IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF TEXAS, HOUSTON DIVISION

ACA INTERNATIONAL and SPECIALIZED COLLECTION SYSTEMS, INC. Plaintiffs, v. CONSUMER FINANCIAL PROTECTION BUREAU; and ROHIT CHOPRA, in his official capacity as Director of the Consumer Financial Protection Bureau, Defendants.	Case No. 4:25-cv-00094

PLAINTIFFS' ACA INTERNATIONAL AND SPECIALIZED COLLECTION SYSTEMS, INC.'S MOTION ON APPLICATION FOR PRELIMINARY INJUNCTION

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I. NATURE AND STAGE OF THE PROCEEDING

Plaintiffs ACA International (ACA) and Specialized Collection Systems, Inc. (SCS) (collectively, Plaintiffs) bring this action against Defendants Consumer Financial Protection Bureau ("CFPB") and Rohit Chopra, in his official capacity as Director of the CFPB, related to a regulation set to take effect on March 17, 2025. Plaintiffs seek a preliminary injunction and expedited briefing schedule to stay the regulation because it violates the Administrative Procedure Act and the First Amendment of the U.S. Constitution.

II. STATEMENT OF FACTS

The CFPB is an independent agency under the Federal Reserve (*see* 12 U.S.C. § 5491(a)), and was created to prevent another financial crisis, not cause one. On January 14, 2025, the CFPB published a final rule that will suppress millions of accurate tradelines on credit reports about owed payments to healthcare providers and will make it more difficult for healthcare providers to secure payment from patients. *See* Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information (Regulation V) (Final Rule or Rule).[1] Specifically, the Rule will suppress about 57% of information about unpaid accounts currently reported on credit reports.[2] At 12 C.F.R. § 1022.30, the Rule removes a long-standing limitation that allowed creditors to use medical debt so long as it was treated no differently than other debt; and at 12 C.F.R. § 1022.38, the Rule now forbids credit reporting agencies from displaying medical debts on credit reports given to creditors for underwriting purposes.

[1] CFPB, *Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information* (Regulation V) (released Jan. 7, 2025), https://files.consumerfinance.gov/f/documents/cfpb_med-debt-final-rule_2025-01.pdf (hereinafter "Notice") also, 90 Fed. Reg. 3276-3374 (Jan. 14, 2025). To be codified as 12 C.F.R. §§ 1022.3(j); 1022.30; 1022.38.

[2] 90 Fed. Reg. 3279 ("The CFPB estimated that medical collections accounted for 57 percent of all collections tradelines in Q1 2022 and 58 percent in Q2 2018.")

With fewer repercussions for unpaid medical debt, many patients will no longer pay their providers what is owed. 90 Fed. Reg. 3323. The CFPB's own estimate is that healthcare providers will forgo an estimated $97.33 billion, per year, growing 4.6%–7.5% annually. 90 Fed. Reg. 3322; *accord* Ex. 2, Nigrinis Decl., ¶¶ 24–25. Thus, over ten years, this Rule will cost the healthcare system over $970 billion in revenue. (Ex. 2, ¶ 80.)

This Rule affecting a major swath of the economy was issued under the Fair Credit Reporting Act (FCRA), 15 U.S.C. § 1681 *et seq.*, a statute meant to meet the needs of consumer credit in modern commerce that is "fair and equitable to the consumer, with regard to the confidentiality, accuracy, relevancy, and proper utilization of such information . . ." 15 U.S.C. § 1681(b). The Rule, however, mandates that credit reporting agencies (CRAs) *suppress* accurate information about consumer obligations and stops relevant speech about unpaid debts from transferring between CRAs and creditors.

A. The Final Rule will Dramatically Impact Healthcare

The CFPB is regulating an area it knows nothing about. Congress delegated rulemaking authority over healthcare to the U.S. Department of Health and Human Services, 42 U.S.C. § 3501 *et seq*., among others. In fact, Congress recently passed the No Surprises Act to address issues related to medical billing. *See* Cons. Approp. Act of 2021, Pub. L. No. 116–260 (2020); (Compl. ¶ 38.)[3] Moreover, Congress establishes healthcare policy—including payments policy—through legislation that is typically codified in Title

[3] The No Surprises Act protects people who are covered under group health plans from surprise medical bills when they receive: Most emergency services; non-emergency items and services from out-of-network providers with respect to patient visits to certain in-network facilities; and services from out-of-network air ambulance service providers. See https://www.cms.gov/files/document/nsa-keyprotections.pdf visited Jan. 21, 2025.

42 of the U.S. Code. *See* 42 U.S.C. § 27 *et. seq.* In contrast, the CFPB is a financial services regulator under Title 12 that wasn't mentioned at all in the No Surprises Act.

Despite CFPB's lack of healthcare mandate, comments in the rulemaking record identified serious impacts to healthcare providers and their ability to provide services to the public if their bills are unpaid—impacts that include *patient deaths*. 90 Fed. Reg. 3344 ("More than one health care provider commenter stated that hospital closures in rural areas will lead to worse health outcomes or more deaths.")[4] Other comments identified that providers will require payment upfront for services, which leads to bad outcomes for patients such as increased prices, health insurance failures, avoiding preventative care, and facility closures.[5] Most saliently, this revenue loss has consequences for Plaintiffs SCS and ACA's collector members: lost collections revenue and closures of their client's practices. (Compl. ¶ 77; Ex. 1, Whipple Decl., ¶ 35; Ex. 2,¶ 22; Ex. 3, Manghisi Decl., ¶ 50–54; Ex. 4, Hebert Decl., ¶ 40–42.) It also removes a vast swath of data for use in creditor's underwriting systems, which directly damages ACA creditor member's ability to confidently underwrite loans and other credit extensions. (Ex. 5, Purcell Decl., ¶¶ 8-12).

[4] E.g., Cmt. CFPB-2024-0023-0524 ("my livelihood is potentially at risk as I depend on the consumers payment of their outstanding medical debt to pay my own bills."); Cmt. CFPB-2024-0023-0732 from a system of care that employs more than 190 physicians and providers, 953 total employees and serves more than 86,000 patients every year across south central Minnesota, stating that "We typically have $4 to $5 million in accounts receivable and $8 to $9 million out with collection agencies. So if patients did not have to pay, we estimate an annual impact of $10 million. Our margins are extremely tight; we will close in 6 months."

[5] E.g., Cmt. CFPB-2024-0023-0368 (Hospitals will be forced to become more aggressive collecting money up-front when a patient is admitted or procedure scheduled. Insurance companies will suffer massive losses when those paying for medical insurance start canceling policies; why pay expensive insurance premiums if emergency treatment is guaranteed and non-emergency access is now on a cash basis? Most health providers offer cash discounts and write off significant amounts of care to charity; that will stop or be reduced at a minimum. Health providers will lay off staff. Rural health clinics will close. Prices will be raised to compensate for lost revenues.)

B. The Final Rule is Politically Motivated and Has no FCRA-authorized Justification

The Rule was predetermined, politically-motivated, and not based on reasoned decision making or evidence. On June 11, 2024, Vice President Harris and CFPB Director Chopra jointly announced the CFPB's Notice of Proposed Rulemaking (NPRM) for medical debt credit reporting,[6] saying the White House "announced a new action by the CFPB that would remove medical debt from credit reports of more than 15 million Americans." In the press release, the final outcome was a foregone conclusion. Yet despite the seeming predetermined nature of the rule, many commenters objected to its basis, data, and overall wisdom.[7] Of note, the Small Business Office of Advocacy objected to its economic impact, and more than two dozen members of Congress wrote to express their concern that suppressing accurate information about medical accounts will harm the credit reporting system and the healthcare system. (Compl. ¶ 47–48.)

The predetermined outcome that medical debt information was not "necessary and appropriate," to include in credit reports relied on a study from 2014 about medical debt's lesser predictive value than other forms of debt (*e.g.*, auto or mortgage). 90 Fed. Reg. 3345. But the market has known this for years, and already adapted its algorithms and procedures to accommodate the distinction. *Id.* 3276. This Rule therefore has no benefit.

But it has harms. Studies from Fair Isaac Corporation (FICO) and Equifax warn that

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

[7] Supra, notes 4-5.

suppressing medical debt tradelines in their entirety would make credit reports less reliable. (Compl. ¶ 90–93.) Further, the record dismisses a study by ACA's expert economist based on the CFPB's subjective views of its flaws, but fails to recreate or improve upon the study, therefore leaving our economist's serious concerns unaddressed. *See, e.g.*, 90 Fed. Reg. at 3319; *infra* § VII.C.2.

CFPB further misleads the public when it says the Rule is justified because "information about medical debt is often plagued with inaccuracies and errors." (Compl. ¶ 58.) First, the CFPB's own data says that between 2017–2022, only 5.7 percent of medical accounts in collections were flagged as disputed.[8] (*Id.* at ¶ 60.) This means that 94.3 percent of medical accounts in collections were *not* flagged as disputed. Moreover, the 5.7 percent dispute rate is roughly the same rate as any type of delinquent tradeline, indicating there is nothing unique about medical debt inaccuracies that would justify the Rule.[9] (*Id.*) In addition, counts of *disputes* do not equate to actual inaccuracies. (*Id.*) Industry participants who track actual inaccuracies state the correction rate is less than 1 percent. (Ex. 1, ¶ 25; Ex. 3, ¶ 20; Ex. 4, ¶ 25.) Rather, many "disputes" derive from consumer confusion about medical bills. For example, patients may be unfamiliar with healthcare providers who are not patient-facing (like pathologists or radiologists), and thus dispute the tradeline until they understand better the bill. (Ex. 4, ¶¶ 24, 35.)

[8] *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/.
[9] *Consumer Fin. Prot. Bureau*, Disputes on Consumer Credit Reports (Nov. 2021), https://files.consumerfinance.gov/f/documents/cfpb_disputes-on-consumer-credit-reports_report_2021-11.pdf at n. 8.

C. Plaintiffs and ACA's Creditor and Collector Members will Face Irreparable Harm from the Rule.

The Rule must be enjoined "to preserve" Plaintiffs' "status [and] rights pending conclusion of the review proceedings." 5 U.S.C. § 705. In considering whether to grant a preliminary injunction, "the harm considered by the district court is necessarily confined to that which might occur in the interval between the ruling on the preliminary injunction and trial on the merits." *Aquifer Guardians in Urb. Areas v. Fed. Highway Admin*., 779 F. Supp. 2d 542, 573 (W.D. Tex. 2011) (internal citation omitted).The Rule causes immediate harm:

- ACA's creditor members will experience financial harm when they have less information when making credit decisions, and therefore experience inevitable losses from flawed underwriting, which may be as soon as the first missed payment. (Ex. 2, ¶¶ 49–51; Ex. 5, ¶¶ 15-17.) At this moment, creditors are working to adjust underwriting and loan pricing to account for less information and more risk. (Ex. 5, ¶16) But there is no reliable evidence that creditors can, in fact, replace the 57% of lost data from this Rule. *Infra* V.C.1.

- ACA's debt collector members and SCS will be harmed when they must invest in complying with the Rule. Compliance requires them to immediately change disclosures, change how they communicate with consumers about medical debt accounts, and change how they implement new methods of incentivizing consumers to pay medical debts. (Ex. 1, ¶¶ 15, 45–50; Ex. 3, ¶¶ 12, 14, 28–29, 44–57; Ex. 4, ¶¶ 15, 46–52.) Some may wind down their businesses entirely. (Ex. 5, ¶ 17.) Further, if CRAs must rush to comply with the rule, debt collectors may also have medical debt information cut off from their account reviews. Response to Mot. for Prelim. Inj. (Dkt. # 16) at 17-18 (citing ECF No. 9-4 at ¶ 6a; ECF No. 9-6 at ¶ 5a), CDIA v. CFPB, 4:25-cv-00016-SDJ (E.D. Tex. Filed Jan. 23, 2025). They, too, will be unable to view 57% of the total data available about consumers' other debts and obligations.

- ACA debt collector members will also suffer financial harm when they lose healthcare provider clients and the placement of the providers' accounts in collections. (Ex. 2 ¶ 52–53; Ex. 4, ¶¶ 46.) At this moment they are working to convince providers to continue to make placements in the hope that this Rule is enjoined. *Id.* They will likewise suffer financial harm when millions of consumers decide not to pay medical debts because they are misinformed by the CFPB's dangerous press that falsely leads consumers to believe there are

> no legal consequences for not paying medical debt. (Ex. 1, ¶ 29; Ex. 2, ¶ 55; Ex. 3, ¶ 27.)

Moreover, the Supreme Court has recognized that the "loss of First Amendment freedoms, even for minimal periods of time, unquestionably constitutes irreparable injury." *Opulent Life Church v. City of Holly Springs*, 697 F.3d 279, 295 (5th Cir. 2012) (quoting *Elrod v. Burns*, 427 U.S. 347, 373, (1976)); *Denton v. City of El Paso*, 861 F.App'x 836, 841 (5th Cir. 2021) (same). ACA creditor members have a First Amendment right to receive protected commercial speech. *Virginia State Bd. of Pharmacy*, 425 U.S. at 756. SCS and ACA collector members have a right to speak through the CRA channel. This right is violated each day that they must expend resources preparing to comply with the Rule. Only by removing the impending curtailment of protected speech will Plaintiffs' constitutional rights be restored. Additionally, the injunction will serve the public interest, as "[i]njunctions protecting First Amendment freedoms are always in the public interest." *Opulent Life Church*, 697 F.3d at 298 (quotation omitted).

Moreover, the constitutional injury to Plaintiffs outweighs any injury to the government Defendants. The balance of the hardships tips strongly in Plaintiffs' favor. The Rule deprives Plaintiffs and Plaintiff members of their constitutional rights. By contrast, enjoining the Rule will not harm the CFPB. Indeed, "[s]ince the current regulations have been in effect for decades, there is little harm in maintaining the status quo through the pendency of this suit." *Oklahoma v. Cardona*, 2024 WL 3609109, at *12 (W.D. Okla. July 31, 2024). The Rule was not necessary in the first place, and if it is enjoined, the CFPB will still have a vast array of relevant enforcement tools and authorities available to it to address any concerns it has. The Fair Debt Collection Practices Act (FDCPA), Regulation F

provisions concerning credit reporting (12 C.F.R. § 1006.30(a)(1)), and the FCRA itself already provide ample tools to ensure that medical accounts are accurate when they appear on credit reports. (Ex. 4, ¶¶ 27–32.)

III. STANDARD OF REVIEW

A. Preliminary Injunction

A party seeking a preliminary injunction must establish "(1) a substantial likelihood of success on the merits, (2) a substantial threat of irreparable injury if the injunction is not issued, (3) that the threatened injury if the injunction is denied outweighs any harm that will result if the injunction is granted, and (4) that the grant of an injunction will not disserve the public interest." *Janvey v. Alguire*, 647 F.3d 585, 595 (5th Cir. 2011) (quoting *Byrum v. Landreth*, 566 F.3d 442, 445 (5th Cir. 2009)). "To assess the likelihood of success on the merits, [courts] look to standards provided by the substantive law." *Janvey*, 647 F.3d at 596 (cleaned up). At this stage, [Plaintiffs] need not prove that it will ultimately succeed on its claim. Instead, it need only establish that it is *likely* to succeed. *See Byrum*, 566 F.3d at 446 ("A plaintiff is not required to prove its entitlement to summary judgment in order to establish a substantial likelihood of success on the merits for preliminary injunction purposes." (cleaned up)).

The Court next considers whether Plaintiffs will suffer irreparable harm absent an injunction. "In general, a harm is irreparable where there is no adequate remedy at law, such as monetary damages." *Janvey*, 647 F.3d at 600. Here, economic injuries are unrecoverable, as "federal agencies generally enjoy sovereign immunity for any monetary damages." *Wages & White Lion Invs., L.L.C. v. FDA*, 16 F.4th 1130, 1142 (5th Cir. 2021).

For this reason, "complying with [an agency order] later held invalid almost *always* produces the irreparable harm of nonrecoverable compliance costs." *Id.* (quoting *Texas v. EPA*, 829 F.3d 405, 433 (5th Cir. 2016)). And so long as a plaintiff shows that it is likely to suffer more than *de minimis* harm, "it is not so much the magnitude but the irreparability that counts." *Louisiana v. Biden*, 55 F.4th 1017, 1035 (5th Cir. 2022) (cleaned up). The cost to First Amendment rights, collectors' revenues, and creditors' ability to underwrite loans is significant. Moreover, all parties must expend funds changing practices, underwriting models, and disclosures—given the thousands of collectors and creditors affected, even a small individual expenditure is vastly important nationwide. (*See* Ex. 4, ¶¶ 48, 50 (over $105,000 in direct compliance costs and a loss of 63% of client accounts in indirect effect).) As the Fifth Circuit has explained, unrecoverable harm is irreparable harm. *See Janvey*, 647 F.3d at 600.

The final preliminary injunction considerations—the balance of equities and the public interest—also weigh in favor of enjoining the Final Rule. As the Supreme Court has explained, "[t]hese factors merge when the Government is the opposing party." *Nken v. Holder*, 556 U.S. 418, 435 (2009). When balancing the equities, the Court "looks to the relative harm to both parties if the injunction is granted or denied." *Nuziard v. Minority Bus. Dev. Agency*, 721 F.Supp.3d 431, 504 (N.D. Tex. 2024) (citing *Def. Distributed v. U.S. Dep't of State*, 838 F.3d 451, 460 (5th Cir. 2016)). And when evaluating public interests, the Court must be particularly mindful of the public consequences of an injunction. *Id.* at 505–506. If the Rule takes effect, it will cost U.S. healthcare providers nearly $ 1 trillion over ten years. The government has no plans to replace those funds. On the other hand, the

market has already adapted to reflect the predictive value of medical debt and as noted in the attached declarations, the CFPB already has regulations to ensure that reported medical debts are accurate. *Supra* II.C.

B. This Court's review must be on the Administrative Record.

When reviewing final agency action, "traditionally, the task of the reviewing court is to apply the appropriate APA standard of review to the agency decision based on the record the agency presents to the reviewing court." *Aztec General Agency v. FDIC*, 111 F.3d 893 (5th Cir. 1997) (citing *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402 (1971)). "Thus, where an agency's decision is based on an administrative record, the decision should be reviewed in light of that record." *Id.* Typically, the focal point for judicial review should be the administrative record as it stood when the agency acted, not a new record made initially in the reviewing court. *Id.* (citing *Camp v. Pitts*, 411 U.S. 138, 142 (1973). The grounds upon which the agency acted must be clearly disclosed in, and sustained by, the record." *Id.* (citations omitted).

IV. STATEMENT OF THE ISSUES AND SUMMARY OF ARGUMENT

Plaintiffs are entitled to a preliminary injunction because they are likely to prevail on the following four arguments: (1) ACA and SCS have standing; (2) The Final Rule is in excess of the CFPB's statutory jurisdiction based on the FCRA's plain language and legislative history; (3) The CFPB's politically-motivated and prejudged Rule ignores clear evidence and fails to consider critical aspects of the problem under *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins., 463 U.S. 29, 43 (1983)*; (4) And by

suppressing accurate and useful medical debt information, the Final Rule is not narrowly tailored and violates the First Amendment.

V. ARGUMENT

A. SCS and ACA Have Standing because their Injuries are Traceable to the CFPB and Director Chopra and are Redressable with a Favorable Ruling.

Plaintiff SCS is a Texas debt collection firm that specializes in collecting medical debt. The health of its business fully depends on its ability to incentivize consumers to repay bills owed to healthcare service providers. (Ex. 4, ¶¶ 15–20.) The Rule will make communication and collection with and from consumers more difficult. (*Id.* at ¶ 47.) That will impact SCS's bottom line, resulting in immediate reductions in payroll expenses, including potential layoffs or furloughs. (*Id.*)

An organization like ACA can sue on its members' behalf through "associational standing" when "(a) the association's members would otherwise have standing to sue in their own right; (b) the interests the association seeks to protect are germane to the organization's purpose; and (c) neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit." *Tex. Ent. Ass'n, Inc. v. Hegar*, 10 F.4th 495, 504 (5th Cir. 2021) (quotations omitted)). The organization's members would otherwise have standing to sue if they have "(1) suffered an injury in fact, (2) that is fairly traceable to the challenged conduct of the defendant, and (3) that is likely to be redressed by a favorable judicial decision." *Spokeo, Inc. v. Robins*, 578 U.S. 330, 338 (2016). "The burden of establishing these elements falls on the party invoking federal jurisdiction, and at the pleading stage, a plaintiff must allege facts demonstrating each element." *Friends of Animals v. Jewell*, 828 F.3d 989, 992 (D.C. Cir. 2016). The plaintiff "must demonstrate

standing separately for each form of relief sought." *Friends of the Earth, Inc. v. Laidlaw Envtl. Servs. (TOC), Inc.*, 528 U.S. 167, 185 (2000). Here, ACA and SCS only seek injunctive relief to vacate the Rule.

ACA both has debt collector members like SCS and many of the nation's largest lenders as creditor members. (Ex. 5, ¶ 7.) Creditor members can sue in their own right because the Rule directs their conduct and prevents them from receiving truthful and useful information in violation of the First Amendment and their rights under the FCRA. *Supra* at 6. In addition, the curtailment of creditors' rights will hinder their ability to accurately underwrite loans, which will cause financial losses when those loans default. *Id.* ACA debt collector members have standing to sue in their own right because the Rule prevents their communication with creditors via the CRA channels and will cause them financial harm. *Id.* ACA can adequately represent both types of members' interests and the claims and relief requested do not require the participation of individual members as the facts center on the CFPB's administrative record and injunctive relief will resolve all ACA member harms. These same facts also show that ACA and SCS have alleged sufficient injury-in-fact and traceability in both their Complaint and the attached declarations. Absent this Rule, the loss of free speech, income, and incentive effect of credit reporting would not occur.

Finally, the Plaintiffs' claims are redressable. "Redressability examines whether the relief sought, assuming that the court chooses to grant it, will likely alleviate the particularized injury alleged by the plaintiff." *Fla. Audubon Soc'y v. Bentsen*, 94 F.3d 658, 663–64 (D.C. Cir. 1996) (footnote omitted). Plaintiffs seek one substantive form of relief: an order from this Court vacating and setting aside the Rule nationwide for all affected

persons in its entirety. (Compl. ¶ 152.) The requested relief, if granted, would redress ACA/SCS's alleged injury and preserve the status quo.

B. Claim 1 – Excess of Statutory Jurisdiction, Authority, or Limitations, or Short of Statutory Right & Major Questions Doctrine–5 U.S.C. § 706(2)(C).

The Court will "hold unlawful and set aside" agency action that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," 5 U.S.C. § 706(2)(A), "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right," *id.* § 706(2)(C), or "without observance of procedure required by law," *id.* § 706(2)(D). In *Loper Bright Enters. v. Raimondo*, the Supreme Court made clear that "[c]ourts must exercise their independent judgment in deciding whether an agency has acted within its statutory authority." 603 U.S. 369, 412 (2024). The exercise of such independent judgment, the Court explained, is rooted in the "solemn duty" imposed on courts under the Constitution to "say what the law is." *Id.* at 385 (citing *United States v. Dickson*, 40 U.S. 141 (1841); *Marbury v. Madison*, 5 U.S. 137, 177 (1803)).

The *Loper Bright* Court recognized that a statute may authorize an agency to exercise a degree of discretion, and "some statutes 'expressly delegate[ ]' to an agency the authority to give meaning to a particular statutory term." *Id.* at 394 (quoting *Batterton v. Francis*, 432 U.S. 416, 425 (1977)). The Court instructed that when a statute delegates discretionary authority to an agency, "the role of the reviewing court under the APA is, as always, to independently interpret the statute and effectuate the will of Congress subject to constitutional limits." *Id.* Courts "fulfill[ ] that role by recognizing constitutional delegations, fix[ing] the boundaries of [the] delegated authority, and ensuring the agency has engaged in 'reasoned decisionmaking' within those boundaries." *Id.* (quotations

omitted). "By doing so, a court upholds the traditional conception of the judicial function that the APA adopts." *Id.* at 395–396.

1. The statute clearly permits and excepts medical debt reporting.

a. *FCRA's plain language permits medical debt reporting.*

The relevant medical information provisions in the FCRA were largely enacted in 2003 in the Fair and Accurate Credit Transactions Act of 2003.[10] Specifically, the critical parenthetical language in § 1681b(g)(2) was enacted after the original version of 12 C.F.R. § 1022.30 that the Rule rescinds.

The FCRA at Section 1681c(a)(6) provides detailed direction on how CRAs must confidentially treat medical information (relevant provisions highlighted below):

§1681c. Requirements relating to information contained in consumer reports

(a) Information excluded from consumer reports

Except as authorized under subsection (b), no consumer reporting agency may make any consumer report containing any of the following items of information:

(1) Cases under title 11 or under the Bankruptcy Act that, from the date of entry of the order for relief or the date of adjudication, as the case may be, antedate the report by more than 10 years.

(2) Civil suits, civil judgments, and records of arrest that, from date of entry, antedate the report by more than seven years or until the governing statute of limitations has expired, whichever is the longer period.

(3) Paid tax liens which, from date of payment, antedate the report by more than seven years.

(4) Accounts placed for collection or charged to profit and loss which antedate the report by more than seven years.

(5) Any other adverse item of information, other than records of convictions of crimes which antedates the report by more than seven years.

(6) The name, address, and telephone number of any medical information furnisher that has notified the agency of its status, unless-

(A) such name, address, and telephone number are restricted or reported using codes that do not identify, or provide information sufficient to infer, the specific provider or the nature of such services, products, or devices to a person other than the consumer; or

(B) the report is being provided to an insurance company for a purpose relating to engaging in the business of insurance other than property and casualty insurance.

[10] The term "medical information" is defined in the FCRA § 603(i) as:

(1) Information 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:
(i) The past, present, or future physical, mental, or behavioral health or condition of an individual;
(ii) The provision of health care to an individual; or
(iii) The payment for the provision of health care to an individual. 15 U.S.C. § 1681a(i)(1); 12 C.F.R. 1022.3(k)(1).

And once a CRA complies with Section 1681c(a)(6) by reporting the identity of medical information furnishers with codes that hide the nature of medical care, several FCRA provisions expressly permit the consideration of medical debt in connection with any determination of the consumer's eligibility, or continued eligibility, for credit. *See* 15 U.S.C. §§ 1681b(g)(1); 1681b(g)(2); 1681b(g)(3).

Specifically, 15 U.S.C. § 1681b(g)(1) provides three exceptions to the general rule that limits providing medical information, denoted below with the highlighted term "unless." The exception relevant to the instant challenge is Section 1681b(g)(1)(C), which excepts information from the general rule if the information pertains solely to transactions, accounts, or balances related to debts arising from the receipt of medical services, products, or devices.

