, Shopping	(4) All, No shopping
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	-0.003	-0.000	-0.001
	(0.026)	(0.014)	(0.012)	(0.007)
	[-0.065,0.039]	[-0.030,0.025]	[-0.023,0.023]	[-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

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$

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 difference 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[311]

	(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

[311] 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 collections over $500 made when the consumer had no medical collections 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+
Panel C: Other credit Accounts				
RD Estimate	-0.010	-0.020	-0.012***	-0.003
	(0.006)	(0.014)	(0.003)	(0.006)
	[-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. Earlier pulls of consumer reports, and the information contained on them, do not have any bearing on inquiry success if those earlier inquiries did not lead to originated account. 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 collections 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. 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[312]

	(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

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

[312] 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 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 collections over $500 made when the consumer had no medical collections 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.

reduction in consumer access to credit, as baseline 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.

Furthermore, 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 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[313]

	(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]
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)

[313] 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 collections over $500 made when the consumer had no medical collections 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.
	[-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. Additionally, creditors can earn higher revenues when providing higher credit limits to consumers who revolve their balance from month-to-month and pay interest fees. 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.

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 proposes to amend 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) through (ix); and

d. Adding paragraphs (e)(1)(x)(A) through (C) and (e)(6) through (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 § 1022.30(e).

(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.

(d) [Reserved].

(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) 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 include, for example, the dollar amount and continued eligibility for disability income, workers' compensation income, or other benefits related to health or a medical condition that is relied on as a source of repayment.

(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 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 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 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 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.

(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 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) 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.

Rohit Chopra,

Director, Consumer Financial Protection Bureau.