> **(g) Protection of medical information**
>
> **(1) Limitation on consumer reporting agencies**
>
> A consumer reporting agency shall not furnish for employment purposes, or in connection with a credit or insurance transaction, a consumer report that contains medical information (other than medical contact information treated in the manner required under section 1681c(a)(6) of this title) about a consumer, unless-
>
> (A) if furnished in connection with an insurance transaction, the consumer affirmatively consents to the furnishing of the report;
>
> (B) if furnished for employment purposes or in connection with a credit transaction-
>
> (i) the information to be furnished is relevant to process or effect the employment or credit transaction; and
>
> (ii) the consumer provides specific written consent for the furnishing of the report that describes in clear and conspicuous language the use for which the information will be furnished; or
>
> (C) the information to be furnished pertains solely to transactions, accounts, or balances relating to debts arising from the receipt of medical services, products, or devises, where such information, other than account status or amounts, is restricted or reported using codes that do not identify, or do not provide information sufficient to infer, the specific provider or the nature of such services, products, or devices, as provided in section 1681c(a)(6) of this title.
>
> **(2) Limitation on creditors**
>
> Except as permitted pursuant to paragraph (3)(C) or regulations prescribed under paragraph (5)(A), a creditor shall not obtain or use medical information (other than medical information treated in the manner required under section 1681c(a)(6) of this title) pertaining to a consumer in connection with any determination of the consumer's eligibility, or continued eligibility, for credit.

The body of § 1681b(g)(1) contains the word "unless", therefore § 1681b(g)(1)(C) clearly contains an exception that allows medical debt reporting—that is—the very specific

information about transactions allowed under § 1681b(g)(1)(C), which is a subset of "medical information" as a whole.

The CFPB argues in the record that the term "unless" before enumerated (A)–(C) does not insulate medical debt information from restrictions in other provisions:

> "[t]he protection in FCRA section 604(g)(1)(C) ensures that the medical information obtained or used by creditors would be anonymized to protect consumers' privacy. The fact that FCRA section 604(g)(1)(C) carves certain anonymized information out of the general prohibition in FCRA section 604(g)(1) does not immunize such anonymized information from restrictions contained in other provisions, such as FCRA section 604(a)'s permissible purpose restrictions or regulations issued under FCRA section 621(e)." 90 Fed. Reg. 3303.

But when interpreting acts of Congress, courts seek the ordinary meaning of the enacted language. *Nat'l Ass'n of Priv. Fund Managers v. SEC*, 103 F.4th 1097, 1110 (5th Cir. 2024). The ordinary, contemporary, and common meaning of "unless" as a conjunction is: *(1) except on the condition that : under any other circumstance than; (2) without the accompanying circumstance or condition that: but that : but.*[11] *See Barr v. Securities and Exchange Commission*, 114 F.4th 441 (2024) (relying upon dictionary to determine ordinary meaning), citing *Belt v. EmCare, Inc.*, 444 F.3d 403, 412 (5th Cir. 2006) ("[W]e routinely consult dictionaries as a principal source of ordinary meaning . . .").

Likewise, § 1681b(g)(2) contains a parenthetical that uses the phrase "other than," which conveys Congressional intent that the limitation on creditors has an exception for medical debt that complies with the confidentiality requirement at Section 1681c(a)(6). (*Supra* at 14.) The ordinary, contemporary, and common meaning of the phrase "other

[11] "Unless." Merriam-Webster.com Dictionary, Merriam-Webster, https://www.merriam-webster.com/dictionary/unless. Accessed 7 Jan. 2025; *accord* The American Heritage Dictionary of the English Language, Fifth Edition. https://ahdictionary.com/word/search.html?q=unless. Accessed 7 Jan. 2025. (defining "unless" as, "Except on the condition that; except under the circumstances that;" and as a preposition as, "Except for; except.")

than" as a preposition is "*with the exception of : except for, besides*." As a conjunction, "other than" means: "*except, but*." [12] Again, Congress used a term that clearly conveys an exception to the general proposition.

Accordingly, the FCRA allows CRAs to provide medical debt information on the condition that it is the specific subset of medical information that pertains solely to transactions, accounts, or balances relating to debts arising from the receipt of medical services *and* where the information is reported using codes that do not identify the specific provider or the nature of such services. *See* 15 U.S.C. § 1681b(g)(1)(C). The CFPB states in the record that the parenthetical in § 1681b(g)(2) means something non-obvious on the face of statute. 90 Fed. Reg. 3314 n. 190. But with all disputes of statutory interpretation, "we begin with the text of the statute." *United States v. Lauderdale Cnty., Mississippi*, 914 F.3d 960, 961 (5th Cir. 2019). CFPB's explanation of parentheticals and "technical amendments" is too convoluted to support the agency's reading, much less that Congress intended such machinations to overwhelm clearly-written text.

b. *FCRA legislative history says that medical debt is reportable.*

The FCRA allows medical debt use on its face; but also, section 1681b(g)'s legislative history shows that 1681b(g) contemplates creditors considering consumer applicants' medical debt in lending decisions. For example, in 2003, when summarizing the then-proposed amendments in the FACTA to the FCRA's governance of medical information in the financial system, House Report 108-263 explained that medical

[12] Webster's "Other than." Merriam-Webster.com Dictionary, Merriam-Webster, https://www.merriam-webster.com/dictionary/other%20than. Accessed 7 Jan. 2025.

information may be included in a credit report if the information does not identify the provider or nature of services:

> Medical information may be included in a report for employment or credit purposes only where the information is relevant for purposes of processing or approving employment or credit requested by the consumer and the consumer has provided specific written consent, *or if the information meets certain specific requirements and is restricted or reported using codes that do not identify or infer the specific provider or nature of the services, products, or devices to anyone other than the consumer (except for certain insurance purposes).*

H.R. Rep. 108-263 (Sept. 4, 2003) (emphasis added).[13]

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

c. *Regulations cannot supersede statutes.*

The CFPB believes that it has the power to supersede Congressional intent and ban medical debt on credit reports under three grants of rulemaking authorities: FCRA Sections 1681b(g)(3)(C), 1681b(g)(5)(a), and 1681s(e)(1). It is incorrect.

[13] This explanation implicitly acknowledges that credit transactions will include medical information as provided in section 604(g), but that redisclosure—in other words unauthorized violations of a consumer's privacy and confidentiality—was prohibited. This same report also expressly notes that, subject to the required restrictions, medical information "may be included in a report for . . . credit purposes" "where the information is relevant for the purposes of processing or approving . . . credit requested by the consumer." *Id.*

The rulemaking authority under Section 1681b(g)(3)(C) allows the Bureau to determine additional situations where disclosure of medical information is not treated as a consumer report, but it does not give authority to suppress medical debt information:

> **(3) Actions authorized by Federal law, insurance activities and regulatory determinations**
>
> Section 1681a(d)(3) of this title shall not be construed so as to treat information or any communication of information as a consumer report if the information or communication is disclosed-
>
> (A) in connection with the business of insurance or annuities, including the activities described in section 18B of the model Privacy of Consumer Financial and Health Information Regulation issued by the National Association of Insurance Commissioners (as in effect on January 1, 2003);
>
> (B) for any purpose permitted without authorization under the Standards for Individually Identifiable Health Information promulgated by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996, or referred to under section 1179 of such Act,[1] or described in section 6802(e) of this title; or
>
> (C) as otherwise determined to be necessary and appropriate, by regulation or order, by the Bureau or the applicable State insurance authority (with respect to any person engaged in providing insurance or annuities).

The above language says that the Bureau can expand and contract its list of information "otherwise determined to be necessary and appropriate," but nothing in the statute says that the CFPB can overwrite the statutory exception. The Fifth Circuit will not allow agencies to rewrite statutes. *VanDerStok v. Garland*, 86 F.4th 179, 195 (5th Cir. 2023), cert. granted, 144 S. Ct. 1390 (2024) ("Where the statutory text does not support [the agency's] proposed alterations, [the agency] cannot step into Congress's shoes and rewrite its words"). Likewise, the FCRA Section 1681b(g)(5)(a) grants the Bureau the rulemaking authority to "permit" additional types of transactions where it may be appropriate to 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:

> **(5) Regulations and effective date for paragraph (2)**
>
> **(A) 2 Regulations required**
>
> The Bureau may, after notice and opportunity for comment, prescribe regulations that permit transactions under paragraph (2) that are determined to 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), consistent with the intent of paragraph (2) to restrict the use of medical information for inappropriate purposes.

In this provision, "paragraph (2)" refers to the limitation on creditors at Section 1681b(g)(2):

> **(2) Limitation on creditors**
>
> Except as permitted pursuant to paragraph (3)(C) or regulations prescribed under paragraph (5)(A), a creditor shall not obtain or use medical information (other than medical information treated in the manner required under section 1681c(a)(6) of this title) pertaining to a consumer in connection with any determination of the consumer's eligibility, or continued eligibility, for credit.

Thus, the CFPB's rulemaking authority is limited to "permitting" transactions that are in addition to those already excepted because the medical debt information is treated as required. To read otherwise would ignore the phrases "permit" and "other than" in the statutory text. The phrase "other than" cannot be ignored to favor the CFPB's interpretation. *See, e.g.*, *Conn. Nat'l Bank v. Germain*, 503 U.S. 249, 253-54 (1992) ("[C]ourts must presume that a legislature says in a statute what it means and means in a statute what it says there."). Therefore, the Rule change at § 1022.30 is inconsequential, as the statute nevertheless permits medical debt information to be reported if it otherwise meets confidentiality requirements.

Finally, CFPB justifies new Rule § 1022.38 under a general grant of rulemaking authority at § 1681s(e)(1) that allows the CFPB to "administer and carry out" the purposes and objectives of the FCRA. 90 Fed. Reg. 3303. Under both the major questions doctrine and the plain text, this authority does not allow the agency to limit credit reporting of particular types of debt. The FCRA's purpose is to promote accuracy and meet the needs of

credit. (*Supra* at ii.) The CFPB's authority to regulate the medical industry is notably absent from Title 42 or the Dodd-Frank Act, 12 U.S.C. § 5512. In fact, in prior publications, the CFPB has stated that it has authority to regulate the debt collection market because that "is a market for financial products and services under the Act," but that debt arising from medical expenses should be excluded because it is "unrelated to consumer financial products or services." 77 Fed. Reg. 9597 (Feb. 17, 2012). Because revised § 1022.30 is contrary to the statutory text and FCRA purpose, new § 1022.38 must be vacated and set aside.

2. Congress did not delegate authority to CFPB under the Major Questions Doctrine.

Not only does the FCRA itself forbid the Rule, the CFPB does not have the power it claims under the Major Questions Doctrine. "[I]n certain extraordinary cases, both separation of powers principles and practical understanding of legislative intent make [the court] reluctant to read into ambiguous statutory text the delegation claimed to be lurking there. To convince [the court] otherwise, something more than a merely plausible textual basis for the agency action is necessary. The agency instead must point to clear congressional authorization for the power it claims." *West Virginia v. EPA*, 597 U.S. 697, 723, (2022) (citation and internal quotation marks omitted). There are three indicators that each independently trigger the doctrine: (1) when the agency "claims the power to resolve a matter of great political significance"; (2) when the agency "seeks to regulate a significant portion of the American economy or require billions of dollars in spending by private persons or entities"; and (3) when an agency "seeks to intrude into an area that is the particular domain of state law." *Id.* at 743–44 (Gorsuch, J., concurring) (citations and

internal quotation marks omitted); *see also Texas v. Nuclear Regul. Comm'n*, 78 F.4th 827, 844 (5th Cir. 2023) (applying the major questions doctrine because of the political significance of the issue).

The Final Rule presents a major question on several bases. *First*, healthcare payment responsibility and billing practices is a matter of great political significance, as demonstrated by the recent passage of the 2020 No Surprises Act, which directly addresses how hospitals bill patients for services. (*Supra* at **Error! Bookmark not defined.**.) The political significance is also shown from the letter by many members of Congress who opposed this rule. (*Id.*) *Second*, the Final Rule regulates a significant portion of the American economy and causes billions of dollars in losses by the healthcare industry: it impacts approximately 15 million private agreements (*supra* at 4) and will cost healthcare providers over $ 970 billion in ten years. (*Id.*) Recent cases applying the doctrine based on economic significance have similarly involved hundreds of billions of dollars of impact. *See e.g.*, *Biden v. Nebraska*, 600 U.S. —, 143 S. Ct. 2355, 2362 (2023) ($430 billion); *West Virginia v. EPA*, 597 U.S. 697, 715 (2022) ($1 trillion by 2040). The instant case falls cleanly within those bounds.

Critically, the CFPB doesn't even regulate healthcare. (*Supra* at **Error! Bookmark not defined.**.) It is implausible that Congress intended a financial services regulator to cause such a massive impact on healthcare policy and payments without an express delegation of statutory authority. Therefore the entire Rule is in excess of statutory authority and must be vacated.

C. Claim 2 – Arbitrary and Capricious–5 U.S.C. §§ 553, 706(2)(A).

In an arbitrary and capricious challenge under 5 U.S.C. § 706(2)(A), the core question is whether the agency's decision was "the product of reasoned decision making." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins.*, 463 U.S. 29, 52 (1983); *see also Allentown Mack Sales & Serv., Inc. v. NLRB*, 522 U.S. 359, 374 (1998) ("the process . . . must be logical and rational"). The court "is not to substitute its judgment for that of the agency." *State Farm*, 463 U.S. at 43. "Nevertheless, the agency must examine the relevant data and articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made." *Id.* (internal quotation marks omitted). When reviewing that explanation, the court "must consider whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment." *Id.* (internal quotation marks omitted).

For example, an agency action is arbitrary and capricious if the agency "entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before [it], or [the explanation] is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Id.* The party challenging an agency's action as arbitrary and capricious bears the burden of proof. *Mississippi Hosp. Ass'n, Inc. v. Heckler*, 701 F.2d 511, 516 (5th Cir. 1983).

Courts across the U.S. and this Circuit have held rules to be arbitrary and capricious on multiple bases, many of which appear in the Final Rule. *See Texas v. United States*, 555 F.Supp.3d 351, 418 (S.D. Tex. 2021) (agency's failure to tie factual considerations to the enumerated policy was arbitrary and capricious); *Ryan LLC v. FTC*, — F.Supp.3d —, 2024

WL 3297524, *11 (N.D. Tex., July 3, 2024) (agency Rule arbitrary and capricious when based on inconsistent and flawed empirical evidence); and *Sw. Elec. Power Co. v. EPA*, 920 F.3d 999 (5th Cir. 2019) (an agency's excuse of "lack of sufficient data" for its rulemaking decisions was arbitrary and capricious).

1. The CFPB ignored clear evidence of usefulness of medical debt in underwriting.

The CFPB concludes from internal studies that removing medical debt from all credit reports in the U.S. will not reduce lender's underwriting models' ability to predict delinquency:

> "Based on this research, the CFPB expects that medical collections can be removed from underwriting models without significantly reducing their ability to predict serious delinquency if underwriting models continue to include other variables that are sufficiently predictive of delinquency risk."

90 Fed. Reg. at 3322–23. But this is a guess, and is not supported by evidence in the record.

First, the CFPB did not study all, a portion, or even a handful of "underwriting models." Creditors' underwriting models are trade secret proprietary information that are not shared. (Ex. 5, ¶ 9.) It is simply impossible for the CFPB to arrive at the conclusion that all underwriting models can adapt to the loss of 57 % of the collections data contained on U.S. credit reports.

Furthermore, its 2014 study actually says that medical debt has a reasonable amount of predictive value, just slightly lesser than other types of debt.[14] (Ex. 2, ¶ 21.) Specifically, the 2014 study determined that "medical debt collections tradelines . . . are less predictive

[14] *See* Andrew Rodrigo Nigrinis, *Comment Letter on Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information (Regulation V)*, at 19 (Aug. 13, 2024), https://www.regulations.gov/comment/CFPB-2024-0023-1019 ("Research by the CFPB indicates that medical debts are less predictive of default—but still predictive. Because medical debts have some predictive value, rules to limit underwriting consideration of medical debts will damage the market.")

of future consumer credit performance than nonmedical collections." 90 Fed. Reg. at 3297. The CFPB's own data shows an estimated credit score difference of 16 to 21 points for medical debts versus non-medical debts. (Ex. 2, ¶ 21.) But in their example, the credit score of a consumer with medical debt tradelines is still almost 100 points lower than their score prior to the tradeline deletion, implying a large impact from the removal of medical debt tradelines under the Rule. (*Id.*) The CFPB's claims that creditors can still "rank order" borrowers after the Rule totally failed to respond to commentary that suggests medical debt is the largest driver of consumer bankruptcy.[15] Imagine a borrower with a "prime" credit score getting a loan and filing bankruptcy days later due to medical debt. Under this Rule, creditors will be unable to trust any scoring model data.

The Rule is similar to the arbitrary and capricious rule in *State Farm* because it also runs counter to the evidence before the agency. *See State Farm*, 463 U.S. at 43. Here, the CFPB study says that medical debt has less predictive value than other types of debts, but this does not justify the conclusion that removing all instances of medical debt from underwriting models will not "significantly reduc[e] their ability to predict serious delinquency…" The CFPB did not actually study this question. It provides a Technical Appendix that has serious methodological flaws. (*See* Ex. 2 ¶¶ 43–47.) But it also fails to address the one relevant question: what will happen to the reliability of underwriting models when vast amounts of relevant data suddenly disappear?

[15] Cmt. CFPB-2024-0023-1075 at 70 ("Anecdotal and self-reported evidence suggests that medical debt is the largest driver of consumer bankruptcy. In turn, invisibility of bankruptcy risk frustrates the utility of credit reports in general for all purposes.")

Further, not only is the Appendix inapposite, it was not released for peer review or public commentary, which alone renders the Rule procedurally flawed. *See Texas v. EPA*, 389 F.Supp.3d 497, 505 (S.D. Tex. 2019) ("an agency commits serious procedural error when it fails to reveal portions of the technical basis for a proposed rule in time to allow for meaningful commentary") (internal quotations omitted). Accordingly, the CFPB's studies fail to support its conclusion that medical debt is unnecessary or inappropriate for credit reporting and that removing it from the credit system will cause no harm to lenders' underwriting models.

The flawed studies alone are significant, but also, the CFPB's conclusion runs contrary to actual observed results submitted by credit scoring and credit reporting agencies like Fair Isaac (FICO) and Equifax.[16] In 2015, FICO reported that "[o]ur research has consistently found that individuals with unpaid collections are more risky (i.e., less likely to repay loans) than those who do not have unpaid accounts."[17] Thus, "ignoring ALL medical collections, regardless of whether those accounts have been paid, can have an adverse impact on score predictiveness."[18] Further, "it is not accurate to claim that empirical evidence shows that, especially in the current credit environment, medical debt is not predictive of future borrower performance and that it is not necessary and appropriate for creditors to obtain or consider medical debt information as part of the credit decision process. The opposite is closer to the truth."[19]

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[16] See, e.g., Amy Crews Cutts, Comment Letter on Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information (Regulation V), at 4 (Aug. 12, 2024), https://www.regulations.gov/comment/CFPB-2024-0023-0973 (reviewing one FICO study and one non-public industry study).
[17] *Id.*
[18] *Id.*
[19] *Id.*

Likewise, Equifax, a nationwide CRA, told the CFPB that that delinquency rates were "at least 8% higher for consumers with medical collections." 90 Fed. Reg. at 3322. Equifax also found that adding medical collections to a model without medical collections data increased the model's predictiveness by 34 percent. *Id.*

It is arbitrary and capricious for the CFPB to offer an explanation for its decision that runs counter to the evidence from the very companies that create credit scores which show that medical debt has some predictive value for underwriting. *See Am. Stewards of Liberty v. Dep't of the Interior*, 370 F. Supp. 3d 711, 728 (W.D. Tex. 2019) (finding agency action arbitrary and capricious when there is "available, substantial scientific and commercial information" to the contrary). Nothing in the 2014 study concluded that medical debt lacked any predictive value, and indeed its own study said that medical debt in fact had some predictive value. *See Sw. Elec. Power Co. v. United States Env't Prot. Agency*, 920 F.3d 999, 1022 (5th Cir. 2019) ("we rely on EPA's own scientific conclusions in the rule itself to conclude that its choice of an outdated and ineffective technology . . . was unlawful under the Act").

It is also arbitrary and capricious to entirely fail to consider an important aspect of the problem. *State Farm*, 463 U.S. at 43. The CFPB did not study the effect of eliminating medical debt information from consumer reporting altogether. It determined without a basis that prediction models would have "other" data to replace medical debt data, but it did not either identify this data or study it. Not could it actually ever test all underwriting models to support this premise. It is therefore unreasonable for the agency to conclude that it is not "necessary and appropriate" for a creditor to consider medical debt when making a credit

decision (and thereby command that medical debt be removed from consumer reports) merely because medical debt is slightly less predictive than other forms of debt.

2. The CFPB advances contradictory measurements of harm to the healthcare system.

Evidence in the administrative record supports the conclusion that with fewer repercussions for unpaid medical debt, consumers would not pay their medical debts under the proposed rule. 90 Fed. Reg. at 3323. CFPB dismisses these consequences saying, "CFPB expects that the reduction in health care provider revenue under the rule would be equal to no more than 2 percent of their total costs." 90 Fed. Reg. at 3328. This analysis was not provided in the NPRM, thus the unnoticed study can be disregarded under *Texas v. EPA*, 389 F.Supp.3d 497, 505. But also, its conclusion is irrational.

The CFPB's determination of a 2 percent increase in "bad debt" costs equates to $97.33 billion per year. Total health consumption expenditures in 2023 were $4.866 trillion per year.[20] This figure is substantial and it is implausible that a $970 billion cost over ten years will not impact market behavior when it decreases revenue for healthcare providers. *State Farm*, 463 U.S. at 43 ("Normally, an agency rule would be arbitrary and capricious if the agency . . . offered an explanation for its decision … so implausible that it could not be ascribed to a difference in view or the product of agency expertise").

Moreover, other evidence shows the CFPB's nonchalance about healthcare provider revenues. In a second analysis, the CFPB estimated a $900 million reduction in recoverable

[20] *Centers for Medicare & Medicaid Services*, National Health Expenditure Data – Historical https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical#:~:text=U.S.%20health%20care%20spending%20grew,For%20additional%20information%2C%20see%20below.

medical debt over 10 years under the rule. 90 Fed. Reg. at 3322. In sum, the CFPB has purported to study the costs of the Rule to healthcare providers and arrived at figures that vary over ten years by over $972 billion. Such a wide spread in costs supports finding this Rule arbitrary and capricious. *See Ryan LLC*, 2024 WL 3297524 at *11 (holding an agency Rule arbitrary and capricious when based on inconsistent and flawed empirical evidence).

Finally, CFPB's cost analysis disregards the cost to healthcare providers and collection agencies of using alternative means—such as multiple letters and litigation—to collect on owed amounts. *See* 90 Fed. Reg. at 3329, Section VII.E.4. The CFPB fails to account for how costs will be distributed across debt collectors, healthcare providers, and consumers. *Id.* It also ignores the recommendations that the SBA made during the SBREFA process. *Supra*, 4. Finally, the analysis does not consider the economic ripple effects, such as worsening financing terms and reduced patient welfare, even though these concerns clearly appear in the administrative record. (*See, e.g.*, Ex. 2-B, ¶ 17.) For example, CFPB made no inquiry whatsoever into the number of people who would not receive care if they must pay cash upfront for services. CFPB's failure to conduct adequate research to estimate the true financial *and human costs* of its Rule provides yet another basis to find the rule arbitrary and capricious. *Texas v. United States*, 555 F.Supp.3d at 418 (the EPA's rulemaking was arbitrary and capricious in part because it failed to consider important aspects of the problem.)

D. Claim 3 – Restriction of Speech Based on Content–5 U.S.C. §§ 553, 706(2)(B); U.S. Const. amend. I.

Courts "hold unlawful and set aside" any agency action that is "contrary to constitutional right, power, privilege, or immunity." *Huawei Tech. USA, Inc. v. FCC*, 2

F.4th 421, 434 (5th Cir. 2021) (citing 5 U.S.C. § 706(2)(B)). The First Amendment provides that "Congress shall make no law. . .abridging the freedom of speech." U.S. Const. amend. I. The Supreme Court has held "that the creation and dissemination of information are speech within the meaning of the First Amendment." *Sorrell v. IMS Health Inc.*, 564 U.S. 552, 566 (2011). "The party seeking to uphold a restriction on commercial speech carries the burden of justifying it." *Bolger v. Youngs Drug Prods. Corp.*, 463 U.S. 60, 71 n.20 (1983).

Restrictions on protected speech trigger First Amendment scrutiny when entities are prohibited from either disseminating or receiving protected speech. *Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Council, Inc*., 425 U.S. 748, 756 (1976). This is because, "[w]here a speaker exists, as is the case here, the protection afforded is to the *communication*, to its source and to its recipients *both*." *Id*. (emphasis added).

1. The Rule is content based because it singles out particular content (medical debt information), communicated by particular speakers (CRAs).

The Rule is content based because it "singles out specific subject matter for differential treatment." *Barr v. Am. Ass'n of Political Consultants, Inc*., 591 U.S. 610, 619 (2020). Under the Rule, a CRA's ability to speak depends on the content of the underlying message. Put differently, the answer to a content based question (*does the message contain medical debt information?*) determines the lawfulness of the speech. The transfer of consumer medical debt information is protected commercial speech. *Sorrell v. IMS Health Inc.*, 564 U.S. 552, 571 (2011) (restrictions on speech from pharmaceutical companies violate the First Amendment despite being purely commercial speech). *Sorrell* involved a state law prohibiting the sale of prescriber data for marketing purposes. *Id.* at 560. The

Vermont law "ha[d] the effect of preventing detailers—and only detailers—from communicating with physicians in an effective and informative manner." *Id.* at 564. Because the regulation in *Sorrell* disfavored commercial speech with a particular content when expressed by certain disfavored speakers, the Court held it unlawfully restricted commercial speech.

Just as the regulation in *Sorrell* singled out a specific subject matter for content regulation, so too does the Rule here. CRAs may continue to communicate information about other types of accounts, such as mortgages, credit cards, and housing rentals; but CRAs may not provide a credit report to creditors with medical debt information if used for credit eligibility.[21] *See* 90 Fed. Reg. at 3372–74 ; (Compl. ¶ 52.) The only way to determine whether a communication runs afoul of the Rule is to evaluate the speech's content and determine who is initiating it and who is receiving it. If the content pertains to medical debt (and medical debt only), and is initiated by CRAs (and CRAs only), the speech is unlawful.

This subjects the Rule to strict scrutiny, which this Rule fails to satisfy. *See Sorrell*, 564 U.S. at 567 (holding that when state action "is directed at certain content and is aimed at particular speakers," the action is content based and requires heightened scrutiny under the First Amendment). Supreme Court precedent is clear: "[i]n the ordinary case it is all but dispositive to conclude that a law is content based and, in practice, viewpoint discriminatory." *Sorrell*, 564 U.S. at 571; *see also R.A.V. v. City of St. Paul*, 505 U.S. 377, 382 (1992) ("Content-based regulations are presumptively invalid").

[21] Moreover, under the Rule, CRAs may still include medical debt on consumer reports to entities other than creditors, like insurers and employers. The Rule is thus (1) content, (2) speaker, and (3) listener based.

2. The Restriction is Not Narrowly Tailored to Further Compelling Governmental Interests

When the government infringes on protected First Amendment expression via content, speaker, or viewpoint discrimination, "the government must show that its action is narrowly tailored to further compelling governmental interests." *McDonald v. Longley*, 4 F.4th 229, 246 (5th Cir. 2021) (describing the strict scrutiny standard); *Hines v. Pardue*, 117 F.4th 769, 774 (5th Cir. 2024). A restriction of protected speech will not be narrowly tailored—and thus fail a strict scrutiny analysis—when it fails to advance a compelling government interest, or is overbroad in its attempts to advance that interest. *Sorrell*, 564 U.S. at 574 ("Rules that burden protected expression may not be sustained when the options provided by the State are…too broad to protect speech").

The Rule fails strict scrutiny review on two primary accounts. *First*, the Rule is overbroad. It restricts communication regarding *all* medical debt in an attempt to eliminate a minority of communications about inaccurate medical debt. (Compl. ¶¶ 58-64.) *Second*, even assuming the CFPB's justifications were compelling, the Rule ignores available alternatives that are less restrictive of protected speech. (*Id.* at ¶¶ 63–64.)

While restricting inaccurate credit reporting may have value, the Rule overbroadly restricts accurate credit reporting information as well. To justify the Rule, the CFPB asserts that of medical accounts in collections between 2017-2022, 5.7 percent of the accounts were flagged as disputed at some time. (Supra at **Error! Bookmark not defined.**.) But this is the same rate as consumers disputing any type of delinquent tradeline—indicating medical debt presents no special frequency of inaccuracy. *Id.* Moreover, this count (5.7 percent) of disputes does not equate to actual inaccuracies. Many times, patients dispute

these bills based on the fact that the patient does not recognize the name of the provider—not because of any factual inaccuracy. *Id.* The actual error rate is believed to be less than 1 percent. *Id.* This clumsy attempt to solve a *de minimis* problem with a content based ban does not survive constitutional scrutiny. *American Academy of Implant Dentistry v. Parker*, 860 F.3d 300, 308 (5th Cir. 2017) (regulation was more extensive than necessary).

Even if the CFPB could produce a compelling government interest justifying the Rule, the Rule still fails because less restrictive alternatives exist. Regulation F—which implements the FDCPA—already prevents debt collectors from furnishing inaccurate information to CRAs. (Compl. ¶ 63.) Regulation F prevents the furnishing of information about a debt before the debt collector communicates with the consumer.[22] Thus consumers may dispute the accuracy of an account with the debt collector before information is shared with a CRA. Even taking the CFPB's posited dispute rate as presenting even a legitimate state interest, Congress and Regulation F already provide a less restrictive means to solve the problem. *See Express Oil Change, L.L.C. v. Mississippi Bd. of Licensure for Pro. Eng'rs & Surveyors*, 916 F.3d 483, 493 (5th Cir. 2019) (holding that the regulatory action at issue fails First Amendment scrutiny because the regulator "fails to address why alternative, less-restrictive means . . . would not accomplish" the regulator's goals).

[22] Specifically, Regulation F prevents the furnishing of information about a debt before the debt collector: (i) speaks to the consumer about the debt in person or by telephone; or (ii) places a letter in the mail or sends an electronic message to the consumer about the debt and waits a reasonable period of time to receive a notice of undeliverability. 12 C.F.R. § 1006.30(a)(1).

3. Even if the Rule is evaluated under the *Central Hudson* standard, it still fails First Amendment scrutiny because the restricted communications contain accurate and lawful information regarding consumer medical debts.

While Supreme Court and Fifth Circuit precedent indicate that restrictions on commercial speech should follow the analysis outlined above, *Sorrell*, 564 U.S. at 567; *Hines*, 117 F.4th at 774, the Rule still fails the intermediate scrutiny analysis outlined in *Central Hudson Gas & Elec. Corp. v. Public Serv. Comm'n of N. Y.*, 447 U.S. 557, 566 (1980).[23] *See also Express Oil Change, L.L.C. v. Mississippi Bd. of Licensure for Pro. Eng'rs & Surveyors*, 916 F.3d 483, 487 (5th Cir. 2019) (applying *Central Hudson* and holding that a restriction on commercial speech violated the First Amendment because less restrictive alternatives were available to regulators).

First, the information in question is largely factual and lawful (only 5.7 percent of accounts are disputed, of which an even smaller portion are actually erroneous). (*Supra* at **Error! Bookmark not defined.**.) By prohibiting all communication regarding medical debts, "truthful and nonmisleading expression will be snared along with" inaccurate medical debt information, tarnishing the Rule. *American Academy of Implant Dentistry v. Parker*, 860 F.3d 300, 308 (5th Cir. 2017). *Second*, the CFPB can claim no substantial interest in restricting accurate medical debts—particularly since they have some predictive value. *Supra* at C.1. *Third*, the Rule fails to directly advance the stated interest of inhibiting communications regarding *inaccurate* debts by instead targeting communication regarding *all* debts. *Fourth*, the Rule ignores already existing regulations and statutes, like Regulation

[23] *See Express Oil Change, L.L.C. v. Mississippi Bd. of Licensure for Pro. Eng'rs & Surveyors*, 916 F.3d 483, 493 (5th Cir. 2019) ("We do not reach the issue of whether *Sorrell v. IMS Health Inc*. altered the commercial speech analysis because the Board's ban fails to meet the traditional scrutiny test outlined in *Central Hudson*.") (citation omitted).

F, that seek to achieve the same goals by less restrictive means. (Compl. ¶¶ 63–64.) That final fact alone dooms the Rule in a First Amendment analysis.

VI. RELIEF REQUESTED

Because the CFPB violated the APA under sections 553 and 706(2)(A)–(D), its actions should be set aside. Here, "vacatur under § 706 is ... the 'default' remedy for unlawful agency action." *Braidwood Mgmt., Inc. v. Becerra*, 104 F.4th 930, 952 (5th Cir. 2024); The Fifth Circuit also clarified the scope of the vacatur remedy, explaining that "setting aside agency action under § 706 has nationwide effect, is not party-restricted, and affects persons in all judicial districts equally." Id. at 951 (internal quotation marks and citations omitted). Accordingly, consistent with the Administrative Procedure Act, 5 U.S.C. § 706(2)(A), and this Circuit's precedent, *see Braidwood*, 104 F.4th at 951, the Advisory Opinion must be set aside as to all affected parties.

Statement Pursuant to Local Rule

Plaintiffs have properly served this request for relief upon the CFPB and Department of Justice by ECF and personally. In addition, on Wednesday, January 15, 2025, Plaintiffs requested the CFPB by email to voluntarily retract the Final Rule or consent to this application for injunctive relief. As of the time of this filing, the CFPB has not responded to either request.

Therefore, Plaintiffs respectfully request this Court immediately enjoin the Defendants from enforcing the Final Rule prior to its effective date on March 17, 2025, among any other relief that the Court deems just and equitable.

Dated: January 24, 2025

Respectfully submitted,

ACA INTERNATIONAL and SPECIALIZED COLLECTION SYSTEMS, INC.

By its attorneys,

BROWNSTEIN HYATT FARBER SCHRECK, LLP

/s/ Sarah J. Auchterlonie
Sarah J. Auchterlonie
(attorney in charge)
CO Bar No. 50932, SD Tex. #3872480
675 Fifteenth Street, Suite 2900
Denver, CO 80202
Telephone: 303-223-1100
Facsimile: 303-223-1111
Email: sja@bhfs.com

and

Leah Dempsey
DC Bar. No. 1033593, (pro hac vice pending)
1155 F Street, NW
Washington, DC, 20004
Telephone: 202-296-7353
Facsimile: 202-296-7009
Email: ldempsey@bhfs.com

and

FROST ECHOLS LLC

Cooper M. Walker
TX Bar No. 24098567, SD Tex. #3136096
18383 Preston Road, Suite 350
Dallas, TX 75252
Phone: (817) 290-4356
Email: Cooper.Walker@frostechols.com

and

MARTIN GOLDEN LYONS WATTS MORGAN PLLC

Eugene Xerxes Martin, IV
TX Bar No. 24078928, SD Tex. #134982737
8750 Northpark Central, Suite 1850
8750 Northpark Central Expressway
Dallas, Texas 75231
Email: xmarin@mgl.law

Certificate of Service

I certify that on January 24, 2025 I electronically filed the foregoing document(s) using the CM/ECF system and they are available for viewing and downloading from the Court's CM/ECF system, and that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system where appropriate. Further, I caused service to be made by personal service at the CFPB office on 1700 G. Street, NW, Washington, D.C. 20552.

/s/ *Kathleen M. Stehling*
Kathleen M. Stehling, Paralegal
Brownstein Hyatt Farber Schreck, LLP
675 Fifteenth Street, Suite 2900
Denver, CO 80202
Phone: 303-223-1100

EXHIBIT 1

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

ACA INTERNATIONAL and SPECIALIZED COLLECTION SYSTEMS, INC., Plaintiffs, v. CONSUMER FINANCIAL PROTECTION BUREAU; and ROHIT CHOPRA, in his official capacity as Director of the Consumer Financial Protection Bureau, Defendants.	Case No. 4:25-CV-00094

SWORN DECLARATION OF JENNIFER WHIPPLE
IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I.
INTRODUCTION

1. I, Jennifer Whipple, am the President of Collection Bureau Services, Inc ("CBS"). I am also the President Elect of the Board of Directors of ACA International.

2. I am over 18 years old and have personal knowledge of the facts sworn to herein and if called to testify, I could and would competently so testify. I submit this Declaration in support of ACA International and Specialized Collection Systems Inc.'s ("SCS") (collectively

"Plaintiffs") Motion for Preliminary Injunction.

3. If the CFPB's Final Rule regarding Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information, published in the Federal Register at 90 FR 3276 (the "Rule") becomes effective on March 17, 2025, my business and my personal financial situation will be irreversibly harmed with no opportunity for recompense.

A. Summary of Testimony that Supports Vacating the Final Rule

4. The Rule must be enjoined from taking effect or my business or I will face financial and asset losses that can never be recovered. My testimony provides the below facts in support of Plaintiffs:

- **Restricts Speech.** The Rule cuts off my firm's only means to communicate accurate information about the medical debts it collects to creditors via the credit reporting agencies ("CRAs"). It infringes upon my First Amendment right to convey and receive accurate information about facts that are important to my business.

- **Harm to Health Care Providers**. The Rule removes an incentive for people to pay my clients many of whom are healthcare providers.

- **Medical Debts are Accurate.** The Rule is based on a fallacy that medical bills are "plagued with inaccuracies." In my experience, medical bills are rarely inaccurate. Rather, consumers need one-on-one conversations with my collections staff to better understand their bills and their payment obligations.

- **Consumers Already Have Protections.** The Rule is unnecessary because my policies and procedures under the Fair Debt Collection Practices Act ("FDCPA") and Fair Credit Reporting Act ("FCRA") provide consumers to right to understand the medical debts they owe and dispute amounts they do not believe they owe. My firm is legally required to correct errors under the FDCPA and FCRA. The Rule is unnecessary because the No Suprises in Billing Act helps alleviate the out-of-network medical expenses consumers have faced in the past.

- **Harm to the Healthcare System.** The Rule will cause medical providers to lose revenue, which causes a host of trouble. It will harm access to healthcare, especially in small and rural communities. It disincentivizes payment for healthcare services and may disincentive people from paying for health insurance.

- **Harm to Consumers**. If CBS must stop furnishing medical debt information in Montana, CBS's collections will decrease significantly. CBS has already felt the effect of the prior regulations that prohibit credit reporting for balances under $500. CBS anticipates it will need to increase telephone contacts, mailing services, and litigation to ensure that healthcare clients

are fairly paid for their services. Additionally, my healthcare clients will stop providing medical services prior to payment, thus more people will need to pay upfront for healthcare services.

B. Collection Bureau Services, Inc. Collects Medical Debt for Healthcare Clients

5. CBS is a licensed third-party debt collector and woman-owned business located in Missoula, Montana. It is a small, local, family-owned business in its third generation of ownership with less than 30 employees. CBS is a dues-paying member of ACA International.

6. CBS's principal purpose is the collection of debts owed or due, or asserted to be owed or due, to another. It is a "debt collector" under the FDCPA and a "covered person" under the Consumer Financial Protection Act. As a debt collector, CBS relies on accurate credit reporting to assess the value of accounts, individuals' propensity to repay, and other important financial data.

7. CBS regularly seeks to recover unpaid past due amounts for services rendered—including for medical and hospital care. CBS works with its healthcare clients to answer consumer questions, resolve disputes, and achieve resolutions, including settlements and payment plans.

8. I also own and manage a medical billing services business under the CBS corporate structure. This business services accounts on behalf of healthcare companies. These services are performed on accounts during the period before the healthcare provider deems the account to be in default. The services that it provides to the healthcare providers and consumers are far different from those provided by CBS because the accounts it services are in an earlier stage of the revenue management cycle and are often still receiving reimbursements from third-party payors. Further, these owed amounts are not yet past due, and often never become past due. Currently, the medical billing services business is not subject to the FDCPA under the currently-established meaning of "default" in the FDCPA and its implementing Regulation F.

9. As a local collection agency, CBS understands the needs of Montana businesses and consumers alike. Over the years we've found that our clients appreciate our willingness to

work with consumers and also our understanding that a consumer may need additional flexibility on a specific account. We prioritize excellence in employee training and compliance with all state and federal laws. Our agency is accredited, and our staff maintains certification through ACA International, the trade association for credit and collection professionals.

10. My agency provides debt collection and billing work for many medical providers in rural Montana, as well as government, utility, and a multitude of other private businesses who provide service to our Montana consumers. I am committed to our clients, the ARM industry, and the work that we do to help every American consumer keep costs low in our economy by returning monies to healthcare, government, and other industries.

11. In my tenure with CBS, I've helped create many policies and procedures to ensure clients are listing accounts that are accurate, consumers are receiving accurate statements, agents on calls are providing accurate information, and credit reporting is accurate. Accuracy is key in our industry, and my agency and the agencies who are part of ACA work hard every day to make certain accurate information is received and presented in every segment of our businesses.

12. I have studied, received training, and provided training on Confidentiality, the Health Insurance Portability and Accountability Act ("HIPAA"), 501(r), the FDCPA, the Gramm-Leach-Bliley Act ("GLBA"), the Fair Credit Reporting Act ("FCRA"), Regulation F, Identity Theft, Red Flags, Accuracy & Integrity, Bankruptcy, and more.

13. I have also actively engaged in regulatory outreach, including participating in a CFPB town hall in 2021 so that Director Chopra would have the opportunity to meet an actual member of the industry. At the town hall, I discussed rural banking in Montana and provided insight about my agency. Many interested parties, including banks and collection agencies attended this town hall and were prepared to answer questions from the CFPB. Despite the opportunity, the

CFPB elected not to ask about credit reporting from any industry stakeholders.

C. My Involvement in the CFPB's SBREFA, Notice, and Comment Process

14. The Rule was published in the Federal Register by the CFPB on January 14, 2025. Prior to the issuance of this Final Rule, the CFPB conducted a Small Business Regulatory Enforcement Fairness Act ("SBREFA") panel in October 2023, followed by publication of the Proposed Rule in the Federal Register on June 11, 2024 at 89 FR 51682.

15. SBREFA is a regulatory process which requires certain agencies, including the CFPB, to obtain input on proposed rulemakings from members of the small business community. This process is intended to give small businesses a meaningful voice in regulatory developments, especially considering the economic burden that increased regulatory and compliance requirements place on small businesses as compared to their larger industry counterparts. Thus, the SBREFA process is meant to promote fairness for small businesses and provide a forum for these entities to share critical information with government agencies about the impact proposed rulemakings will have on their businesses, industry, and the American economy generally.

16. I participated in the SBREFA process as a Small Business Entity Representative ("SER"). Through this process, I participated in industry discussions with the CFPB, provided feedback on the Bureau's first round of proposals, and identified significant issues with the proposals. I also submitted a comment letter as part of the SBREFA process.

17. In my opinion, the SBREFA process was largely inadequate because it failed to include appropriate participants, and failed to fully comply with the procedural requirements of SBREFA. Specifically, the proposals circulated by the CFPB were incredibly vague and demonstrated a lack of understanding regarding the intersection between the healthcare industry, the medical billing industry, and the credit reporting industry. The SBREFA panel meetings and discussions were on an inappropriately short timeline. The CFPB failed to include key industry

stakeholders such as doctors and other medical or health care providers who would be directly impacted by the proposals that, in large part, now make up the Rule.

18. Following the SBREFA process, the CFPB published the Proposed Rule on June 11, 2024. I reviewed that Proposed Rule and found that many of the concerns raised by myself and other SERs during the SBREFA process remained unaddressed. It is my belief that the CFPB wholly ignored my SBREFA comment letter and the comments of other SERs, instead choosing to proceed with a Rule it knew was seriously flawed and would harm American businesses and consumers, including small businesses like CBS. CBS timely submitted a comment to the CFPB regarding the significant deficiencies in the Proposed Rule. It was over sixty pages long and included significant data informing the CFPB that the Proposed Rule would harm consumers, harm the healthcare industry, and cause significant negative market effects.

19. CBS, through its comment letter, provided data and estimates of CBS's cost of compliance for the CFPB to consider the impact of the rulemaking on the industry. Now, the CFPB has published the Rule, which contains the same flawed data, methodologies, and purported solutions. The Rule largely fails to consider the myriad problems, costs, and negative externalities raised by commenters, including CBS. It is unlawful and will irreparably harm my businesses, consumers, the credit and account receivables industries, and the American economy generally.

II.
THE RULE IS UNNECESSARY AND WILL HARM THE ECONOMY AND PEOPLE'S ACCESS TO MEDICAL CARE

A. The Rule's Restriction of Speech Directly Harms Me and CBS

20. Federal law does not stop CRAs from providing medical debt information on credit reports. But under the Rule, no creditor can get information about consumer medical debts.

21. If there is no longer any utility in furnishing medical debt information to CRAs, CBS will stop furnishing medical debt information under this Rule. The Rule stops me and CBS

from conveying truthful speech about past due medical accounts to creditors in the United States.

22. The Rule, by suppressing accurate medical debt information from credit reports, removes a consequence for failing to pay amounts fairly owed. Without this consequence, consumers are less likely to pay. This hurts my revenue and also means healthcare providers are not compensated for their services. To address this, CBS and other agencies are more likely to use litigation to collect on accounts. Litigation is more costly for CBS, its clients, and consumers.

23. The cost to CBS to collect a hypothetical $ 1,500 account in Montana state courts is $127.50 in filing and service fees alone. That cost is included in the amount owed by the consumer, and therefore increases the total amount due from the consumer. In cases with higher balances at issue, these filing fees increase. In some cases, CBS may also add the cost of attorney's fees depending on the underlying contract with the consumer. Once CBS receives a judgment, we may garnish wages, tax returns, or funds in bank accounts. Before the Rule, if a consumer made a payment arrangement during a typical collections conversation, that consumer would have any number of choices about payment timing and amounts, but the Rule eliminates that option.

B. CBS Collects Accurate Medical Debt in Compliance with the FDCPA and FCRA

24. CBS currently collects medical debts that are accurate and fairly owed. It has policies and procedures to ensure that medical debt accounts are accurate, that consumers receive accurate statements, that call agents provide accurate information, and credit reporting is accurate.

25. When a patient disputes a medical debt, they usually are incorrect and need help understanding their bill. In my experience, less than 1% of medical debt disputes received by CBS are actually inaccurate. The CFPB's data concerning credit reporting disputes and complaints about medical debt are inapposite. Complaints and disputes do not corroborate actual inaccuracies.

C. Consumers Already Have Adequate Protections

26. CBS complies with the FDCPA, the FCRA, Regulation F, the GLBA, HIPAA, and

numerous other laws. These, and many state laws, already address the CFPB's concerns related to inaccurate credit reporting and consumer privacy. Under the FCRA, when CBS receives a medical debt dispute, it follows this process: if the dispute is made within the validation period, CBS suspends the account, contacts the client, and verifies or corrects the disputed information. Then, CBS informs the consumer of the results and unsuspends the account. If the dispute is received beyond the validation period, CBS reviews the dispute against client records and responds to the consumer if appropriate. Consumers also have protections through the No Suprises Billing Act.

27. Finally, Healthcare Financial Management Association ("HFMA") and ACA International, in 2020, jointly published the 2nd edition of Best Practices for Resolution of Medical Accounts with input from consumer groups and providers. These Best Practices further enhanced controls over credit reporting, and purposefully arrived at a recommended standard that causes furnishers to wait 120 days from the date of first discharge billing to begin credit reporting. This recommendation ensures accuracy in the final adjusted amounts and provides time for the consumer to file a claim with the third-party payer (usually insurance) if needed.

28. The Bureau appears to have issued the Rule as a solution to medical billing or insurance denial issues, but a back-end approach is not a solution to a front-end concern. The risk of inaccurate credit reporting is already well regulated by a number of existing laws.

D. <u>The Rule Will Damage the Healthcare System in Multiple Ways</u>

29. The Rule disincentivizes consumers to pay their medical debts. People pay their debts so they are attractive to lenders. Likewise, people avoid becoming delinquent on their debts because they understand negative marks on their consumer reports will hinder their eligibility for credit in the future. But if a debt is not reflected on their report, some consumers believe they don't need to pay it. For those that do understand they still have an obligation to repay, there is little incentive to pay those debts if it will not impact their future credit eligibility.

30. When healthcare providers lose revenue due to this Rule, it will hurt the availability of medical care. I am aware of healthcare providers in Montana consolidating with other firms or closing their doors when they are not earning sufficient revenue. It is not uncommon for small towns to only be served by a few medical providers. If small providers cannot get paid, they may close or merge with a large company, leading to further market consolidation.

31. In rural parts of America, there is a dearth of healthcare access—including Montana. This Rule will make it harder for patients in rural areas to receive medical care. In parts of Montana, this may mean traveling dozens, or even hundreds of miles to access critical medical services. While this may be a matter of convenience for those who have the luxury of time, it could mean life or death for others. A likely result in rural areas like Montana is that a sick or injured person must drive 45 minutes or more to receive care. If the medical need is great enough to warrant ambulance services or an air lift, the consumer is then saddled with excessive costs for that emergency transport. For example, Eagle Ambulance stopped providing emergency medical services in Granite County, Montana in July 2023. According to a public article, reimbursement and payment were the main factors.

32. In my own experience, I have observed a marked decrease in the collection of medical accounts following the CFPB's rhetoric surrounding medical debt and the Bureau's position on removing it from consumer credit reports. I anticipate that some consumers will also stop paying for health insurance because there is no incentive to do so when a consumer can forego paying monthly premiums, incur healthcare costs, and then not pay them, without any real consequence. This, in turn, may result in a large reduction in insurance dollars, causing a reduction in coverage, services, or staff available to patients.

33. In my role as President-Elect of the Board of Directors of ACA International, I

participated in a webinar on July 10, 2024 wherein ACA members were polled on their experiences related to the Proposed Rule. In response to a query regarding whether they believed consumers would forego health insurance if credit reporting on unpaid medical debt ceased. Approximately 75% of responding members stated they believed there was a moderate to high chance that consumer views on the need for medical insurance would be impacted by the Rule and its suppression of credit reporting for medical debt.

E. Harm to Consumers

34. In my experience, when clients are not reaching revenue targets from collections, one of their options is to require consumers to pre-pay for services. I anticipate that this will become more frequent if my healthcare clients are unable to collect on accounts where service was provided before payment. This will cause significant harm to consumers because: (a) People may not seek and receive preventative care meaning small or preventable medical issues could grow into life-threatening emergencies; (b) People who cannot afford the out-of-pocket costs for care will be forced to use high-cost financing methods like credit cards, or forgo medical treatment all together; (c) People who cannot pay upfront will be denied access to care; and (d) The reduction in access to credit will lead some consumers to the black market for healthcare items.

35. Indeed, during ACA's July 2024 webinar regarding the anticipated effects of the Rule, ACA members were asked, "What options do you see your own provider organization taking to mitigate losses from eliminating credit reporting – including overall behavior changes even if you don't credit report?" 72% of those polled responded that they would "require full or partial payment in advance from patients for non-emergency procedures." Over 38 % stated they would "start or increase the use of legal strategies for collection in-house or in partnership with third-party agencies." Over 15% responded that they would raise prices. More than 22% stated they would "send accounts to collection agencies earlier than we currently do" and over 24% stated

they would "send accounts to the early out process earlier than we currently do."

III.
THE RULE WILL CAUSE IRREPARABLE HARM TO CBS AND MY RIGHTS

36. If the Rule is not enjoined, CBS will face substantial and irreparable harm. To comply with the Rule by March 17, 2025, CBS must expend significant money and time to make compliance changes, including rewriting policies and procedures, re-negotiating contracts with medical clients, employee training, and system updates. There will also be the cost of hiring additional legal counsel if collections become more difficult, and increased litigation becomes necessary. Hiring in-house or outside law firms, and the cost of litigation may be approximately a $100-150 thousand dollars a year for CBS. CBS may need to update computer programs and software, invest in different technologies, and renegotiate contracts with vendors and third parties to accommodate the changing nature of each business and how they are covered by the FCRA.

37. The Rule interferes with our ability to conduct efficient collections at the same volume CBS currently collects, and therefore will result in a reduction of revenue. To offset the Rule's limitations, I anticipate increased call campaigns which will require additional staff to make more phone calls and send more letters. Employment hiring is extremely challenging, and it will be very difficult to increase my staff within just two months. I am concerned about attrition in current staff, by having limited resources due to loss of ability to collect. I need ample time to prepare CBS and my clients for such a large change.

38. I also expect a reduction of settlement options to consumers. Due to increased costs of collection and reduction in remedies under the Rule, healthcare clients and agencies will likely reduce offerings for discounts and settlements.

39. To reduce the risks and offset the costs created by the Rule, many small businesses, including CBS will likely reduce or restrict product and service offerings. For example, CBS is

considering removing its offering of credit reporting altogether and would also need to consider the cost/benefit of certain medical and governmental debt and could restrict certain accounts or balances from acceptance to our listing process.

40. These compliance and cost burdens are exacerbated for small businesses, like mine, who have fewer staff members and less in-house legal counsel. In some instances very specific client bases will be disproportionally impacted, and fewer resources will be available to devote to duplicative compliance requirements. The Rule is set to take effect on March 17, 2025. It represents a massive change, so small entities will need as much time as possible to take necessary measures to comply. It will be impossible for many small businesses, including CBS, to achieve full compliance by that deadline and we will be at risk of fines, penalties, and enforcement action.

41. The Rule and its departures from existing standards creates significant hardship for CBS. They will both cost time and money when implemented, and to maintain, draining the finite resource of CBS staff time and energy.

Pursuant to Local Rules, I declare under penalty of perjury that the foregoing is true and correct.

Executed on January 16, 2025.

Jennifer Whipple, President

Collection Bureau Services, Inc.

EXHIBIT
2-A

Economic Analysis of the Consumer Financial Protection Bureau's FCRA Rule Proposals

By Andrew Rodrigo Nigrinis, Ph.D.

Contents

Qualifications and Assignment

1. I am an economist at Legal Economics LLC., a consulting firm specializing in economic and statistical analysis. Before joining Legal Economics, I was the sole enforcement economist at the Consumer Financial Protection Bureau (CFPB) in consumer financial services. I led the Bureau's economic analysis and evaluation of over 70 cases. Throughout my career, I have managed investigations related to allegations of unfair or deceptive practices, fair lending, disputes between financial services providers and lenders, allegations of mortgage and student loan servicing issues, credit card fees, debt collections, and dark patterns. I also provided economic analysis of consumer financial regulations and policies and have extensive experience with sampling and big data. While at the CFPB, I worked with State Attorney Generals, DOJ, and OCC officials on various matters. I earned a Ph.D. in Economics from Stanford University. I completed a master's in economics at Queen's University in Canada and my bachelor's degree at the University of Alberta in Canada. I won the economics medal at the University of Alberta. I was a Carmichael Fellow at Queens University and a Stanford Institute for Economic Policy Research fellow at Stanford.

2. Brownstein Hyatt Farber Schreck LLP hired me to provide my opinion concerning the economic analyses and empirical evidence cited in the Consumer Financial Protection Bureau's (CFPB) Proposed Rule addressing several consumer reporting topics under the Fair Credit Reporting Act (FCRA). Brownstein Hyatt Farber Schreck LLP also asked me to provide my opinion concerning the possible economic impact of the proposed rule on the debt collection industry and the

expected impact on the consumer finance industry. I am being compensated for this report.

Summary of conclusions

3. My review of the proposed changes to the regulatory framework of the FCRA is that the CFPB (Bureau) needs to do a meaningful analysis of the effects on consumers, lenders, small businesses, or the broader market that relies on credit reporting. The CFPB did not provide a valid economic analysis of the impact of the proposed rule:

- There would be increased levels of financing for unqualified borrowers.
- There would be decreased access to credit-qualified borrowers.
- There would be an increase in difficulty in meaningfully repairing credit scores.
- The loss of income to medical providers from losses due to non-payment for services.
- Potential increase in litigation costs to collect debts.
- There would be increased uncertainty in consumer finance as predictive information is removed from credit reports.
- The loss in consumer benefits from the internet if data brokerage rules materially reduce the effectiveness of digital marketing.
- There is potential to harm consumers without health insurance, chronic diseases, or protected class members.
- The unintended consequence would be the loss of predictive information on credit reports, which may result in more lending of the type that precipitated the financial crises that culminated in the formation of the CFPB.

- Expected liquidation rates of referred debts to collectors to lower by 10%.[1]
- Reduction in collections for physicians.
- Disproportionately impact the South and Mid-West States.

4. The CFPB should have provided an analysis of the impact this rule will have on small business providers of healthcare services. There is no analysis of how consumers of private market healthcare providers can finance these services. The CFPB has yet to study whether providers will respond by refusing to provide credit and cutting off the consumers the Bureau purports to be helping from health services or whether healthcare providers will respond by raising prices on all consumers and hurting everyone, or if they will respond by requesting cash up-front for co-pays and deductibles, hurting low-income community members who can't afford to pay those all at once, thereby reducing their access to health care. They've also not studied if negatively impacted small and/or rural Providers will be an impetus for those physicians to move to urban areas or to change their practice models—such as to the concierge model, thereby reducing access for low-income community members.

Background

5. Medical debt tradelines are a large portion of consumer debt reported in the U.S. A recent CFPB study found that[2]

- From Q1 2018 to Q1 2022, the total number of collections tradelines on credit reports declined by 33 percent, from about 261 million tradelines in 2018 to about 175 million in 2022.

[1] I am using industry nomenclature. To decrease by 10% means the value of accounts collectors are collecting, "liquidating", has fallen by 10%. I.e., Collectors receive less from accounts referred to them.
[2] Market Snapshot: An Update on Third-Party Debt Collections Tradelines Reporting, Feb 2023

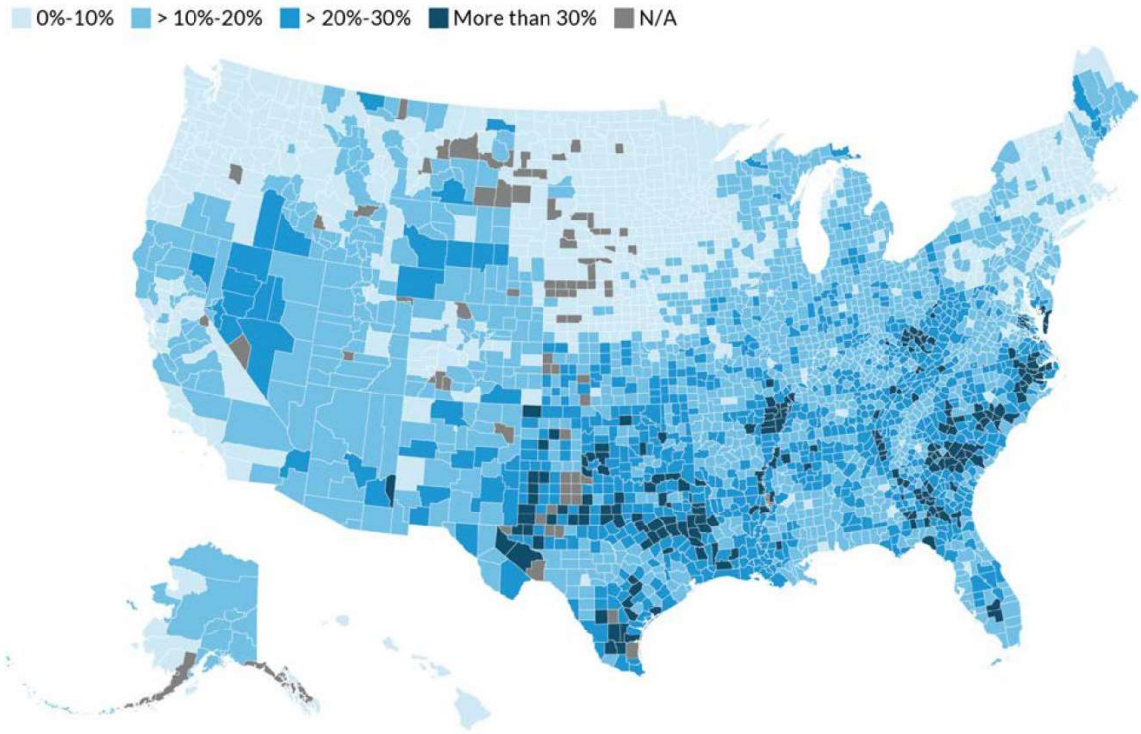
- Medical bills account for 68.9 percent of furnished collections by contingency-fee-based debt collectors, followed by telecommunications at 12.5 percent and utilities at 4.5 percent.
- Medical collections tradelines still constitute a majority (57 percent) of all collections on consumer credit reports.

The last point emphasizes how the Bureau's proposal to remove medical collections is a significant change in credit reporting with market-wide implications. This rule will drastically reduce the information available to lenders on the creditworthiness of potential borrowers.

6. The distribution of these medical debt tradelines around the U.S. is not random. The Urban Institute[3] produces the following graph with 2021 data:

FIGURE 1

Percentage of Consumers with Medical Debt in Collections, August 2021



Source: Urban Institute Analysis of August 2021 credit bureau data.
Note: N/A = not available because the sample size is too small.

[3] Blavin, Fredric, Breno Braga, and Anuj Gangopadhyaya. "Which County Characteristics Predict Medical Debt?." *Washington, DC: Urban Institute* (2022).

As can be seen from the national map, medical debt is overwhelmingly a problem for consumers in the rural Southern United States. The following table from the same report shows the ten counties with the highest percentage of consumers with medical debt compared to the U.S. average:

TABLE 1

Counties with the Highest Share of Consumers with Medical Debt in Collections as of August 2021 and the Counties' Characteristics

County	State	Pop.	% with medical debt in Collections	% Uninsured	Avg. Income	% Hispanic	% Black non-Hispanic	% 6+ CCP
Warren	GA	5,215	50.5	13.0	$53,077	1.0	58.4	20.3
Greene	NC	20,451	46.0	16.6	$53,007	14.4	35.2	17.3
Lenoir	NC	55,122	44.7	12.5	$56,708	7.9	40.0	20.3
McDuffie	GA	21,632	43.1	12.1	$55,341	3.7	40.0	19.7
Anson	NC	22,055	41.6	11.1	$52,077	3.0	44.6	19.5
Nolan	TX	14,738	40.9	19.0	$64,120	36.3	4.2	24.5
Pecos	TX	15,193	40.8	18.1	$68,797	71.4	3.3	16.4
Brooks	GA	16,301	40.7	18.1	$60,621	5.9	34.9	23.7
Haskell	TX	5,416	40.6	20.8	$49,230	25.4	3.3	17.2
Harmon	OK	2,488	40.3	15.2	$65,261	29.7	6.0	22.8
Average top 10			42.9	15.7	$57,824	19.9	27.0	20.2
Average top 100			36.9	14.8	$57,825	19.2	23.6	20.5
US			13.9	8.8	$88,607	18.7	12.1	17.7

Sources: Urban Institute Analysis of August 2021 credit bureau data combined with county-level characteristics (see table A.1 for additional details).

Notes: Pop. = population, CCP = chronic condition prevalence.

A few key takeaways can be gleaned from this table. Medical debts are high in counties with a high percentage of uninsured consumers. As of this writing, Texas and North Carolina have not implemented the Medicaid expansion. Oklahoma implemented the Medicaid expansion in July 2021 (just before the Urban Institute's analysis)[4]. These counties are in the rural South with low average incomes and a high percentage of a non-Hispanic Black population. According to CMS data, the 6+CCP is the percent of the Medicare population with six or more

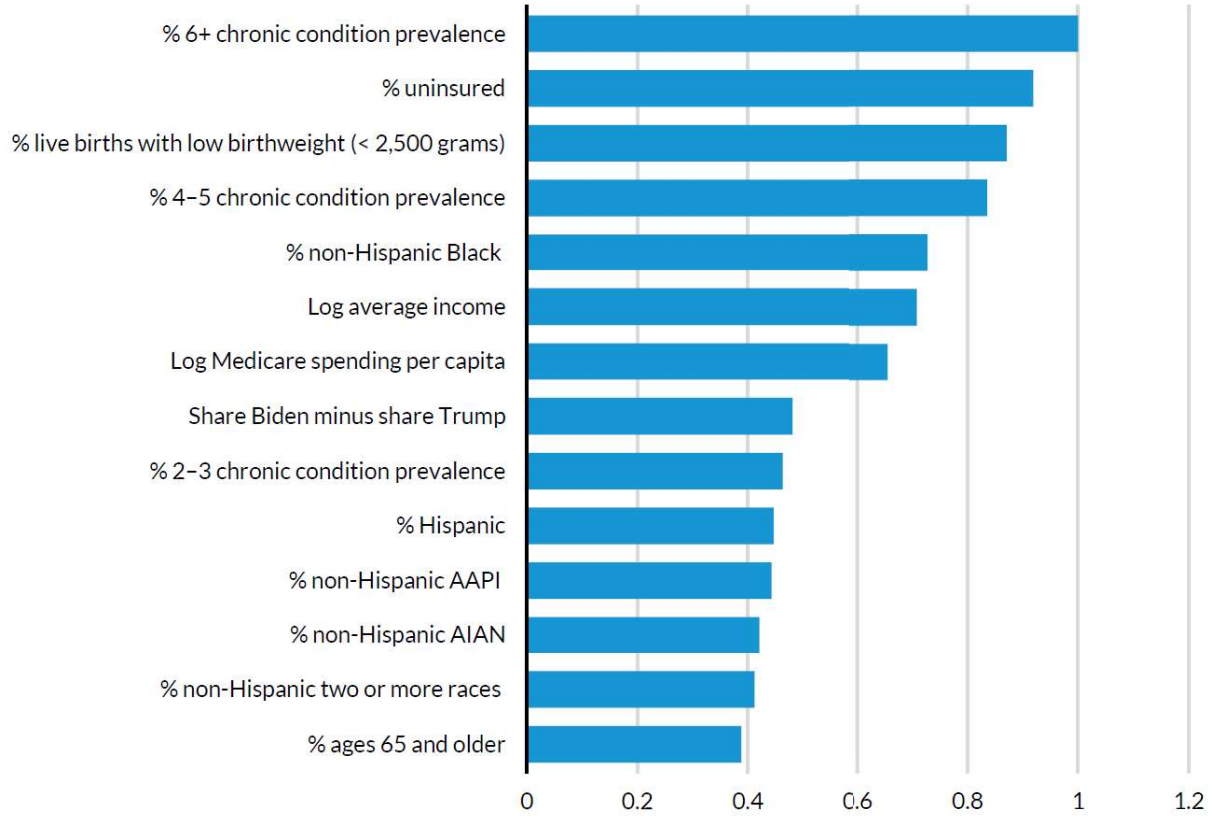
[4] The other states that have not implemented the Medicaid expansion are AL, GA, FL, KS, MS, SC, TN, WI, and WY.

out of 21 chronic conditions. It is a proxy for the underlying health of the people. Medical debt is concentrated in counties with high levels of chronic disease.

7. The study then uses a machine learning algorithm to determine the factors most contributing to medical debt. The following table shows the results:

FIGURE 3

The Relative Importance of Predictors for Percentage with Medical Debt in Collections



Sources: Urban Institute August 2021 credit bureau data combined with county-level characteristics (see table A.1 for additional details).

Notes: We use a machine learning random forest algorithm to predict the share of adults with medical debt in collections. Variable importance is calculated by adding up the improvement in the objective function given in the splitting criterion over all internal nodes of a tree and across all trees in the forest, separately for each predictor variable. In the implementation of random forest, the variable importance score is normalized by dividing all scores over the maximum score; the importance of the most importance variable is always 100 percent. AAPI = American Asian and Pacific Islander, AIAN = American Indian and Alaska Native.

Though this is not a causal analysis, it is informative. Counties with high levels of medical debt on credit reports are impoverished counties in politically conservative jurisdictions (that rely on market-based healthcare) with high percentages of

uninsured people. The high levels of chronic disease in the Medicare population and the high rate of low-birth-weight live births point to a general problem of poverty. Medical debt appears not to be the problem but rather a symptom of decisions made in the medical system. Removing medical debts from credit report tradelines will not fix people's inability to make payments. This solution will make financing financial services more difficult for people who require financing options.

What is the purpose of credit scores?

8. The fundamental question in assessing the proposed rule by the CFPB is, what is a credit score? The CFPB provides a basic answer: "A credit score is a prediction of your credit behavior, such as how likely you are to pay a loan back on time, based on information from your credit reports."[5]

9. In practice, there are two dimensions. The first is the 3-digit score, and the second is the tradelines with information on a consumer's accounts. These accounts can be active, closed, delinquent, etc. The 3-digit score is meant to compress the data to a single number that predicts an adverse credit outcome (delinquency or default). Thus, each credit score can be the result of a multitude of factors. To paraphrase Tolstoy, each perfect credit score is alike, and each imperfect credit score is unique.

10. The economic value of a credit report is to facilitate financing by allowing financing firms to assess the true riskiness of a potential borrower. The value of the credit score is increased by increasing its precision. Market forces determine the actual pricing of risk. Because of competition, firms cannot expect sustained long-

[5] https://www.consumerfinance.gov/ask-cfpb/what-is-a-credit-score-en-315/

run profits by mispricing risk. Nor can they be expected to remain solvent by extending credit to poor risks that are not profitable.

11. Risk assessment is critical to efficient credit markets' functioning. Without information, all borrowers would be priced at the same terms. Market forces would ensure a fair equilibrium price of credit, and all would have credit extended at the same terms. However, a consumer with a history of paying debts should be considered a safer risk than one with a default history. Thus, the safer borrower is a profit center for the financing firm, and the risky borrower is a source of losses. If the safer borrower can be reliably identified, they can be provided better terms of financing that reflect their lower risk. Conversely, the poor risk would pay more to compensate for expected losses. Providing financing on the same terms forces good risks to pay more as an implicit subsidy to the poor risk customers. The poor risks gain, but the good risks lose.

12. Credit scores and reports aim to identify the type of risk a consumer is. Both types of borrowers can be serviced by the financial markets but at different financing terms. This is a gamble, as safe risks can default, and risky customers can pay. However, the more information there is, the more nuanced and customized financial markets can be. This may seem a remedial point, but it is fundamentally missing from the CFPB's proposal. The CFPB is proposing the degradation of credit reporting.

13. As markets can segment consumers by risk, they can expand. As consumers are more finely judged by risk, more specialized financing can be available. Mechanisms such as collateral, the threat of credit reporting, and down payments can be deployed to reduce exposure to financing risks. Credit reporting facilitates this by allowing different customers to be given other options to reveal risk types (as an augmentation to a credit report) or to identify risk pools where risks can be

shared to extend credit. The increase in credit reporting accuracy makes companies more profitable by risk segment and expands the market for consumer credit.

14. Credit reports are not definitive in credit decisions but are an essential input. The market is dynamic, and competition encourages experimentation to identify better risks. Credit reports and scores are valuable inputs but do not determine lending. Credit scores are used in mortgage markets, as are other metrics, such as loan-to-home value. Many firms have proprietary risk algorithms that use credit scores and reports as inputs. No one is obligated to use this data. However, if these data are degraded, there is no alternative input.

15. The market will not use the information if medical debt tradelines do not identify risk. As will be shown later (Section 2014 Model Critique), the CFPB's research indicates that medical tradelines are informative in assessing a potential consumer's risk. However, given that there is no obligation to use credit report data, ***if*** medical debt had no value in assessing risks, then good risks, having depressed credit scores due to medical debts, were being offered bad financing terms. Enterprising firms would be incentivized to identify this mispriced risk and provide better financing terms. The business stealing effect is real, powerful, and disciplines markets. By removing medical tradelines, the CFPB is, on the one hand, eliminating valuable information for the pricing of risk or removing information the market would not use if it were not relevant.

16. By the CFPB's admission, the market is responding. In the CFPB's 2023 report on medical debt, they state that "The FHFA has further announced that it will implement FICO 10T and VantageScore 4.0 as the credit scores that Fannie Mae and Freddie Mac will use as thresholds for screening in loans. These credit scores underweight or do not include medical collections, unlike the credit score models that FHFA-backed loans have historically used for screening-in

decisions."[6] Presumably, the market demanded credit scores that removed or underweight medical debt, and now the market has alternative credit scores that exclude or exclude underweight medical debt. If medical debt depresses credit scores in an uninformative manner for predicting delinquency, profits incentivize the market to incorporate these new tools. The CFPB proposal is a solution without a problem.

Effect on protected classes and others

17. If the Bureau's proposed rule is implemented, a significant unintended consequence will be a restriction of lending to various protected classes. The information on how much uncollected medical debt exists and who is not paying is well known (see background section). Financial firms in the market understand the distribution of this debt. Financial firms are under competitive pressure to maximize profits and avoid losses from lending to bad risks. It is common knowledge that medical debt predicts delinquency or default. As a result, financial firms will engage in statistical discrimination. Statistical discrimination occurs when there is imperfect information about individuals, such as their lending risk, but there is information about group averages. From the Urban Institute report,[7] it is well known that one of the most significant predictors of medical debt is the percentage of the non-Hispanic black population in a county. Lesser predictors are Hispanics, Asian Americans, and Native Americans percentages in a county. The market will use all the information it has due to competitive pressures. As firms try

[6] Alyssa Brown and Eric Wilson "Data Point: Consumer Credit and the Removal of Medical Collections from Credit Reports", *Washington, DC: CFPB* (2023). Pg24

[7] Blavin, Fredric, Breno Braga, and Anuj Gangopadhyaya. "Which County Characteristics Predict Medical Debt?." *Washington, DC: Urban Institute* (2022).

to avoid losses or be compensated for taking on extra risks, they will restrict access to credit to these protected classes or offer credit on worse terms.

18. The Bureau's rule will disproportionately damage financing to the poor, sick, rural, and conservative populations. The Urban Institute also finds that counties with lower levels of income, significant levels of chronic disease, located in the rural South, and that voted for Trump over Biden have higher levels of medical debt. Income and chronic illness as indicators of the likelihood of holding medical debt are straightforward to explain as these populations interact with the medical system more and have lower levels of income to pay various co-pays and deductibles. The effect of the Bureau's rule on Southern counties that supported Trump is that the regions of the U.S. that supported Trump over Biden are more likely to rely on market mechanisms in their health care and are more likely to have uninsured populations due to not expanding Medicaid with the implementation of the Affordable Care Act. Any rule that makes the financing of medical debt more complicated will disproportionately affect jurisdictions that rely on market mechanisms and minimize the transfer of resources to poorer populations. Regardless of one's political views, profit-maximizing firms must restrict financing or increase the cost of financing medical services based on easily verifiable data.

Deterrence

19. No analysis of the effect of removing medical debt from credit reports on the deterrence to consumers in not paying legal medical debts. In a simple model of deterrence, there are two actions. Pay the debt or not pay it. The probability of being caught is 100 percent, and not being caught is 0 percent. Thus, a consumer is deterred from not paying if the non-payment cost exceeds the alternative use of the

funds. Many people are cash-constrained, so a market without a legal deterrent is not feasible.

20. This gets to the central failing of the CFPB's analysis of deterrence. It fails to account for the fact that deterrence is a continuum. Medical debts are medical income for medical goods and service providers. These providers need to be paid, and the market has three methods to ensure payment:

- Forgiveness or ignoring the debt and not reporting it.
- Report the debt to a credit reporting agency.
- Litigate to collect the debt in court.

The Bureau is proposing the end of reporting medical debts. This will allow for only one of two responses. The first is to refrain from reporting medical debts. The second is litigation for repayment.

21. If the ability to report medical debts is eliminated, some consumers will not have medical debts reported, and some will see litigation. Currently, medical debts are only reported to credit reporting agencies if sent there by the debt collector or the health care provider. There will be a substitution from reporting medical debt to not reporting medical debts. Undeniably, these consumers will benefit. However, on the other end of the continuum, some firms will substitute credit reporting for litigation.

22. The social costs of litigation will be increased and borne by consumers. As more debt collectors and health care providers turn to the legal system, the consumers the Bureau's rule was intended to benefit will be forced to pay for litigation and court expenses. Although the civil judgment cannot be disclosed in a credit report, the civil judgment would still exist and can be discovered by checking public records. From a social viewpoint, litigation is an expensive method to transfer resources from a debtor to a creditor and is a loss to society. All

consumers will bear the ultimate costs of this litigation since one can only estimate the bad debtors in advance through increased financing costs or by providers refusing to see patients who require credit. This loss of access to health care would make these and other consumers net losers if the Bureau's proposal is accepted.

23. If there is no litigation over medical debts, then the Bureau's proposal would make medical debt payment voluntary. Since litigation is expensive for all parties (including debt collectors), the result would be a voluntary payment system if litigation is never used as a substitute for the loss of credit reporting. Some consumers will pay their debts due to strong cultural norms of honoring obligations. But this would quickly unravel the medical debt market. If health providers cannot expect to be paid for services rendered (even if it is just a deductible or co-payment), they will react to protect themselves. One option could be to raise prices to account for losses due to uncollectable medical debt. Another option would be to refuse to see patients who require financing. Finally, one option would be to require payments of cash up-front for the co-pay and deductible. Or to require levels of collateral for patients based on their credit scores. It's realistic to expect some mixture of these options to unfold in the market. All these scenarios are inefficient and destructive for consumers. Specifically, bad for the consumers, the Bureau intends to assist with this policy. Beyond that, if the Provider community, especially small or rural physicians and/or dentists, get too frustrated, they might move to urban areas, or they might switch their practices to the concierge model where they only take cash-paying patients, again leaving low-income community members without access to care.

Credit Repair

24. The credit score and tradelines are not constant but can be improved by consumer action. Credit scores are not one-way streets that only go down. Since failure to pay medical debts is predictive of default (see Section: 2014 Model Critique), clearing those debts is predictive of a consumer being a reasonable risk to lend to. Consumers can improve their credit reports by resolving medical tradelines – by paying off debts or correcting erroneous tradelines. This avenue for improving credit scores would be lost for those who want to improve them. The desire and actions to raise a credit score are often done before a major purchase, such as a house. A contrary opinion holds that removing all medical debts would raise credit scores. This is true, but the credit scores would be less predictive, resulting in more default risk and lower financing terms. Those who diligently work to raise their credit scores would be denied the opportunity and lumped into a general risk pool, with those who do not resolve their medical debts and would not be able to signal to lenders their better risk profile through meaningful actions.

Lack of analysis of the potential consequences

25. The Bureau cites internal research that does not predict or illuminate the expected consequences of its proposed rule. There are many blog posts and documents, but everything comes down to two key pieces of research. The first is "Data Point: Consumer Credit and the Removal of Medical Collections from Credit Reports" from April 2023. This report finds a 25-point increase in credit scores after their last medical collection is removed. They also find that consumers with a medical collection deleted are more likely to have a first-lien mortgage inquiry. This is to be expected given that those who are in the market for a mortgage are active in clearing tradelines off their credit report. Except for this

immediate consequence, there is no study of the general impact on medical debt collection or consumer credit. Second, the CFPB cites a 2014 work, "Data point: Medical debt and credit scores." This work finds that medical debts are not as predictive as other types of unpaid debt. This is an interesting result, but it is not to be interpreted as medical debt tradelines have no predictive power in credit scores. The Bureau repeatedly uses the less predictive claim to justify removing medical debt, which, according to the CFPB's research, would make credit reports less accurate.

26. None of the CFPB's research has been peer-reviewed or had the results questioned or vetted. If the CFPB seeks to make decisions in an evidence-based way, its results need to be open to public scrutiny. In economics, this is by publishing results. At the least, they should turn over all data and codes to industry to verify their results.

27. Additionally, none of these results shed any light on the implications of their rule on consumer financial markets. A study should be conducted to determine the effect of their rule's implementation on medical debt payment. An investigation should be performed into how medical providers respond to falls in collections. The Bureau may be protecting consumer finance consumers, but these same consumers will also need to access healthcare services. Finally, the degradation of consumer credit reports will affect every industry that relies on them for risk assessment. Currently, there are no Bureau studies or estimates in an evidence-based way to answer these preliminary concerns.

2023 Model Critique

28. The 2023 report[8] by the CFPB Office of Research is the primary citation used to quantify the change in credit scores from removing medical debt credit lines. The authors find that the average person who removes medical tradelines of less than $500 has a 21-point increase in their credit score. For debts over $500, the increase is 32 points on average. This result is used to justify the potential for a significant consumer benefit by eliminating the reporting of medical debt.

29. The study is based on an event analysis conducted by the Bureau and not on a more rigorous difference-in-differences analysis. The Bureau's analysis is a simple event analysis that analyzes how credit scores change over time after removing a medical debt tradeline. However, time often cures credit scores as tradelines drop off credit reports. Old tradelines are often given less weight. Thus, a comparable group should be created to provide a basis for comparison. No control group is ever built. If a control group is included, the magnitude should fall significantly. A rise in credit score should happen regardless since removing negative information should make a consumer appear to be a safe risk. However, the magnitude of benefits is likely overstated by this analysis.

30. The study constructs its measure incorrectly, which makes any accurate measurement of benefits impossible to interpret. The study uses as its sample consumers who have had a medical debt removed from their credit reports. This excludes consumers who never had a medical debt tradeline nor those who had medical tradelines and could not remove them. An obvious hypothesis is that those who can have a medical debt tradeline removed are disproportionately likely to have a medical debt reported by mistake. Alternatively, they have clean records

[8] Alyssa Brown and Eric Wilson "Data Point: Consumer Credit and the Removal of Medical Collections from Credit Reports", *Washington, DC: CFPB* (2023).

with this anomalous tradeline. This means that these records included in the sample *are likely different from* those with a medical debt tradeline.

31. The ability to remove medical debt tradelines means the consumers are different from the norm. By actively monitoring and acting to clear up their credit reports, these consumers have shown diligence and attentiveness to their records, which likely means that the Bureau used a non-representative sample.

32. The results indicate reverse causation. One of the results of this study shows that those who have cleared up a medical tradeline were more likely to have a first-lien mortgage inquiry. The authors responsibly acknowledge that "Because medical collections are not removed from credit reports randomly, the event study analysis does not provide causal evidence."[9] Simply put, are consumers removing medical debt tradelines because they intend to use more credit? Or is it because removing the medical tradeline gave them more access to credit? If it is the former, where consumers actively remove medical tradelines in anticipation of using credit, then the results are biased. A simple example is a consumer who is planning to purchase a home. When buying a home, it helps to have a higher credit score. But also, the need to save for a downpayment and clear up old debts and tradelines results in a behavioral change involving removing medical tradelines as part of a general move to boost their credit score. Thus, the analysis is overstating the benefits of the medical tradeline removal as it is concurrent with other changes. The results are most likely a mixture of the two effects. But, the results of this research would be overstated.

33. Additionally, the study design allows consumers to remove multiple medical tradelines. In a more rigorous difference-in-differences design, repeated treatment of the change in credit reports from medical tradeline removal would bias the

[9] Alyssa Brown and Eric Wilson "Data Point: Consumer Credit and the Removal of Medical Collections from Credit Reports", *Washington, DC: CFPB* (2023). Pg.25

results. Recent work has shown that the formation of the groups and the frequency and timing of treatment would radically change the results.[10]

34. The data used is out of date. The data used in this study is from March 2011 to June 2022, where medical collections were removed between June 2012 and December 2020. The first problem is that data is being used from vastly different time periods with no statistical controls. The data from the COVID-19 period is different from pre-COVID data. And hopefully, it will not be comparable to future data. During COVID, there were massive transfers from government to consumers. Additionally, student loan payments were suspended. It is shown in another Bureau research that consumers with medical debt delinquencies are also likely to have student loan delinquencies. The increase in credit scores from removing medical debt tradelines may result in consumers having more resources to devote to student loan debt. The pre-COVID period was before the implementation of the changes to Regulation F that decreased the expected number of reported medical tradelines.

35. In the future, the results will be less informative. The No Surprises Act was enacted on January 1st, 2022,[11] which will reduce emergency services costs and out-of-network insurance bills. This will reduce the easier-to-challenge medical tradelines that may drive the Bureau's observed results. The No Surprises Act and Regulation F have already reduced medical debt tradelines on credit reports.

36. Even if one accepts the results, the rise in credit scores shouldn't be surprising -- but the unintended consequences may be. The results of this study likely overstate the benefits to consumers from removing medical tradelines. But it

[10] Technical note: To estimate the effect would require a difference in differences instrumental variables analysis as proposed in Baker et al (2022). The decision to seek out medical tradelines is potentially endogenous. In addition, repeated treatments that may also be endogenous will bias any results.

[11] "Complaint Bulletin: Medical billing and collection issues described in consumer complaints", *Washington D.C.: CFPB* April 2022

isn't a surprising result. Those who have negative information removed should have their credit scores increased. However, this research doesn't capture the unanticipated effects of this rule. It has no predictions for the increase in unpaid debts due to less deterrence from the possibility of having a negative tradeline. It does not estimate the cost to consumer lending markets from the degradation of credit reports that lenders rely on to assess risk. Nor does it quantify the higher borrowing costs borne by diligent and responsible borrowers with high credit scores. In short, the Bureau has identified the obvious beneficiary of this rule without studying the costs paid by others.

2014 Model Critique

37. The subsequent major work that the Bureau cites to justify its claim that eliminating medical debt from credit reports is "Data point: Medical debt and credit scores" from May 2014. This paper is the source that justifies the following statement:

> "The CFPB has long-standing concerns about the usefulness of medical debt collections tradeline information in predicting a consumer's creditworthiness. For example, research by the CFPB and others has raised questions about the predictive value of this information."[12]

There are two problems with this statement. First, the research into the predictive problems of medical debt has serious methodological issues. Second, the Bureau has misinterpreted the research's conclusion to justify its rulemaking.

38. The research splits consumers into two groups that fail to isolate the effect of medical debts on delinquency – their measure of risk. Their research design assigns consumers into one category: medical (MM) debt and non-medical debt

[12] SMALL BUSINESS ADVISORY REVIEW PANEL FOR CONSUMER REPORTING RULEMAKING OUTLINE OF PROPOSALS AND ALTERNATIVES UNDER CONSIDERATION, September 15, 2023, Pg. 17

(MNM). They also do tests with unpaid and paid debts. That would be mostly paid medical debts (MPM) and unpaid (MUM). They then study delinquency by credit score for the MM and MNM groups over time. The problem is that an MM and a MNM are a mixture of credit lines.[13] This is not a clean test of the effect of medical tradelines on a credit report at the margin.

39. By not providing data on the composition of the groups, it is impossible to make an apples-to-apples comparison. We do know that medical debt is not random in the U.S. population. Medical debt falls most heavily on low-income counties that have a high percentage of uninsured people.[14] This study does not use any standard statistical controls of economic research. The effect of medical debt may be confounded with the income and healthcare policy of the states in which the people of the sample reside. This analysis is not performed.

40. The work is interesting but has yet to be peer-reviewed or published outside the CFPB. Before using research to make major policy changes, the CFPB should open up its code and data to the public to scrutinize it. A data-driven agency should welcome transparency.

41. The data used needs to be updated for any policy analysis today. The dates used are from October 2011 to September 2013. This data is more than a decade old. Specifically, it predates the Medicaid expansion of the Affordable Care Act, which decreased the percentage of uninsured people. The Urban Institute shows that a county's percentage of uninsured people significantly drives medical bills.[15] Additionally, this work predates the changes to Regulation F and the No Surprises

[13] Consumers with an even split are removed.
[14] Blavin, Fredric, Breno Braga, and Anuj Gangopadhyaya. "Which County Characteristics Predict Medical Debt?." *Washington, DC: Urban Institute* (2022).
[15] Blavin, Fredric, Breno Braga, and Anuj Gangopadhyaya. "Which County Characteristics Predict Medical Debt?." *Washington, DC: Urban Institute* (2022).

Act that reduced medical debt tradelines on credit reports. These final two changes are particularly relevant as, by the author's admission:

> "The account-level information that is included in the credit records comprising the CCP allows us to identify which debts reported by third-party collection agencies were from medical or non-medical bills. While we can identify those collections that were from medical bills, nothing in the data reveals anything about the identity of the medical service provider, the type of institution that provided the service, or the nature of the services that were performed."

This analysis cannot distinguish between medical debts that would have been removed by the No Surprises Act and Regulation F. Given that these rules were to eliminate or regulate expensive emergency healthcare services, out-of-network charges, and debt misreporting, the remaining medical debts may be equally predictive as non-medical debts. Without further studies, there is no way to tell.

42. Even if we took the results at face value, the conclusion that medical debt tradelines can be removed with little impact on credit scores is false. The authors have a motivating example:

> "To understand the approach we take, consider two consumers with identical credit records, at the start of the performance period, neither of whom has any collections. Because their credit records are identical, both will have the same credit score, say 780, and would be expected to have the same likelihood of delinquency during the ensuing performance period. Now assume that at the start of the performance period each of the consumers had a debt collection reported on their credit record, one a medical collection and the other a non-medical collection. If the scoring model treats medical and non-medical collections equally, then the scores of both consumers will be decreased by

> the same amount. Using the estimates published by Johnson (2012), we might expect the scores of these consumers to be decreased by about 115 points relative to the starting assumed credit score of 780. Both consumers would now have scores of 665. Since lower credit scores suggest greater risk, lenders would interpret this as reflecting an increased likelihood of delinquency during the performance period."[16]

The authors are not saying that medical debt removal is irrelevant to the predictive value of the credit score. As they state:

> "If the credit scoring model nonetheless treated both types of collections equally, these consumers would both have 665 scores. This means that, if medical collections are truly less predictive about a consumer's creditworthiness than are non-medical collections, consumers with medical collections should perform better."[17]

This work results in an estimated credit score difference of 16 to 21 points for medical debts. This is an average effect, and the impact will depend on the observed credit score level. But as a first-order approximation, it will give a decent approximation. So, in their example, an accurate credit score would be from 780 to 665 for non-medical debts and 665 plus 16 to 21 points, or 681-686 credit score for medical debt. Yes, medical debts are less predictive, but medical debt has an informative value (780 to 681-686) for risk assessment. There are methodological issues that make the estimates suggestive but not definitive. But the Bureau's work,

[16] Kenneth P. Brevoort and Michelle Kambara "Data point: Medical debt and credit scores", *Washington, DC: CFPB* (2014) Pg. 9
[17] Kenneth P. Brevoort and Michelle Kambara "Data point: Medical debt and credit scores", *Washington, DC: CFPB* (2014) Pg. 9

which they base policy on, concludes that medical debts have a predictive value that their removal from credit reports would lose.

43. Given the competitive nature of consumer finance, once this issue is realized, the market will be incentivized to re-price risk based on medical versus non-medical tradelines**.** An example of this from the CFPB's work is that "The FHFA has further announced that it will implement FICO 10T and VantageScore 4.0 as the credit scores that Fannie Mae and Freddie Mac will use as thresholds for screening in loans. These credit scores underweight or do not include medical collections, unlike the credit score models that FHFA-backed loans have historically used for screening-in decisions."[18] Firms are not obliged to use credit scores and reports, but they often use them as part of their internal decision-making and can weight medical debt tradelines as they are compelled to by market forces.

The CFPB needs a valid analysis of the consequences of the data brokerage changes they propose.

44. In the proposed changes to data brokerage stating that:

> "provide that consumer information provided to a user who uses it for a permissible purpose is a "consumer report" regardless of whether the data broker knew or should have known the user would use it for that purpose or intended the user to use it for that purpose."[19]

This overbroad definition could limit marketers' ability to use basic levels of consumer information for targeting ads.

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[18] Alyssa Brown and Eric Wilson "Data Point: Consumer Credit and the Removal of Medical Collections from Credit Reports", *Washington, DC: CFPB* (2023). Pg.25

[19] SMALL BUSINESS ADVISORY REVIEW PANEL FOR CONSUMER REPORTING RULEMAKING OUTLINE OF PROPOSALS AND ALTERNATIVES UNDER CONSIDERATION, September 15, 2023, Pg. 7

The Attention Economy

45. One of the most interesting issues in digital economics is that a plethora of content and services are provided at zero prices on the Internet. This has led to an interest in "Attention Markets." Attention markets are where consumers consume content, and advertisers offer advertisement placements. The value of these ads increases the more they are customized to a customer's profile. A personal finance blog may serve up mortgage or credit card ads. If customers are sub-prime and view the page to get advice, then ads for credit products aimed at sub-prime consumers are beneficial. Alternatively, diligent consumers who read about personal finance and have super-prime credit would benefit from advertisements for consumer products specialized for them. Both types of consumers may visit the webpage or App. Thus, the ability to buy data to target individuals or sub-groups makes the ad placement more profitable. This ad-driven model is the primary funding source for the free services of Google, Facebook, and many websites and Apps.[20]

46. The value of the Attention Economy is enormous, and any regulation that shrinks it can be economically destructive. The most recent estimate of the internet portion of the Attention economy by Evens (2020)[21] is determined by looking at the time Americans spend on these services. The value of time is the implicit price being paid for these free goods. In 2019, Americans spent 514 billion hours on ad-supported content. The time value used was $13.60 per hour, taken from a U.S. Department of Transportation study. This led to a valuation of $7 trillion for ad-supported content in 2019. Because this value is so high, I include other valuations as cited by Evans:

[20] An interesting take is on the personal finance blog Mr. Money Mustache https://www.mrmoneymustache.com/2011/06/01/an-experiment-with-blog-moneymaking/

[21] Evans, David S. "The economics of attention markets." *Available at SSRN 3044858* (2020).

Study	Summary	Yearly Value Per U.S. Adult User of the Medium	Aggregate Yearly Value (in billions)
Brynjolfsson, Collis, and Eggers (2019)	Utilized online discrete choice experiments during 2017 to estimate the monetary compensation consumers needed to compensate losing access to various digital goods.	Search engines: $17,957 Social Media: $330 Online video: $274 Online music: $70	$3,797
Allcott, Braghieri, Eichmeyer, and Gentzkow (2019)	Used a Becker-DeGroot-Marschak mechanism to elicit Facebook users' willingness to-accept (WTA) to stay deactivated from Facebook for four weeks during 2018.	Facebook: $2,340	$410
Brynjolfsson and Oh (2012)	Used data on consumers time spent using the internet and their opportunity cost of time (income) to estimate consumer surplus from the internet during 2011.	Internet: $4,880	$928
Goolsbee and Klenow (2006)	Used data on consumers time spent using the internet and their opportunity cost of time (income) to estimate consumer surplus from the internet during 2005.	Internet: $2,053 - $3,120	$287-436

Note: Authors' estimates are multiplied by a factor that represents my estimate of the proportion of the media that is accounted for by an ad-supported model. If the author estimates are on a per-user basis, I compute aggregate valuations based on estimates of the number of U.S. adults that use the media form. See Appendix B for details.

The Brynjolfsson and Oh[22] estimates are from the most defensible methods. In 2011, this was $928 Billion **a year** in value. This would be about $1.2 trillion in 2023. If the data brokerage rules reduce the value of ad-supported content by a mere 1%, then $12 Billion of economic value could be destroyed **annually**. Of course, the CFPB has no estimates on how they will affect this market. With

[22] Brynjolfsson, Erik, Seon Tae Kim, and Joo Hee Oh. "The attention economy: measuring the value of free goods on the internet." *Information Systems Research* (2023).

numbers this large, the Bureau should proceed carefully and analyze the implications of restricting data access.

The effect of this rule on other industries

47. The CFPB needs to study the effect a degradation in the quality of credit reports would have on the consumer finance lending industry. Currently, analysis has yet to be done on the end users of the credit reports and the potential consequences of removing the predictive information in the medical debt tradelines. Below are two case studies based on academic work.

Case Study: Improved credit assessment

48. Few studies document how improving credit scoring affected lenders and lending. The Bureau is proposing reducing the information value, i.e., degrading, of the credit reports by removing predictive information about risks faced in consumer lending to potential consumers. Einev et al. (2013)[23] studied the effects on a car dealership with a few locations that provided auto financing in a low-income, high-risk market. This firm operates in a high default population where profitability depends on identifying consumer risk quality. Furthermore, the firm matches cars (high or low value) to consumers and offers customized lending terms. It is important to remember that computational, data-intensive, and readily available credit scores are a relatively modern phenomenon. Credit reports are ubiquitous today, but even 30 years ago, they were not commonly used. The benefits of credit reports to the financial markets are often taken for granted.

49. This firm went from a low to a higher information environment. The lender adopted credit scoring by the end of June 2001. Before this, employees made judgments on credit based on information they elicited out of the sales process.

[23] Einav, Liran, Mark Jenkins, and Jonathan Levin. "The impact of credit scoring on consumer lending." *The RAND Journal of Economics* 44.2 (2013): 249-274.

This firm began using credit reports and inputting the information into its proprietary algorithms to assess risk. This is a case study of using data to make more informed decisions.

50. The effects of improved risk assessment are apparent. The firm was able to identify better risks and extend more credit to them to increase profitability. This was achieved by more accurately identifying customers as low or high risks. The company closed deals with less than half the high-risk customers than before. However, the default rate fell as the firm was better at avoiding bad risks. Additionally, as higher risks, they were required to put higher down payments for purchases. Credit became tighter for this population. The applicants identified as low-risk were able to take out bigger loans.

51. The Bureau's proposed rule is to take this process of improving lending through predictive credit information backward. The proposed rule changes would result in credit reports being less accurate, and consequently, lenders in consumer finance will be less able to assess default risks. The low-risk borrowers will be less able to signal their lower risk level and have access to credit constrained. Lenders will see a fall in profitability as they unwittingly take on risky borrowers. This will result in more credit for the risky borrowers. But more defaults.

Case Study: Data Privacy

52. There are few studies about how the restriction in the flow of data through privacy laws affects consumer financial markets. Kim and Wagman (2015) study the effect of privacy on consumer finance on theoretical and empirical levels. They show that a firm's ability to sell consumer information can lead to lower prices, higher screening intensities, and increased social welfare. Empirically, they show their model is consistent with the fall in denial rates in home loans and refinancing in counties that adopted more stringent privacy regulations. Subsequently, these

counties had higher foreclosure rates in the 2007-2008 financial crises. This issue of unstable mortgage origination and high foreclosure during this exact crisis was the raison d'etre for establishing the CFPB itself.

53. The motivation for this academic work was the 1999 enactment of the Gramm-Leach-Bliley Act (GLBA), allowing a variety of financial institutions to sell, trade, share, or give out nonpublic personal information about their customers. In their model, financial institutions use data to reduce customer service costs. Market competition results in cost savings passed to consumers via price cuts or better financing terms. For this to be profitable, firms use the newly available information more heavily to screen applicants, and as a result, potentially high-risk borrowers are denied credit. Thus, industry and borrowers, but not rejected applicants who would not have defaulted[24], benefit as consumer information increases.

54. The test for this theory was when three out of five counties in the San Francisco-Oakland-Fremont Metropolitan Statistical Area (MSA) adopted a privacy ordinance on January 1, 2003, requiring consumers to opt-in to releasing information under GLBA. Given most people's status quo bias, this effectively reduced the amount of privacy information lenders could access. By studying loan data of conventional home purchases at the census tract levels in these counties from 2001 to 2006, they established market behavior before and after the enactment of the privacy ordinance.

55. The theoretical results are consistent with their empirical findings. The theory predicts that these weaker privacy laws would result in less screening of mortgage applicants. This would result in a fall in loan denial rates. But foreclosure rates eventually rise as these weaker risks are more likely to default. When looking

[24] Rejected applicants who would have defaulted would have benefited if the costs of default, e.g., foreclosure, is high.

at the data, the census tracts with higher shares of 2003-04 originated loans in the counties that enacted the privacy opt-in had a higher foreclosure rate. As the authors put it:

> "The results in this paper give rise to the conjecture that privacy acts may have played some role in the subprime mortgage crisis by weakening lenders' incentives to screen loan applications."[25]

56. The Bureau's rule is essentially a privacy rule against medical debt tradelines. The result would be a move to a lower information environment. Only if consumers voluntarily disclose their medical collections history will lenders have a complete picture. This will result in more credit being available to unqualified borrowers.

The effect of this rule on debt collection

57. To quantify the magnitude of these proposed changes on debt collectors, I have used a data set contributed directly to me by collection agency members of ACA International (ACA). These data contain 1,615 client accounts (not consumers, but 1,615 creditor organizations) from 19 self-reported debt collection agencies. These data include the number of referrals, collections, and the estimated impact of the rule change on liquidation rates of referred debts to collectors (or writing off debt) due to the changes. This data reflected the restrictions on reporting medical debts under $500[26]. The Bureau is proposing restricting all medical debt balances—a more drastic rule with more drastic consequences. Unfortunately, a more rigorous analysis was not conducted due to the rushed nature

[25] Kim, Jin-Hyuk, and Liad Wagman. "Screening incentives and privacy protection in financial markets: A theoretical and empirical analysis." *The RAND Journal of Economics* 46.1 (2015): Pg. 7

[26] This change went into effect April 1, 2023. The credit reporting agencies also took two other actions prior to that (removing paid medical debt, and delaying credit reporting for a year), none of which has been empirically studied for potential degradation of the lending environment.

of the SBREFA process. However, this is more evidence of the effects of the proposed rule change on the industry than the Bureaus have conducted.

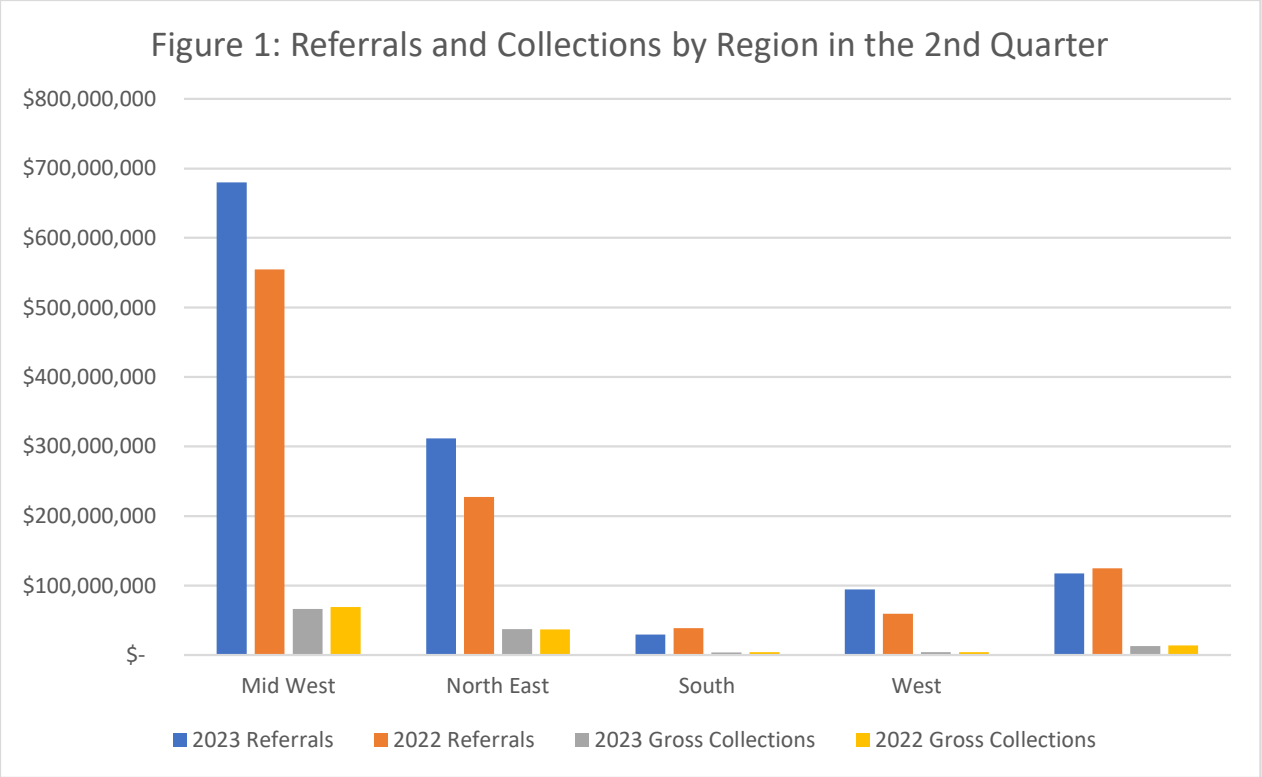
58. The data is disproportionately weighted to California. California makes up 60.3% of the sample. This is not a representative sample of the U.S. However, I split the data into the four regions defined by the Census Bureau: North-East, Mid-West, South, and West. Despite this aggregation, the general results will reflect the West and California.

Table 1: Data by Region

region	Freq.	Percent
Mid-West	193	14.89
North-East	30	2.31
South	113	8.72
West	960	74.07
Total	1,296	100

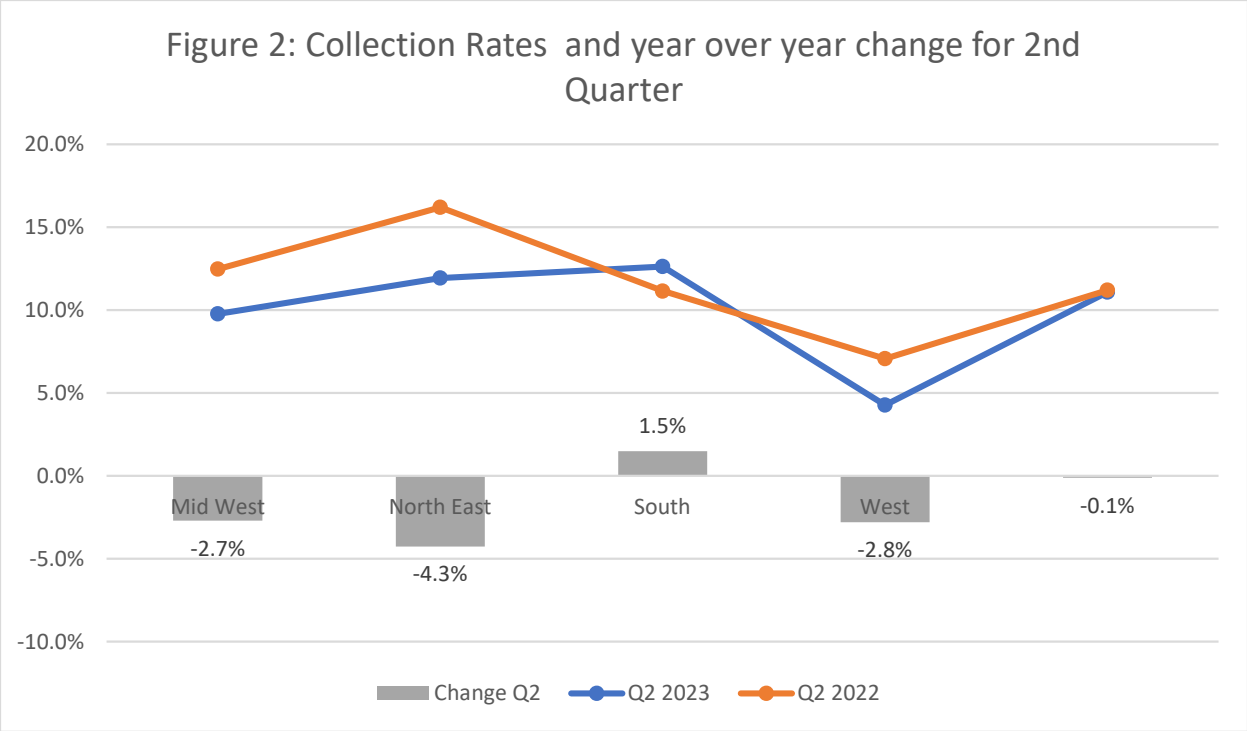
The remaining observations did not have an identified State and, thus, region.

59. The data includes referrals (amounts to be collected) and gross collections. I used the 2nd Quarter data for 2022 and 2023. Debts might not be collected in the quarter they are referred so this approach is an approximation. Figure 1 shows the referrals and collections for Q2 2022 and 2023 for the data collected by ACA. This data will be skewed by who submitted the data. Referrals to collect increased in the U.S. increased in 2023 compared with 2022. The cause of the increase in these referrals is unknown. However, this could result from providers receiving fewer payments for their medical services and consequently making more debt collection referrals. Gross collections remained stable from 2022 to 2023.



60. The geographic distribution of the data does not reflect the data overall. The West constitutes about 74% of the data, but most collections originate in the Mid-West.

61. The number of collections determines the size of the market, but the collection rate indicates whether payments are occurring. I find the collections rates by dividing gross collections by referrals for 2022 and 2023. The results by region are in Figure 2. Collection rates are between 10-15%, with the Mid-West in 2022 as a high outlier and the South as a low outlier.



62. The data was collected after new rules limiting the ability to report medical debts came into effect. Thus, the fall in collection rates in Figure 2 may already reflect the reduction in creditors' rights these last few years. The change in the collection rates by region suggests that the message behind the message is that medical debts do not need to be paid. For the U.S., in Figure 2, the collection rate fell by 2.7%. However, this obscures meaningful differences within the U.S. In the regions where obstructions to the reporting of medical debt have spread, the North-East and West (mainly California), we see a slight increase in collections or no change. However, in the Mid-West and the South, there are large reductions in the collections of medical debts. This could be an anticipatory effect of the belief that debts would not have to be paid. These amounts are large and could be a harbinger of future problems for the industry created by the proposed rule change. A good metric would be to see the decrease in expected liquidation rates of referred debts to collectors that could be attributed to limits to credit reporting.

63. The ACA data has estimates if the rate of liquidation of referred debts to collectors is caused by ceasing credit reporting and indicates that it will decrease[27]. The data submitted by the ACA members show the expectations of a decrease in liquidation of referred debts due to the proposed rule, see Table 2.

Table 2: Estimate of Change in decrease of Liquidation of Referred Debts Percentage due to not Credit Reporting

	Mean	Median
U.S.	-10.1%	-4%
U.S. less California	-10.8%	-4%
Mid-West	-13.1%	-8%
North-East	-7.3%	-4%
South	-9.8%	-3%
West	-9.5%	-3%

I present two sets of numbers, the mean and median response. The mean/average is the best estimate for the actual value, but extreme values may skew it. The median is a more conservative number.

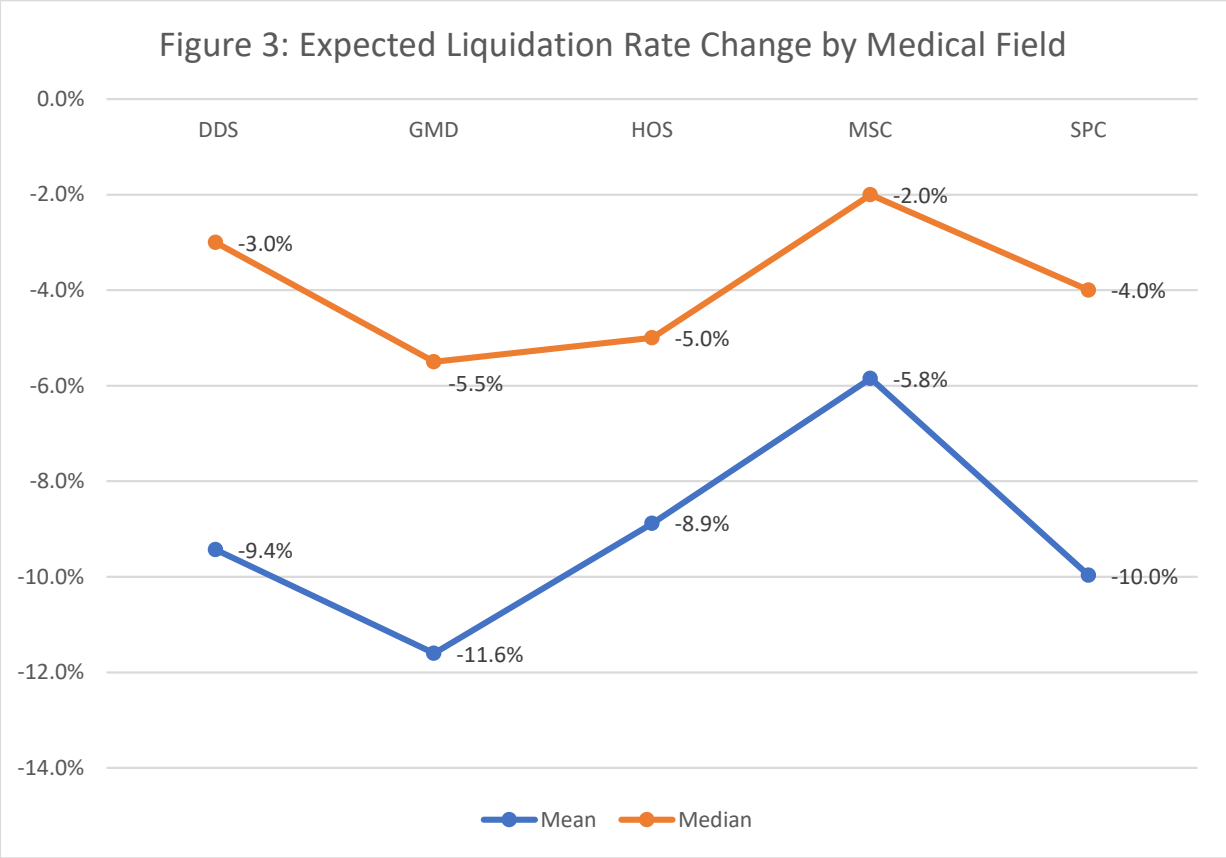
64. The effect of ending credit reporting on liquidation rates of referred debts to collectors varies by region. The overall amount decreases by 10.1% on average or a median of -4%. Because the data is so heavily California-centric, I calculated the difference for the rest of the U.S. I get a slight rise in the average and the same median. By region, we see that the Mid-West will be most affected by the proposed rule changes—a shockingly high average decrease of 13.1% on average. Even the more conservative median value is an 8% decrease.

65. **T**he median values align with what has been seen elsewhere. In an amicus brief filed by the Nevada Hospital Association (NHA), the NHA estimated that an

[27] I am using industry nomenclature. To decrease by 10% means the value of accounts collectors are collecting, "liquidating", has fallen by 10%. I.e., Collectors receive less from accounts referred to them.

increase of a "cooling off" period on reporting medical debts to 60 days would result in an expected loss of 1.5% to 5% for 2022[28]. This proposed rule differs because the "cooling off" period is permanent. Thus, the losses should be higher and align with the mean values reported in Table 2 (-9.5% in Western States). This is not proof but evidence that my estimates are reasonable.

66. I repeat the exercise of observing the estimated liquidation rates of referred debts to collectors by medical specialty in Figure 3. Again, to be conservative, I graph the mean of the estimated rate and the median (which is more conservative).



The highest change is in GMD -- general medicine. These are primarily family physicians and general practitioners. The fall in expected liquidations of referred

[28] Brief for the Nevada Hospital Association as Amicus Curiae, *Aargon Agency, Inc. v. O'Laughlin*, 70 F.4th 1224 (9th Cir. 2023).

debts is 11.6%. Even the conservative estimate using the median is a 5.5% decrease. Thus, industry is expecting a large decline in the local physicians' ability to collect revenue. Additionally, we see a considerable reduction in HOS, hospital services, DDS, dental services, SPC, specialty medicine, and MSC, miscellaneous (for difficult-to-categorize services). The Bureau has not considered how the impact will vary by medical practice. However, few businesses operating under market principles can sustain such sudden drops in revenue by collectors that will pass them on to medical practices.

67. The impact on small businesses is substantial. Table 3 shows the data's decrease in expected liquidations of referred debts from small business clients[29]. The small business rate is slightly higher than the average for the U.S. The key takeaway is that this proposed rule change will drastically affect the ability of small business physician practices to collect revenue via collections.

Table 3: Small Businesses and Metro Area
Estimate of Change in Liquidation of
Referred Debts Percentage

	Mean
Small Business	-10.2%
Non-Metro	-10.4%
Metro	-9.9%

68. The impact disproportionately hurts rural physicians. The data was matched via zip codes to the Rural-Urban Commuting Area (RUCA) defined by the U.S. Census Bureau. These codes measure census tracts and zip codes and the flow of people living in that area into a primary metropolitan area. For example, Hoboken, N.J., is part of New York City. The code I used for a business to be included in a

[29] I am using industry nomenclature. To decrease by 10% means the value of accounts collectors are collecting, "liquidating", has fallen by 10%. I.e., Collectors receive less from accounts referred to them.

metro is 10% commuting or higher. This captures most suburban communities that use a metro area's medical facilities. Thus, my definition of non-metro is towns sufficiently far away from metro areas, so commuting is uncommon. Physicians in non-metro zip codes have a more considerable decrease in expected liquidations of referred debts. 10.4% of these accounts represent a substantial loss of revenue to collections on behalf of rural physicians.

69. The impact on expected liquidation of referred debts in the data depends on whether a firm was already credit reporting delinquent accounts. Table 4 shows the fall in the expected liquidations of referred debts for non-credit reporting collection agencies is -5.8% and -10.9% for credit reporters. This could be due to credit reporters being in States that severely limit their ability to report or collect debts, or it could be due to the type of medical debt collected. In the data, 84.7% of accounts are credit reporters; thus, the impact will be substantial if the proposed rule changes are implemented. This is consistent with the deterrent effect of credit reports. The removal of credit reporting causes a large decrease in liquidations. Firms that don't report to credit reporting agencies have already adjusted to this policy. However, non-credit reporters expect a fall of almost 6% since the message that medical debts need not be paid will be clear and well-known amongst borrowers.

Table 4: Credit Reporting and Usage of Legal System Estimate of Change of Liquidation of Referred Debts Percentage

	Mean
No Credit Reporting	-5.8%
Credit Reporting	-10.5%
Do not use legal collections	-10.9%
Uses legal collections	-7.3%

70. Using the legal system to enforce collections is an essential differentiator amongst collection firms, and consequently, the expected liquidation rate of referred debts decreases due to non-credit reporting. In the deterrence section, I emphasized there were three levels of consequences for non-payment of debt. The first was not to have the debt reported or no consequence. The second was to report delinquency to the credit bureaus – the medium step. The third was to use legal collections. The data shows that 84.7% are credit reporters, but only 25% use legal collections.[30] Table 4 shows that collectors who do not use legal collections expect a fall of 10.9%, but firms that use legal collections expect only a 7.3% decrease. This difference cannot be known from this data, but presumably, this may be due to legal collectors planning to use the legal system to enforce their rights to receive payment. If some debts could be collected via credit reporting but now require legal action, this would entail a net social loss due to the costs of the legal system.

The effect of this rule on debt collectors

71. The net effect of these data is to show a contraction in the debt collection industry. Debt collection is a necessary part of financial markets. The service they provide is to enforce payment of contracts. They, of course, do this for a fee. It is a competitive industry, resulting in fees aligning with costs. Thus, by reducing the effectiveness of collectors, the result will be a rise in collection costs or a reduction in collectible amounts, which will be passed on to their consumers –companies providing financing. Some firms will leave the market, reducing competition, employment, and options for collection companies and, by extension, healthcare providers.

[30] There is no limit to using credit reporting and legal collections. Given legal collections are more costly to initiate than a credit report, I assume legal collectors are credit reporters and that legal collections are an escalation in the collections process.

The effect of this rule on medical providers

72. The struggles of debt collectors will be passed on to companies financing medical procedures and, ultimately, medical providers. Without efficient debt collection, medical providers would have to raise the cost of financing or cut consumers off from medical services. America has a market-based healthcare system, and with competitive pressures, systematically losing revenue cannot be written off. The data shows net losses in collections can be over 5-10% and concentrated in rural areas and general medicine. Given the competitive nature of this industry, much of these losses will be passed on to medical providers and subsequently – their patients. Further, this will be a systematic issue across the entire country. Unfortunately, there is no data documenting the losses to providers from the reduction in the ability to collect medical debts. Given that Americans pay co-pays, deductibles, and out-of-pocket expenses in market-based healthcare, this amounts to a large portion of provider's incomes being put at risk by the proposed Bureau rule change. However, in Figure 1, I have shown how referrals of debts for collections have increased. It is consistent with the data to hypothesize that the message consumers are getting is that they do not need to pay their medical debts. If true, this would result in providers receiving less compensation. This hypothesis should be studied before any new rules are promulgated because, ultimately, medical providers will need to protect themselves and deny care. This could result in heavier government or non-profit care usage or people going without medical treatments, goods, or services.

The effect of this rule on medical consumers

73. The final stakeholder who will ultimately lose is the consumer of medical services. Consumers who gain by having their medical debt records removed or never reported will potentially suffer from worse financing terms or the inability to

access health care and, ultimately, debt financing. Consumers who diligently pay their medical debts will not get credit for doing so but potentially lose access to medical access. A market-based health system without financing would be a terrible equilibrium.

Andrew Nigrinis

Andrew Nigrinis, Ph.D.

November 6th, 2023

EXHIBIT
2-B

Economic Analysis of the Consumer Financial Protection Bureau's Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information (Regulation V)

By Andrew Rodrigo Nigrinis, Ph.D.

Contents

Qualifications and Assignment

1. I am an economist at Legal Economics LLC, a consulting firm specializing in economic and statistical analysis. Before joining Legal Economics, I was the sole enforcement economist at the Consumer Financial Protection Bureau (CFPB) in the enforcement division. I led the Bureau's economic analysis and evaluation of over 70 cases. Throughout my career, I have managed investigations related to allegations of unfair or deceptive practices, fair lending, disputes between financial services providers and lenders, allegations of mortgage and student loan servicing issues, credit card fees, debt collections, and dark patterns. I also provided economic analysis of consumer financial regulations and policies and have extensive experience with sampling and big data. While at the CFPB, I worked with State Attorney Generals, DOJ, and OCC officials on various matters. I earned a Ph.D. in Economics from Stanford University. I completed a master's degree in economics at Queen's University in Canada and my bachelor's degree at the University of Alberta in Canada. I won the economics medal at the University of Alberta. I was a Carmichael Fellow at Queens University and a Stanford Institute for Economic Policy Research fellow at Stanford.

2. Brownstein Hyatt Farber Schreck LLP hired me to provide my opinion concerning the economic analyses and empirical evidence cited in the Consumer Financial Protection Bureau's (CFPB) Proposed Rule on the Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information (Regulation V). Brownstein Hyatt Farber Schreck LLP also asked me to provide my opinion concerning the possible economic impact of the proposed rule on the debt collection industry and the expected impact on the consumer finance industry and medical providers. I am being compensated for this report.

Summary of Conclusions

3. My review of the proposed changes to the regulatory framework of the FCRA is that the CFPB (Bureau) has not done—but absolutely must—perform a meaningful analysis of the effects on consumers, lenders, small businesses, Providers, or the broader market that relies on credit reporting before promulgating the proposed rule. The proposed rule has many foreseeable economic impacts that the Bureau has not evaluated:

- Restricting the use of accurate information about valid debts would cause increased financing for unqualified borrowers.
- There would be decreased access to credit for credit-qualified borrowers.
- There would be an increase in difficulty in meaningfully repairing credit scores.
- The proposed rule would cause conflicting obligations on creditors under the Truth in Lending Act (TILA) and Regulation , particularly under the ability to repay provisions.
- There would be adverse effects if certain medical debts were excluded from underwriting decisions or consumer reports.
- Medical providers would suffer a loss of income from non-payment of services. The loss in the first year is estimated to be $24 billion. The estimated range for the losses over time ranges from $82 billion to $655 billion.
- There is a likely increase in litigation costs for medical providers to collect debts, including increased costs to consumers facing that litigation.

- There would be increased uncertainty in consumer finance as predictive information is removed from credit reports.
- There is potential to harm consumers, including those without health insurance and many in protected classes.
- There is a strong possibility of more lending of the type that precipitated the financial crises that culminated in the formation of the CFPB.
- There is a risk of health insurance markets entering a death spiral if young and healthy consumers who infrequently use health care forgo insurance due to not needing to pay for medical treatment.

The commentary and analysis supporting the proposed rule failed to provide any quantitative or empirical evidence addressing these readily predictable results of the rule. These predictions are informed both by modern economic theory and, specifically, research performed by other economists and myself. The research in the arena of information relied upon for underwriting credit decisions irrefutably demonstrates facts and outcomes that advise against the adoption and implementation of the proposed rule. In sum, curtailing the use of accurate information about consumer debt burdens is inefficient and places an undue burden on society:

- The research shows that improved accuracy of credit reports, which this rule undermines, leads to an expansion of lending to reasonable risks and a reduction in poor risks. This is done by providing more credit at better terms to low-risk consumers while reducing access and raising costs for lower-risk consumers. Overall, this benefits businesses as profitability rises.

- Medical account collections referred to third-party debt collectors will decrease by 8%, thus reducing revenue for medical service providers.
- There will be increases in write-offs at the Provider level as more patients interpret the message behind the message that medical debt should take a back seat to the priority of paying other debts.
- Assess whether the burdens associated with regulations could result in market exits for small medical care providers and debt collectors.
- Medical debt disproportionately impacts the South and Mid-West States.
- The CFPB, in their technical appendix, shows that medical debt is predictive of expected losses the credit card industry faces. I do not accept their methodology, but these estimated losses that the CFPB calculates are understated as they do not reflect the changes the proposed rule will have on medical debt collection.

4. Furthermore, the CFPB should have provided an analysis of this rule's impact on small business healthcare service providers. Many consequences of the proposed rule have not been studied:

- There is no analysis of how consumers of private-market healthcare providers can finance these services.
- The CFPB has yet to study whether providers will respond to reduced collections by refusing to provide credit and thereby cutting off access to healthcare services for the consumers the Bureau aims to help or whether healthcare providers will respond by raising prices for all consumers, which would harm everyone. Additionally, providers might request cash up-front for co-pays and deductibles,

disadvantaging consumers who cannot afford to pay these amounts all at once, thus reducing their access to healthcare.

- The CFPB has also not examined how rural and underserved communities operating on thin margins could be impacted.
- Furthermore, it must evaluate whether changes in the ability to recoup payment cause shifts to a concierge model, which could further reduce access for low-income community members.

Background

5. Medical debt tradelines are a large portion of consumer debt reported in the U.S. A recent CFPB study found that:[1]

- From Q1 2018 to Q1 2022, the total number of collections tradelines on credit reports declined by 33 percent, from about 261 million tradelines in 2018 to about 175 million in 2022.
- Medical bills account for 68.9 percent of furnished collections by contingency-fee-based debt collectors, followed by telecommunications at 12.5 percent and utilities at 4.5 percent.
- The share of consumers with at least one medical collections tradeline dropped from nearly 20% in 2017 to 14% by March 2022.
- Medical collections tradelines still constitute a majority (57 percent) of all collections on consumer credit reports.

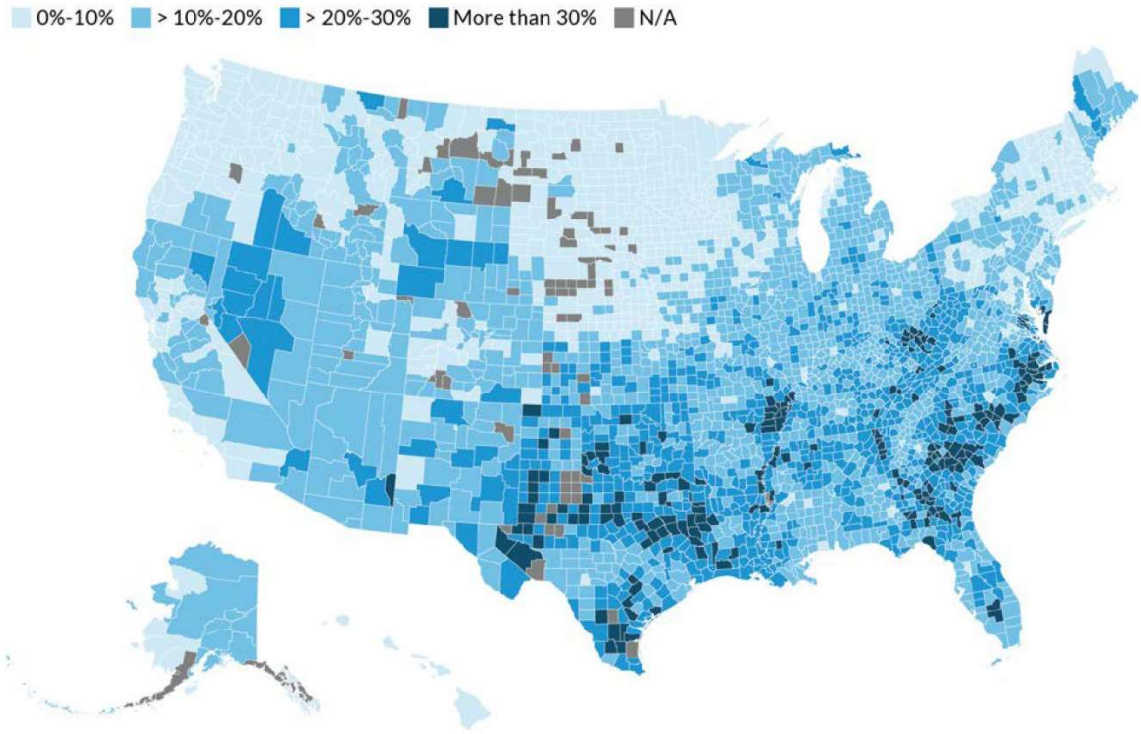
The last point emphasizes how the Bureau's proposal to remove medical collections is a significant change in credit reporting with market-wide implications. This rule will drastically reduce the information available to lenders on the creditworthiness of potential borrowers.

[1] Market Snapshot: An Update on Third-Party Debt Collections Tradelines Reporting, Feb 2023

6. The distribution of these medical debt tradelines around the U.S. is not random. The Urban Institute[2] produces the following graph with 2021 data:

FIGURE 1

Percentage of Consumers with Medical Debt in Collections, August 2021



Source: Urban Institute Analysis of August 2021 credit bureau data.
Note: N/A = not available because the sample size is too small.

As can be seen from the national map, medical debt is overwhelmingly higher for consumers in the rural Southern United States. The following table from the same report shows the ten counties with the highest percentage of consumers with medical debt compared to the U.S. average:

[2] Blavin, Fredric, Breno Braga, and Anuj Gangopadhyaya. "Which County Characteristics Predict Medical Debt?." *Washington, DC: Urban Institute* (2022).

TABLE 1

Counties with the Highest Share of Consumers with Medical Debt in Collections as of August 2021 and the Counties' Characteristics

County	State	Pop.	% with medical debt in Collections	% Uninsured	Avg. Income	% Hispanic	% Black non-Hispanic	% 6+ CCP
Warren	GA	5,215	50.5	13.0	$53,077	1.0	58.4	20.3
Greene	NC	20,451	46.0	16.6	$53,007	14.4	35.2	17.3
Lenoir	NC	55,122	44.7	12.5	$56,708	7.9	40.0	20.3
McDuffie	GA	21,632	43.1	12.1	$55,341	3.7	40.0	19.7
Anson	NC	22,055	41.6	11.1	$52,077	3.0	44.6	19.5
Nolan	TX	14,738	40.9	19.0	$64,120	36.3	4.2	24.5
Pecos	TX	15,193	40.8	18.1	$68,797	71.4	3.3	16.4
Brooks	GA	16,301	40.7	18.1	$60,621	5.9	34.9	23.7
Haskell	TX	5,416	40.6	20.8	$49,230	25.4	3.3	17.2
Harmon	OK	2,488	40.3	15.2	$65,261	29.7	6.0	22.8
Average top 10			42.9	15.7	$57,824	19.9	27.0	20.2
Average top 100			36.9	14.8	$57,825	19.2	23.6	20.5
US			13.9	8.8	$88,607	18.7	12.1	17.7

Sources: Urban Institute Analysis of August 2021 credit bureau data combined with county-level characteristics (see table A.1 for additional details).

Notes: Pop. = population, CCP = chronic condition prevalence.

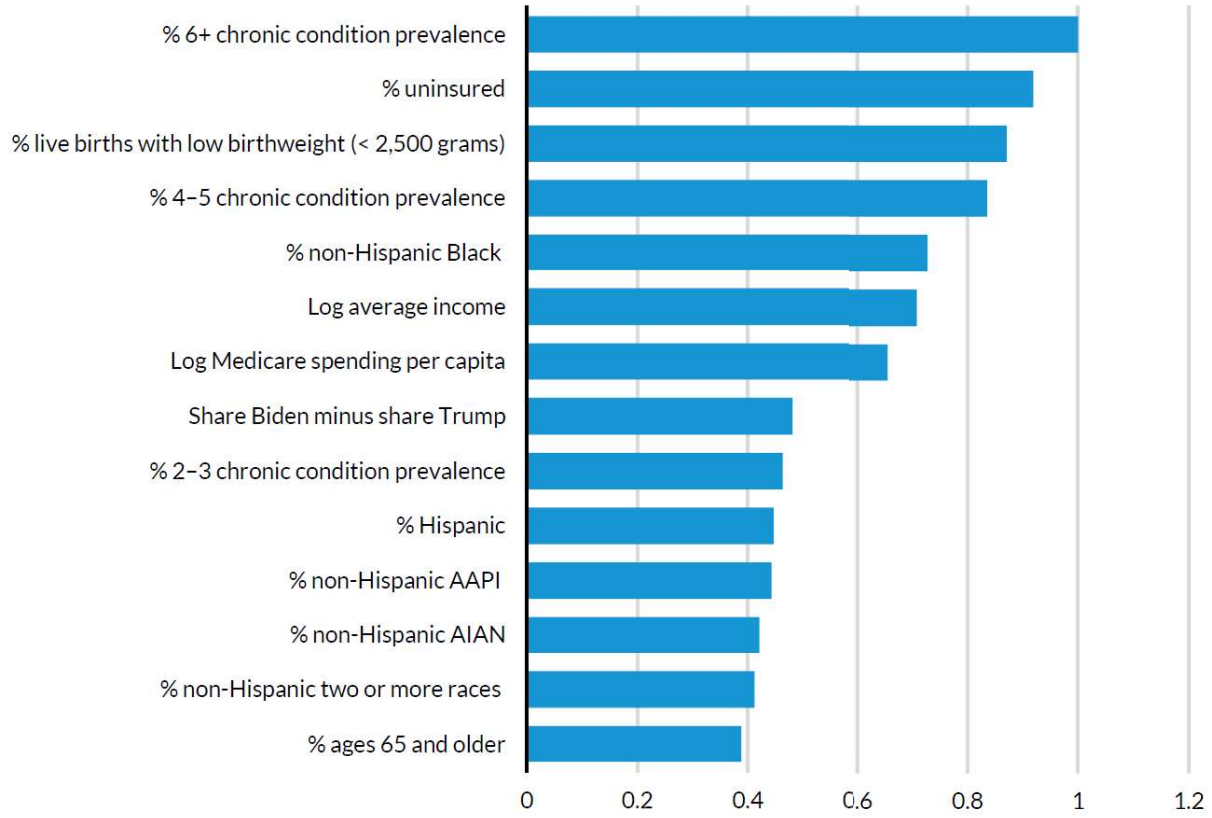
This table provides a few key takeaways. Medical debts are high in counties with a high percentage of uninsured consumers. As of this writing, Texas and North Carolina have not implemented the Medicaid expansion. Oklahoma implemented its' Medicaid expansion in July 2021 (just before the Urban Institute's analysis).[3] These counties are in the rural South, with low average incomes and a high percentage of non-Hispanic Blacks. According to CMS data, the 6+CCP is the percent of the Medicare population with six or more out of 21 chronic conditions. It is a proxy for the underlying health of the people. Medical debt is concentrated in counties with high levels of chronic disease.

7. The study then uses a machine learning algorithm to determine the factors most contributing to medical debt. The following table shows the results:

[3] The other states that have not implemented the Medicaid expansion are AL, GA, FL, KS, MS, SC, TN, WI, and WY.

FIGURE 3

The Relative Importance of Predictors for Percentage with Medical Debt in Collections



Sources: Urban Institute August 2021 credit bureau data combined with county-level characteristics (see table A.1 for additional details).

Notes: We use a machine learning random forest algorithm to predict the share of adults with medical debt in collections. Variable importance is calculated by adding up the improvement in the objective function given in the splitting criterion over all internal nodes of a tree and across all trees in the forest, separately for each predictor variable. In the implementation of random forest, the variable importance score is normalized by dividing all scores over the maximum score; the importance of the most importance variable is always 100 percent. AAPI = American Asian and Pacific Islander, AIAN = American Indian and Alaska Native.

Though this is not a causal analysis, it is informative. According to The Urban Institute, counties with high levels of medical debt on credit reports are impoverished counties that rely on market-based healthcare with high percentages of uninsured people. The high levels of chronic disease in the Medicare population and the high rate of low-birth-weight live births point to a general problem of poverty. Medical debt appears not to be the problem but rather a symptom of decisions made in the medical system. Removing medical debts from credit report

tradelines will not fix people's inability to make payments. This solution will make financing financial services more difficult for people who require financing options.

What is the Purpose of Credit Scores?

8. Because the proposed rule is designed to inflate what is commonly known as a "credit score" for persons with medical debt, one first must evaluate: What is a credit score? The CFPB provides a straightforward answer: "A credit score is a prediction of your credit behavior, such as how likely you are to pay a loan back on time, based on information from your credit reports."[4]

9. In practice, credit assessment involves two dimensions. The first component is a credit score, which is usually three digits. The second is the tradelines containing information on a consumer's accounts. These tradelines can be active, closed, or delinquent, and importantly for this report, they are used to objectively determine the amounts a consumer owes to lenders and providers every month or in total balances. The three-digit score is derived from one of many predictive models that try to anticipate a consumer's likelihood of default on a given obligation.

10. There are currently 16 distinct versions of the FICO Score used by creditors and other authorized users of personal credit data, such as landlords, utility companies, and companies performing certain pre-employment background checks. These are just a portion of the dozens of FICO Score versions issued since 1989. For example, the FICO Auto Score 10 model is specially designed to

[4] CFPB, *What is a credit score?* (LAST REVIEWED: AUG 28, 2023, available at https://www.consumerfinance.gov/ask-cfpb/what-is-a-credit-score-en-315/ last accessed June 17th, 2024)

gauge the likelihood that a borrower will repay an auto loan. FICO Bankcard Score 10 adapts the scoring framework of FICO Score 10 to predict how borrowers may pay their credit card bills.

11. A credit report's economic value lies in its ability to facilitate financing by enabling firms to accurately assess potential borrowers' riskiness. The precision of a credit score enhances its value. Market forces determine the actual pricing of risk. Due to competition, firms cannot expect to sustain long-term profits by mispricing risk, nor can they remain solvent by extending credit to high-risk, unprofitable borrowers.

12. Risk assessment is crucial for the efficient functioning of credit markets. Without reliable information, all borrowers would receive credit on the same terms, as market forces would ensure a uniform equilibrium price. However, a consumer with a history of timely debt payments should be considered less risky than one with a history of defaults. Consequently, the less risky borrower becomes a profit center for financing firms, while the risky borrower generates losses. By reliably identifying safer borrowers, firms can offer them better financing terms that reflect their lower risk. Conversely, higher-risk borrowers would pay more to offset the expected losses. Providing financing on identical terms forces low-risk borrowers to pay more, effectively subsidizing higher-risk customers. This benefits high-risk borrowers but disadvantages low-risk borrowers.

13. Credit scores and reports aim to categorize consumers based on their risk levels. Both low-risk and high-risk borrowers can access financial markets but receive different financing terms, such as varying credit limits and interest rates. While there is always some uncertainty—low-risk borrowers may default, and high-risk borrowers may repay—detailed information allows for more nuanced and customized financial products. This fundamental but essential point is missing

from the CFPB's proposal. The CFPB is proposing the degradation of credit reporting.

14. As markets segment consumers by risk, they can expand. More precise risk assessment allows for the availability of more specialized financing options. Mechanisms such as collateral, the threat of credit reporting, and down payments can be employed to mitigate financing risks. Credit reporting facilitates this process by enabling different customers to access various options to reveal their risk profiles or to identify risk pools where risks can be shared to extend credit. Enhanced credit reporting accuracy makes companies more profitable by better segmenting risk and expanding the market for consumer credit.

15. Overall, credit scores and reports are fundamental in facilitating efficient credit markets by providing lenders with valuable information to assess borrower risk and tailor financing terms accordingly. As a former CFPB director stated:

> "Credit reporting is an important element in promoting access to credit that a consumer can afford to repay. Without credit reporting, consumers would not be able to get credit except from those who have already had direct experience with them, for example from local merchants who know whether or not they regularly pay their bills. This was the case fifty or a hundred years ago with "store credit," or when consumers really only had the option of going to their local bank. But now, consumers can instantly access credit because lenders everywhere can look to credit scores to provide a uniform benchmark for assessing risk. Conversely, credit reporting may also help reinforce consumer incentives to avoid falling behind on payments, or not paying back loans at all. After all, many consumers are aware that they should make efforts to build solid credit." [5]

Likewise, the current CFPB director has recognized that credit scores and reports are fundamental in facilitating efficient credit markets. He stated that including Buy

[5] CFPB, *Field hearing on new credit reporting supervision in Detroit, MI* uly 16, 2012, available at https://www.consumerfinance.gov/about-us/events/archive-past-events/field-hearing-on-new-credit-reporting-supervision-detroit-michigan/ , last accessed June 17th, 2024)

Now Pay Later balances in credit reports will enable lenders to make more informed decisions and avoid overextending credit to consumers. This same logic should be applied in the context of medical debt. Yet, in its proposal for medical debt, the CFPB leaves it to consumers to self-report their medical debt, thereby leaving lenders at risk of extending credit to individuals who cannot repay the loan.[6]

16. Credit reports are not definitive in credit decisions but serve as essential inputs. The market is dynamic, and competition fosters experimentation to identify risks better. While credit reports and scores are valuable, they do not solely determine lending decisions. In mortgage markets, credit scores are used alongside other metrics, such as loan-to-home value ratios. Many firms use proprietary risk algorithms that incorporate credit scores and reports. Although the use of this data is optional, if its quality is degraded, no adequate alternative inputs are available.

17. The market's response to medical debt tradelines is significant. The CFPB's research (Section 2014 Model Critique) demonstrates that medical tradelines are informative in assessing a potential consumer's risk. If medical debt had no value in risk assessment, consumers with depressed credit scores due to medical debts would be offered unfavorable financing terms. This would create an opportunity for enterprising firms to identify and capitalize on this mispriced risk by providing better financing terms. The business-stealing effect is a real and powerful force that

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[6] CFPB, *Director Chopra's Prepared Remarks on the Release of the CFPB's Buy Now, Pay Later Report* (September 15, 2022, available at https://www.consumerfinance.gov/about-us/newsroom/director-chopras-prepared-remarks-on-the-release-of-the-cfpbs-buy-now-pay-later-report/ , last accessed June 17th 2024,) ("Overextension is also a significant issue in the broader credit card market as well, but is compounded by a host of issues we describe in the report. Additionally, consumer reporting companies have been slow to develop mature credit reporting protocols with respect to Buy Now, Pay Later. Mortgage lenders and auto lenders have raised concerns to me that the growth of Buy Now, Pay Later with no associated credit reporting makes it more challenging to know whether a borrower can afford a mortgage or auto loan. The Buy Now, Pay Later firms themselves also may have no idea how many other loans a consumer may have with other Buy Now, Pay Later providers.")

disciplines markets. By removing medical tradelines from underwriting considerations, the CFPB either eliminates valuable information for pricing risk or removes information that the market would naturally disregard if it were irrelevant.

18. The CFPB's empirical analysis of the predictability of medical debts forms a feeble basis for the proposed rule. The study is deeply flawed—discussed at length below—and the results it purports to observe are nonconsequential. By the CFPB's admission, the market already factors into its scoring and underwriting decisions the inherent limitations on the predictability of medical debt at specific dollar amounts. Indeed, in the CFPB's 2023 report on medical debt, it is noted that "The FHFA has further announced that it will implement FICO 10T and VantageScore 4.0 as the credit scores that Fannie Mae and Freddie Mac will use as thresholds for screening loans. These credit scores underweight or do not include medical collections, unlike the credit score models that FHFA-backed loans have historically used for screening-in decisions."[7] This indicates that the market demanded credit scores that exclude or underweight medical debt, and such alternative credit scores now exist. If medical debt depresses credit scores in a way that is not informative for predicting delinquency, market forces driven by profit incentives will adopt these new tools.

Effect on Protected Classes and Others

19. If the Bureau's proposed rule is implemented, a significant unintended consequence will likely be a restriction of lending to various protected classes. Financial firms know the extent of uncollected medical debt and the demographics of those not paying (see background section). These firms understand the distribution of this debt and are under competitive pressure to maximize profits

[7] Alyssa Brown and Eric Wilson "Data Point: Consumer Credit and the Removal of Medical Collections from Credit Reports", *Washington, DC: CFPB* (2023). Pg24

while minimizing losses from lending to risky individuals. Medical debt is widely recognized as a predictor of delinquency or default—including bankruptcies. Knowing a borrower's medical debt helps assess their ability to repay, leading to more informed lending decisions.

20. Financial firms may engage in statistical discrimination, which occurs when there is imperfect information about individuals' lending risk but information about group averages is available. According to the Urban Institute report[8], one of the most significant predictors of medical debt is the percentage of the non-Hispanic black population in a county, followed by lesser predictors such as the percentages of Hispanics, Asian Americans, and Native Americans. Due to competitive pressures, the market will utilize all available information. As firms seek to avoid losses or be adequately compensated for taking on additional risks, they may restrict access to credit for these protected classes or offer credit on less favorable terms.

21. The Bureau's rule is expected to disproportionately impact financing for disadvantaged populations, including the poor, sick, rural residents, and conservative communities. According to the Urban Institute, these regions are more likely to rely on market mechanisms for healthcare and have larger uninsured populations due to not expanding Medicaid under the Affordable Care Act. Any regulatory measure that complicates medical debt financing will disproportionately impact jurisdictions reliant on market mechanisms and may exacerbate disparities in resource allocation to underserved populations. Profit-driven financial institutions will adjust their lending practices based on readily available data irrespective of political affiliations, potentially exacerbating inequalities in access to credit and healthcare services. Regardless of political views, profit-maximizing

[8] Blavin, Fredric, Breno Braga, and Anuj Gangopadhyaya. "Which County Characteristics Predict Medical Debt?." *Washington, DC: Urban Institute* (2022).

firms will likely need to restrict financing or increase the cost of financing medical services based on easily verifiable data. This process is already underway, with many hospitals and medical providers requiring upfront payments.[9]

Deterrence

22. The Bureau has yet to conduct an analysis of the effect of removing medical debt from credit reports on the deterrence to consumers from paying validly owed medical debts. In a simple model of deterrence, there are two actions: Pay the debt or not pay it. The probability of being caught is 100 percent, and not being caught is 0 percent. Thus, a consumer is deterred from not paying if the non-payment cost exceeds the alternative use of the funds. Many people are cash-constrained, so a market without deterrence to non-payment is not feasible.

23. This gets to the central failing of the CFPB's analysis of deterrence. It fails to account for the fact that deterrence is a continuum. Medical debts are medical income for medical goods and service providers. These providers need to be paid, and the market has four market mechanisms to ensure payment:

- Forgiveness or ignoring the debt and not reporting it.
- Report the debt to a credit reporting agency.
- Litigate to collect the debt in court.
- In the longer term, the option to withhold credit allocation.

The Bureau proposes restricting lenders' access to credit reports with medical debt information. This will allow for only one of two responses: refraining from reporting medical debts or litigation for repayment.

[9] Melanie Evans, (2024) "Hospitals Are Refusing to Do Surgeries Unless You Pay in Full First", *The Wall Street Journal*, May 9th.

24. If the ability to report medical debts is eliminated, some consumers will not have medical debts reported, and some will see litigation. There will be a substitution from reporting medical debt to not reporting medical debts; undeniably, some consumers will initially benefit from the change. However, on the other end of the continuum, some firms will substitute credit reporting for litigation. As a result, if the ability to report medical debts is eliminated, specific consumers will avoid having their medical debts reported. In contrast, others may face legal action from firms seeking to recover debts through litigation rather than credit reporting.

25. Unfortunately, the social costs of litigation will be increased and borne by consumers. As more debt collectors and healthcare providers turn to the legal system, the consumers the proposed regulation is intended to benefit will be forced to pay for litigation and court expenses. Litigation is a more expensive method to transfer resources from debtors to creditors than through less formal agreements to pay contractual obligations outside the court system. Ultimately, if there is an increase in litigation, all consumers may face increased financing costs or experience providers refusing patients who rely on credit, resulting in losing access to healthcare and making them net losers if the proposed regulation is enacted. Specifically, consumers who face litigation will pay more and have less privacy than if a consumer debt was resolved through non-litigation means. On a market level, the proposed regulation would make medical debt payment voluntary if there is no litigation over medical debts.

Credit Repair

26. Credit scores and tradelines are not fixed but can be enhanced through consumer action. They are not solely downward trajectories; consumers can take

steps to improve them. Since failure to pay medical debts predicts default (see Section: 2014 Model Critique), clearing such debts indicates a consumer's potential as a reliable borrower. Restricting credit reporting can greatly impact consumers aiming to enhance their credit scores and repair their credit history. One crucial method of boosting credit scores is addressing and resolving negative tradelines. If all medical and credit card debts are removed from credit reports, although this might temporarily boost credit scores, it would also diminish their predictive value regarding an individual's creditworthiness. Limiting credit reporting prevents diligent consumers from distinguishing themselves from those who neglect their financial obligations. Instead, all consumers may be grouped into a general risk category, making it harder for responsible borrowers to showcase their improved risk profile and access preferable financing terms. Limiting credit reporting undermines consumers' ability to effectively signal their creditworthiness to lenders. The CFPB's criticisms against the Buy Now Pay Later "BNPL" industry have been based on the need for credit reporting for consumers to build and repair their credit.

> "Until recently, few BNPL lenders furnished information about consumers to the nationwide consumer reporting companies (NCRCs). This lack of furnishing could have downstream effects on consumers and the credit reporting system. It could be bad for BNPL borrowers who pay on time and may be seeking to build credit, since they may not benefit from the impact that timely payments may have on credit reports and credit scores. It may also impact both BNPL lenders and non-BNPL lenders seeking to understand how much debt a prospective borrower is carrying."[10]

27. The Bureau recognizes the value of credit reporting in incentivizing constructive behaviors that enhance credit scores. However, this opportunity for

[10] CFPB, *Buy Now, Pay Later and Credit Reporting*, (June 15th, 2022, available at https://www.consumerfinance.gov/about-us/blog/by-now-pay-later-and-credit-reporting/, last accessed on June 17th, 2024)

credit score improvement would be lost for individuals seeking to enhance their creditworthiness. The desire and efforts to improve a credit score often occur before significant purchases, like buying a house. Some argue that removing all medical debts would raise credit scores, which is true. However, these inflated credit scores would be less indicative of creditworthiness, leading to higher default risks and less favorable financing terms. Individuals who diligently work to enhance their credit scores would lose the opportunity to differentiate themselves and be grouped into a general risk pool with those who neglect to resolve their medical debts. As a result, they would be unable to demonstrate to lenders their improved risk profile through meaningful actions.

Making the Ability to Repay Analysis More Difficult

28. Under several regulations promulgated by the CFPB, lenders must verify a borrower's ability to repay a loan by considering underwriting factors like current debt obligations and monthly debt-to-income ratios. Typically, lenders rely on consumer credit reports to confirm this information. However, excluding medical debt from credit reports can distort the accuracy of these reports, potentially hindering lenders' ability to make accurate underwriting decisions. Research by the CFPB indicates that medical debts are less predictive of default – but still predictive. Because medical debts have *some* predictive value, rules to limit underwriting consideration of medical debts will damage the market. The exclusion of valid and accurate predictive information about debt is contrary to the Fair Credit Reporting Act's objective of ensuring accuracy and fairness in credit reporting. Lenders may struggle to assess borrowers' accurate financial positions and capacity to fulfill loan obligations without access to complete credit reports, including medical debt information. As a result, removing medical debt from credit

reports complicates the ability-to-repay analysis mandated by federal law and undermines the fairness and precision of the lending process.

29. The proposed rule would contradict regulations and enforcement actions the CFPB has previously engaged in related to an ability-to-repay analysis. In a legal action against an auto lender, the CFPB accused the lender of conducting an insufficient ability-to-repay analysis, deeming its failure to assess all payments as "abusive." The complaint asserts that the lender overlooked or didn't mandate dealers to inquire about the borrower's recurring financial obligations, including rent or mortgage payments and crucial monthly expenses like food, healthcare, or childcare. This contention is exemplified in the *Consumer Financial Protection Bureau v. Credit Acceptance Corporation* (1:23-cv-00038), filed in the Southern District Court of New York, where the CFPB criticized the lender for neglecting to consider recurring healthcare expenses and other debt obligations. Despite the absence of a mandate to evaluate weekly food and childcare expenses, the CFPB criticized the lender for its oversight in not accounting for these financial aspects in its credit extension decisions.

Lack of Analysis of the Potential Consequences

30. The Bureau relies on internal research that fails to predict or shed light on the expected consequences of its proposed rule. Two key pieces of research are frequently cited. The first, "Data Point: Consumer Credit and the Removal of Medical Collections from Credit Reports" from April 2023, notes a 25-point increase in credit scores after removing the last medical collection. It also finds that consumers with a deleted medical collection are likelier to have a first-lien mortgage inquiry. This Data Point proves little. It is well-understood that when individuals work to actively clear negative tradelines off their credit report, they

are more likely to be in the market for a mortgage. This Data Point fails to study anything beyond this immediate effect and has no informative conclusions about the broader impact on medical debt collection or consumer credit. The second cited work is a 2014 study titled "Data Point: Medical Debt and Credit Scores," which suggests that medical debts are not as predictive as other types of unpaid debt. While this finding is intriguing, it should not be interpreted as indicating that medical debt tradelines have *no* predictive power in credit scores. The Bureau frequently uses the less predictive claim to justify the removal or suppression of medical debt, which, according to the CFPB's research, would diminish the accuracy of credit reports and the underwriting based on credit reports.

31. The CFPB's research has not been subjected to rigorous peer review, nor has its results been scrutinized or validated. Opening its findings to public scrutiny is imperative for an institution that seeks to base its decisions on evidence. In economics, this is typically done through the publication of results. At the very least, the CFPB should grant industry stakeholders access to all data and codes, enabling them to verify the Bureau's results.

32. Additionally, none of these findings provide insights into the potential implications of the Bureau's rule on consumer financial markets. A comprehensive study should be conducted to evaluate the impact of implementing the rule on medical debt repayment. Furthermore, an investigation should explore how medical providers react to collection declines. While the Bureau may be aiming to protect consumer finance consumers, it's crucial to consider that these same consumers also require access to healthcare services. Lastly, the degradation of consumer credit reports will affect every industry reliant on them for risk assessment. The Bureau lacks evidence-based studies or estimates to address these initial concerns.

2023 Model Critique

33. The 2023 report[11] by the CFPB Office of Research is the primary citation used to quantify the change in credit scores from removing medical debt credit lines. The authors find that the average person who removes medical tradelines of less than $500 has a 21-point increase in their credit score. For debts over $500, the increase is 32 points on average. This result is used to justify the potential for a significant consumer benefit by eliminating the reporting of medical debt.

34. The 2023 Model has many serious errors and deficiencies, summarized immediately below and explained in the paragraphs that follow:

- The "event analysis" methodology is not as rigorous as a difference-in-differences analysis that incorporates a control group;
- The consumer records used in the study have inherent biases because they are comprised of only consumers who were able to have medical tradelines removed;
- The analysis overstates the benefits of medical tradeline removal concurrent with other changes. The results are most likely a mixture of effects;
- The data is outdated and is being used from vastly different time periods with no statistical controls;
- This research doesn't capture the unanticipated effects of this rule;
- The research does not reflect impacts from the No Surprises Act, enacted on January 1st, 2022;

35. The study, as presented in the 2023 report by the CFPB Office of Research, is based on an event analysis conducted by the Bureau, which is not as rigorous as

[11] Alyssa Brown and Eric Wilson "Data Point: Consumer Credit and the Removal of Medical Collections from Credit Reports", *Washington, DC: CFPB* (2023).

a difference-in-differences analysis. The Bureau's analysis is a straightforward event analysis that tracks how credit scores change over time after removing a medical debt tradeline. However, credit scores often improve over time as tradelines are removed from credit reports. Old tradelines are typically given less weight. Therefore, a control group should be established for a more accurate comparison. Unfortunately, no control group has ever been created. If a control group were included, the magnitude of the results would likely decrease significantly. A rise in credit score should occur regardless, as removing negative information should make a consumer appear to be a safer risk. However, the analysis likely overstates the magnitude of the benefits.

36. The study constructs its measure incorrectly, which makes any accurate measurement of benefits impossible to interpret. The study uses consumers who have had medical debt removed from their credit reports as its sample. This excludes consumers who never had a medical debt tradeline or those who had medical tradelines and could not remove them. An obvious hypothesis is that those who can have a medical debt tradeline removed are disproportionately likely to have a medical debt reported by mistake. Alternatively, they have clean records with this anomalous tradeline. This means that these records included in the sample *are likely different from* those with a medical debt tradeline.

37. The ability to remove medical debt tradelines means the consumers are different from the norm. By actively monitoring and acting to clear up their credit reports, these consumers have shown diligence and attentiveness to their records, which likely means that the Bureau used a non-representative sample.

38. The results indicate reverse causation. One of the results of this study shows that those who have cleared up a medical tradeline were more likely to have a first-lien mortgage inquiry. The authors responsibly acknowledge that "Because medical collections are not removed from credit reports randomly, the event study

analysis does not provide causal evidence."[12] Simply put, are consumers removing medical debt tradelines because they intend to use more credit? Or is it because removing the medical tradeline gave them more access to credit? If it is the former, where consumers actively remove medical tradelines in anticipation of using credit, then the results are biased. A simple example is a consumer who is planning to purchase a home. When buying a home, it helps to have a higher credit score. However, the need to save for a downpayment and clear up old debts and tradelines also results in a behavioral change involving removing medical tradelines as part of a general move to boost their credit score. Thus, the analysis overstates the benefits of medical tradeline removal concurrent with other changes. The results are most likely a mixture of the two effects. But, the results of this research would be overstated.

39. Additionally, the study design allows consumers to remove multiple medical tradelines. In a more rigorous difference-in-differences design, repeated treatment of the change in credit reports from medical tradeline removal would bias the results. Recent work has shown that the formation of the groups and the frequency and timing of treatment would radically change the results.[13]

40. The data used is out of date. The data used in this study is from March 2011 to June 2022, where medical collections were removed between June 2012 and December 2020. The first problem is that data is being used from vastly different time periods with no statistical controls. For example, the Affordable Care Act's provisions for Charity Care were enacted in December 2014. The data from the

[12] Alyssa Brown and Eric Wilson "Data Point: Consumer Credit and the Removal of Medical Collections from Credit Reports", *Washington, DC: CFPB* (2023). Pg.25

[13] Technical note: To estimate the effect , a difference-in-differences instrumental variables analysis would be required, as proposed in Baker et al. (2022). The decision to seek out medical tradelines is potentially endogenous. In addition, repeated treatments that may also be endogenous will bias any results.

COVID-19 period is different from pre-COVID data. And hopefully, it will not be comparable to future data. During COVID, there were massive transfers from government to consumers.[14] Additionally, student loan payments were suspended. It is shown in another Bureau research that consumers with medical debt delinquencies are also likely to have student loan delinquencies. The increase in credit scores from removing medical debt tradelines may result in consumers having more resources to devote to student loan debt. The pre-COVID period was before the implementation of the changes to Regulation F, which decreased the expected number of reported medical tradelines.

41. In the future, the results will be less informative. The No Surprises Act was enacted on January 1st, 2022,[15] which will reduce emergency services costs and out-of-network insurance bills. This will reduce the easier-to-challenge medical tradelines that may drive the Bureau's observed results. The No Surprises Act and Regulation F have already diminished the presence of medical debt tradelines on credit reports. However, the primary component of the No Surprises Act, which involves obtaining an Advanced Explanation of Benefits, is still pending implementation. The anticipated benefits of this element, such as fostering increased competition and encouraging price shopping, have yet to materialize.

42. Even if one accepts the results, the rise in credit scores shouldn't be surprising -- but the unintended consequences may be. The results of this study likely overstate the benefits to consumers from removing medical tradelines. But it isn't a surprising result. Those who have negative information removed should have their credit scores increased. However, this research doesn't capture the

[14] During COVID, people held the medical profession in very high regard and even referred to them as "Healthcare Heroes," and probably more patients were willing to pay their medical bills.
[15] "Complaint Bulletin: Medical billing and collection issues described in consumer complaints", *Washington D.C.: CFPB* April 2022

unanticipated effects of this rule. It has no predictions for the increase in unpaid debts due to less deterrence from the possibility of having a negative tradeline. It does not estimate the cost to consumer lending markets from the degradation of credit reports that lenders rely on to assess risk. Nor does it quantify the higher borrowing costs borne by diligent and responsible borrowers with high credit scores. In short, the Bureau has identified the obvious beneficiary of this rule without studying the costs paid by others.

2014 Model Critique

43. The subsequent major work that the Bureau cites to justify its claim that eliminating medical debt from credit reports is "Data point: Medical debt and credit scores" from May 2014. This paper is the source that justifies the following statement:

> "The CFPB has long-standing concerns about the usefulness of medical debt collections tradeline information in predicting a consumer's creditworthiness. For example, research by the CFPB and others has raised questions about the predictive value of this information."[16]

This statement has two problems. First, the research into the predictive problems of medical debt has serious methodological issues. Second, the Bureau has misinterpreted the research's conclusion to justify its rulemaking.

44. The research splits consumers into two groups that fail to isolate the effect of medical debts on delinquency – their measure of risk. Their research design assigns consumers into one category: medical (MM) debt and non-medical debt (MNM). They also do tests with unpaid and paid debts. That would be mostly paid medical debts (MPM) and unpaid (MUM). They then study delinquency by credit

[16] SMALL BUSINESS ADVISORY REVIEW PANEL FOR CONSUMER REPORTING RULEMAKING OUTLINE OF PROPOSALS AND ALTERNATIVES UNDER CONSIDERATION, September 15, 2023, Pg. 17

score for the MM and MNM groups over time. The problem is that an MM and a MNM are a mixture of credit lines.[17] This is not a clean test of the effect of medical tradelines on a credit report at the margin.

45. Without data on the composition of the groups, it is impossible to make an apples-to-apples comparison. We do know that medical debt is not random in the U.S. population. Medical debt falls most heavily on low-income counties with a high percentage of uninsured people.[18] This study does not use standard statistical controls for economic research. The effect of medical debt may be confounded by the income and healthcare policies of the states in which the people of the sample reside. This analysis is not performed.

46. The work is interesting but has yet to be peer-reviewed or published outside the CFPB. Before using research to make major policy changes, the CFPB should open its code and data to the public for scrutiny. A data-driven agency built on trust and accountability should welcome transparency.

47. The data used in this analysis, collected from October 2011 to September 2013, predates significant policy changes such as the Medicaid expansion of the Affordable Care Act. As shown by the Urban Institute, this expansion notably decreased the percentage of uninsured people, a factor that significantly drives medical bills. Therefore, updating the data for any policy analysis today is crucial to ensure its relevance and accuracy.[19] Additionally, this work predates the changes to Regulation F and the No Surprises Act that reduced medical debt tradelines on credit reports. These final two changes are particularly relevant as, by the author's admission:

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[17] Consumers with an even split are removed.

[18] Blavin, Fredric, Breno Braga, and Anuj Gangopadhyaya. "Which County Characteristics Predict Medical Debt?." *Washington, DC: Urban Institute* (2022).

[19] Blavin, Fredric, Breno Braga, and Anuj Gangopadhyaya. "Which County Characteristics Predict Medical Debt?." *Washington, DC: Urban Institute* (2022).

> "The account-level information that is included in the credit records comprising the CCP allows us to identify which debts reported by third-party collection agencies were from medical or non-medical bills. While we can identify those collections that were from medical bills, nothing in the data reveals anything about the identity of the medical service provider, the type of institution that provided the service, or the nature of the services that were performed."

This analysis cannot distinguish between medical debts that would have been removed by the No Surprises Act and Regulation F. Given that these rules were to eliminate or regulate expensive emergency healthcare services, out-of-network charges, and debt misreporting, the remaining medical debts may be equally predictive as non-medical debts. This underscores the urgent need for further studies and consideration. Without these, there is no way to tell.

48. Even if we took the results at face value, the conclusion that medical debt tradelines can be removed with little impact on credit scores is false. The authors have a motivating example:

> "To understand the approach we take, consider two consumers with identical credit records, at the start of the performance period, neither of whom has any collections. Because their credit records are identical, both will have the same credit score, say 780, and would be expected to have the same likelihood of delinquency during the ensuing performance period. Now assume that at the start of the performance period each of the consumers had a debt collection reported on their credit record, one a medical collection and the other a non-medical collection. If the scoring model treats medical and non-medical collections equally, then the scores of both consumers will be decreased by the same amount. Using the estimates published by Johnson (2012), we might expect the scores of these consumers to be decreased by about 115 points relative to the starting assumed credit score of 780. Both consumers would now have scores of 665. Since lower credit scores suggest greater risk, lenders would interpret this as reflecting an increased likelihood of delinquency during the performance period."[20]

[20] Kenneth P. Brevoort and Michelle Kambara "Data point: Medical debt and credit scores", *Washington, DC: CFPB* (2014) Pg. 9

The authors are not saying that medical debt removal is irrelevant to the predictive value of the credit score. As they state:

> "If the credit scoring model nonetheless treated both types of collections equally, these consumers would both have 665 scores. This means that, if medical collections are truly less predictive about a consumer's creditworthiness than are non-medical collections, consumers with medical collections should perform better."[21]

This work results in an estimated credit score difference of 16 to 21 points for medical debts. This is an average effect, and the impact will depend on the observed credit score level. However, as a first-order approximation, it provides a decent estimate. So, in their example, an accurate credit score would be from 780 to 665 for non-medical debts and 665 plus 16 to 21 points, or 681-686 credit score for medical debt. Yes, medical debts are less predictive, but medical debt has an informative value (780 to 681-686) for risk assessment. There are methodological issues that make the estimates suggestive but not definitive. But the Bureau's work, which they base policy on, concludes that medical debts have a predictive value that their removal from credit reports would lose.

49. The recent changes in medical collections reporting, initiated by the three nationwide credit reporting companies in March 2022, have significant implications for risk assessment in consumer finance. Once this issue is realized, the market will be incentivized to re-price risk based on medical versus non-medical tradelines. For instance, the FHFA has announced the implementation of FICO 10T and VantageScore 4.0 as the credit scores Fannie Mae and Freddie Mac will use as thresholds for screening loans. These credit scores underweight or do not include medical collections, unlike the credit score models that FHFA-backed

[21] Kenneth P. Brevoort and Michelle Kambara "Data point: Medical debt and credit scores", *Washington, DC: CFPB* (2014) Pg. 9

loans have historically used for screening-in decisions.[22] Firms are not obliged to use credit scores and reports, but they often use them as part of their internal decision-making and can weight medical debt tradelines as they are compelled to by market forces.

Recent Works

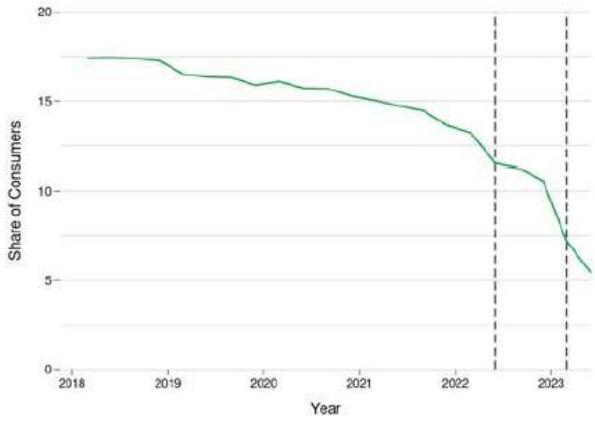
50. In a recent CFPB report, [23] The Bureau finds that the recent changes in medical collections reporting, initiated by the three nationwide credit reporting companies in March 2022, have led to significant shifts in the landscape of consumer credit records. These changes included extending the period before unpaid medical collections appear on a consumer's credit record from 180 days to one year and excluding paid medical collections altogether. Additionally, unpaid medical collections with balances below a threshold of $500 were no longer reported on consumer credit records as of April 1, 2023.

51. The impact of these changes has been notable. By June 2023, the share of consumers with medical collections on their credit records had plummeted from around 14 percent in March 2022 to only five percent. This sharp decline was attributed to removing low-balance medical collections and other factors, including a trend towards fewer medical collections being reported independently of the reporting changes. However, despite these reductions, most medical collections balances remain on credit records, totaling approximately $49.2 billion.

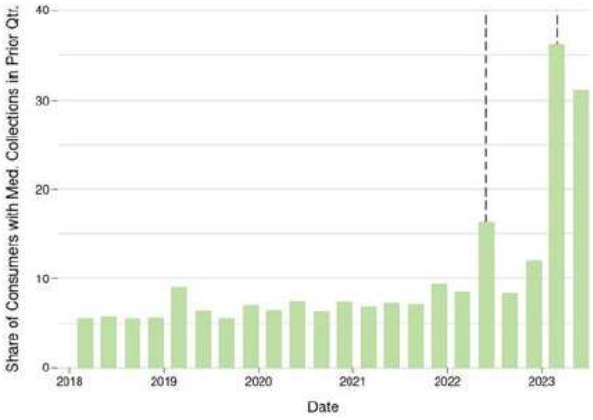
[22] Alyssa Brown and Eric Wilson “Data Point: Consumer Credit and the Removal of Medical Collections from Credit Reports”, *Washington, DC: CFPB* (2023). Pg.25

[23] Ryan Sandler and achary Blizard, "Data point: Recent Changes in Medical Collections on Consumer Credit Records", *Washington, DC: CFPB* (2024)

FIGURE 1: SHARE OF CONSUMERS WITH MEDICAL COLLECTIONS, AND SHARE OF CONSUMERS WITH A MEDICAL COLLECTION THE PREVIOUS QUARTER WHO HAVE ALL MEDICAL COLLECTIONS REMOVED, OVER TIME



(a) SHARE WITH AT LEAST ONE MEDICAL COLLECTION



(b) SHARE WITH ALL MEDICAL COLLECTIONS REMOVED SINCE PRIOR QUARTER

52. One demographic group that benefited significantly from these changes is consumers residing in majority-white and high-median-income census tracts. The report found that most of the changes were likely to come from removing low-balance medical collections, indicating that consumers with lower medical debt were more likely to benefit (Table 2 of the report replicated below). Additionally, the report suggested that consumers in certain states, particularly those with higher median incomes and majority-white populations, were more likely to see their medical collections removed.

TABLE 2: DISTRIBUTION ACROSS CENSUS TRACT CHARACTERISTICS OF CONSUMERS WITH MEDICAL COLLECTIONS IN MARCH 2022, BY STATUS IN JUNE 2023

		Consumers with Med. Collections in 3/22		
% of Consumers in tracts that are...	All CCP Consumers	All	At Least One Med. Collection Removed by 6/23	All Med. Collections Removed by 6/23
Majority Black	6.3	10.4	10.1	9.9
Majority Hispanic	10.5	12.3	11.3	11.2
Majority White	73.3	68.0	69.7	70.0
Majority Other or No Majority	9.8	9.2	8.9	9.0
Median Income $0 to $50K	20.3	31.7	30.6	29.2
Median Income $50K to $75K	34.8	39.5	39.8	39.5
Median Income $75K to $100K	22.4	17.8	18.2	18.9
Median Income $100K+	22.5	11.0	11.4	12.4
Number of Consumers in CCP	5,894,336	785,042	601,302	457,577

53. The data analysis through June 2023 further confirms that consumers with medical collections remaining on their credit records tend to have lower credit scores and reside in lower-income census tracts compared to the larger population that had medical collections on their credit records before the reporting changes. This suggests that consumers in higher-income areas, who may have had relatively lower medical debts, were more likely to have their medical collections removed, benefiting from improved credit scores and financial opportunities (Table 1 of the report is replicated below).

TABLE 1: CHARACTERISTICS OF CONSUMERS WITH MEDICAL COLLECTIONS, BEFORE, DURING AND AFTER RECENT REPORTING CHANGES

	Month Observed with Medical Collections		
	March 2022	December 2022	June 2023
Credit Score	598.2	591.8	582.0
At Least One Credit Card (Percent)	58.6	59.1	57.1
At Least One Auto Loan (Percent)	51.3	50.5	48.6
At Least One Non-Medical Collection (Percent)	35.5	36.9	40.9
No Other Tradelines (Percent)	18.0	18.3	18.5
Census Tract Percent Black	16.7	17.2	17.9
Census Tract Percent Hispanic	19.7	20.2	21.1
Census Tract Median Income ($)	65,645.3	65,018.2	63,149.6
Age 18–29 (Percent)	15.0	16.0	15.8
Age 30–44 (Percent)	33.5	33.7	37.4
Age 45–61 (Percent)	31.2	30.9	31.2
Age 62 + (Percent)	18.1	17.7	14.8
Medical Collections Per Consumer	2.5	2.4	1.7
Average Total Balance ($)	2,090.9	1,886.8	3,148.7
Medical Debts Less than $500 (Percent)	65.2	62.2	0.0
Number of Consumers in CCP	786,321	635,679	325,788

54. Moreover, consumers residing in majority-white census tracts likely benefited disproportionately from the reporting changes. The data show that residents of majority-white census tracts represent a slightly larger share of consumers who had all their medical collections removed than their share of consumers with any medical collections on their credit records. This indicates that consumers in majority-white areas were more successful in having their medical collections removed, potentially due to their higher financial resources and access to credit.

55. The effect of this policy is apparent; consumers who benefited most from the changes in medical collections reporting were those residing in higher-income, majority-white census tracts and were more likely to have low-balance medical collections removed from their credit records. These changes have contributed to disparities in access to credit and financial stability, as consumers in lower-income

areas and communities of color continue to face challenges related to medical debt and credit scores. As a policy to alleviate hardship for low-income consumers, the Bureau's research shows it to be a failure. This underscores the need for policy changes to address these disparities.

56. In a recent Datapoint Blog post,[24] The CFPB attempts to measure the recent changes in reporting low-balance medical collections and whether they had notable early impacts on consumer credit records and credit scores. Specifically, removing medical collections tradelines with initial balances of less than $500 has led to significant improvements in the credit scores of affected consumers. On average, consumers who had all their medical collections removed experienced a rise in credit scores by an average of 20 points. This improvement is unsurprising, given previous work. It would be odd if removing negative tradelines did not improve credit scores.

57. The other main result is that removing medical collections has not yet prompted consumers to seek more credit. While many consumers with medical collections made inquiries for new accounts between April 2023 and August 2023, there was no discernible difference in credit-seeking behavior between consumers whose medical collections were expected to be removed and those whose medical collections were expected to remain on their credit records. This is an early result and has not been vetted or reviewed.

58. To better understand the effects of the reporting changes, researchers focused on consumers whose largest medical collections tradeline in December 2022 was just under $500, leading to the expectation that all their medical collections tradelines would be removed. They compared them to consumers

[24] CFPB, *Early impacts of removing low-balance medical collections*, (May 16th, 2024, available at https://www.consumerfinance.gov/data-research/research-reports/data-spotlight-early-impacts-of-removing-low-balance-medical-collections/, last accessed on June 17th 2024).

whose largest medical collections tradeline was just above $500, indicating that some of their medical collections tradelines would likely remain on their credit records. This approach aimed to capture the differential impact of having all medical collections tradelines removed compared to having some or none removed, shedding light on the specific effects of the reporting changes on consumer credit outcomes. However, there is no control group, which makes any conclusions challenging to validate. Additionally, the benefits to a person having their negative tradelines removed are obvious. The cost will be higher delinquency rates as poor risks look better than they should. This will take time to manifest in large enough levels to be detectable in the data. The Bureau does not attempt to quantify or even acknowledge the economic costs that imprecise credit scores will create. They affect credit scores, so the damage to others is a real effect.[25]

Proposed Rule Technical Appendix Research Critique

59. In the proposed rule,[26] The CFPB includes a new analysis in a technical appendix at the end, frequently referencing it to justify their conclusion that removing medical debts from credit reports will not have negative consequences. This analysis is presented unusually, as it is not a report, blog post, or peer-reviewed study. The CFPB is presenting work that has not undergone a peer review process to verify its validity, nor have they allowed the industry to review the data or code used to generate the results. Consequently, there is no way to validate these

[25] If credit scores didn't change when negative information is removed, then there would be no mechanism for poor credit risks to misprice risk pools.

[26] 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)

results, which, as I will show, have serious methodological issues. Given the implications of this work, the CFPB should be more transparent in its research.

60. The CFPB analysis aims to demonstrate that removing medical debt tradeline information did not impact consumers' access to credit. They claim this conclusion implies no negative consequences from implementing the proposed rule. To support this, the analysis utilizes a 2017 change in consumer reporting practices that prevents medical collections less than 180 days past their date of first delinquency from appearing on consumer reports obtained from the nationwide consumer reporting agencies (NCRAs). The CFPB observes credit inquiries and whether a tradeline is opened, defining an inquiry as "successful" if it results in an open tradeline. However, this definition of "success" is problematic, as it does not necessarily indicate that the specific credit application generating the inquiry was approved. The CFPB cannot directly observe whether the specific credit application associated with an inquiry was approved. Hence, the CFPB's research does not have a clean standard for the analysis to report a successful outcome. Despite this methodological issue, the CFPB continues with the analysis.

61. The CFPB asserts that its analysis "can be interpreted as modeling credit decisions and outcomes from creditors' perspective, rather than modeling the decisions of consumers or debt collectors."[27] While the data is structured to reflect what a creditor would see, this analysis omits critical aspects of risk management that creditors must consider. From a simplified risk management perspective, creditors need to account for three core concepts: the probability of default (PD), exposure at default (EAD), and loss-given default (LGD).

[27] ibid

62. The CFPB's analysis attempts to proxy for PD by examining 30-, 60-, and 90-day delinquency rates within two years of credit origination. However, it neglects to consider EAD and LGD.

63. The EAD represents the total value a creditor is exposed to in the event of default, varying by loan type. EAD is typically the entire credit limit for credit cards, as defaulters can max out their limit before defaulting. It is usually the remaining balance for mortgage products, plus fees and interest charges. The LGD represents the loss a creditor incurs when a loan defaults, accounting for mitigating factors such as the recovery rate, collateral that can be seized, and the value of the debt when sold to a debt buyer. As noted before, recoverable debt values are expected to fall, reducing the value of outstanding debt. The expected loss is calculated as:

$$\text{Expected Loss} \quad PD \quad EAD \quad LGD$$

The CFPB's analysis, at most, demonstrates that PD remains unchanged under the proposed rule. However, any risk practitioner—and the CFPB itself—should recognize that the cost to the industry also includes EAD and LGD. The CFPB's research does not focus on the implications of the proposed rule on the other dimensions of credit risk. Nor does the CFPB look at how markets would respond by limiting credit limits or using more aggressive recovery methods such as litigation. Therefore, the CFPB's claims are based on a fundamentally incomplete market analysis from a creditor's perspective.

64. To study the problem, the CFPB created two datasets. The first dataset includes all inquiries made 180 days before and after each medical collection's addition to a consumer report. The second dataset tracks the two-year performance of all credit account tradelines, which can be traced back to an inquiry in the inquiry dataset. The analysis focuses on inquiries associated with medical collections first reported at least six months after the final implementation of the

NCAP in September 2017. This ensures that all medical collections are identifiable and that all consumers with reported medical collections had a past-due medical bill for at least 180 days before the medical collection appears on their consumer report. Additionally, each dataset includes a subsample of inquiries and tradelines associated with medical collections that had initial balances over $500 and were made when any other medical collections on the consumer report also had initial balances over $500. However, the CFPB acknowledges a limitation: “the CFPB cannot be certain that the observed inquiry is associated with a specific opened tradeline.”

65. The problem with the data is that it suffers from self-selection bias. Only consumers actively seeking credit are included in the dataset. Additionally, the behavior of consumers changes when they are in the market for credit. For example, before applying for a mortgage, a consumer might engage in positive behaviors such as reducing non-medical debt or making all payments on time. This self-selection leads to data anomalies that the CFPB acknowledges: "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 that most consumers in the sample have thin credit files 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."[28] These issues make the entire analysis questionable and further strengthen the argument for the CFPB to be open and transparent, lending legitimacy to their analytical work.

66. The CFPB used an inappropriate model in the technical appendix, resulting in biased outcomes. Their research relies on regression discontinuity (RD), which is based on a straightforward concept: a threshold variable determines on which

[28] ibid

side of the "quasi-experimental" treatment an observation falls. When applied correctly, this methodology enables causal analysis. For example, consider low birthweight babies: if they weigh less than 1,500 grams, they receive extra medical treatment; if they weigh more, they do not. The difference between a baby weighing 1,501 grams and one weighing 1,499 grams is negligible. Here, the threshold variable is birthweight, and the treatment is extra medical attention. An RD analysis would compare the survival rates of babies just below and just above the threshold, attributing differences in survival rates causally to the extra medical care. An estimate of the value of medical care is obtained. The CFPB applied 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. While similar to RD, RDiT analyzes effects over time. However, this application of RDiT by the CFPB is inappropriate, leading to biased results.

67. The CFPB acknowledges their work's limitations and potential biases, particularly with regression discontinuity in time (RDiT) designs when they state. Such designs can introduce bias if observations far from the threshold period are included for identification, possibly due to autoregressive properties or unobservable confounders. Moreover, academic literature highlights concern about bias when consumers improve their credit behavior during the threshold period, subsequently applying for credit and maintaining improved behavior. The severity of this bias cannot be accurately assessed because the CFPB has not released the data and code to independent researchers for scrutiny and verification.

68. The CFPB's research spans from 2017 to 2022 in the inquiry or performance dataset. Due to the focus on two-year performance, credit account tradelines opened after January 2022 are excluded from the analysis because the CFPB cannot observe a full two years after origination. However, the CFPB states, "The

key assumption of a regression discontinuity analysis is that nothing is changing discontinuously across the threshold besides the treatment."[29] Surprisingly, the CFPB would utilize a methodology requiring stability. The period from 2017 to 2022 was marked by *significant instability* in the medical debt collection environment, including the COVID-19 crisis, student loan debt moratoriums, government cash payments, and the implementation of Regulation F at the federal level, alongside numerous state-level changes. Adding to this, the regression employed in their analysis lacks statistical controls. Despite substantial state-level variations during this period, the CFPB's model does not incorporate state-level controls. This suggests that according to their model, there is no differentiation between a creditor operating in Alabama versus California.

69. Given the issues identified, the CFPB's findings that medical debt significantly influences credit origination decisions are unsurprising. However, the core of the CFPB's argument—that medical debt has no effect on the likelihood of 90-day delinquency over the two-year performance dataset—raises skepticism. Accepting this conclusion at face value suggests that medical debt may prevent credit origination unnecessarily. Based on the critiques of sample size and model validity mentioned earlier, I am skeptical of these results. Moreover, the analysis presents evident anomalies. For instance, the point estimates indicate that not having non-medical debt (such as student loans, car loans, etc.) makes a consumer more likely to be delinquent than one who carries consumer debt like credit cards. This should be reversed, as having non-medical debt should make delinquency more likely. The lack of effect on mortgages over two years is expected, as consumers typically adjust their behavior to meet rigorous underwriting standards before applying for mortgages. However, some results, such as the near-significant

[29] ibid

impact of non-medical debt on delinquency, appear unusual given the stringent nature of mortgage underwriting. These anomalies in the data suggest fundamental issues with either the data itself or the analysis methodology, which cannot be clarified due to the lack of transparency from the CFPB. These critical questions should undergo rigorous scrutiny in a peer review process, promoting accountability and ensuring the validity of their findings.

70. The CFPB's findings reinforce industry concerns. To reiterate, expected losses are calculated as:

$$\text{Expected Loss} = PD \times EAD \times LGD$$

Using this framework, the CFPB observes that for credit cards, the average credit limit is $247.49 lower, amounting to 18.9% less on an average of $1,312.25 due to the presence of medical debt. The CFPB asserts that the probability of default (PD) remains unchanged. However, their results are incomplete. I replicate Table 17, Panel A below, to demonstrate that an initial estimate of the loss given default (LGD) is substantial and noteworthy. For credit cards in the sample where medical debt exceeds $500, the LGD is -$215.20, representing a 30.2% increase on an average value of $713.72. For the entire sample, the loss amounts to $62.83 on a base of $643.68, equating to a 9.8% increase. The CFPB set out to show that medical debt was irrelevant for credit originations as delinquency is not more likely. Instead, if you take their work at face value, they show that consumers with medical debt have higher expected losses. In a competitive market for credit card debt, consumers with medical debt will have to pay more for credit or have their credit reduced. This research shows that medical debt is predictive of expected losses in lending and that the industry has been managing this risk by managing credit lines. Additionally, though not shown in this work, this risk could be managed with the terms of lending.

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

71. The actual Loss Given Default (LGD) is complex and goes beyond the scope of this report. However, the CFPB's research indicates significant losses to the industry resulting from removing medical debt reporting. A more comprehensive LGD estimate would factor in the reduced recovery rates typically associated with medical debt collections. Additionally, I present survey results from ACA International members below, demonstrating an anticipated 8% decrease in expected liquidation rates of debts referred to collectors.[30] Combined with the primary losses highlighted by the CFPB, these findings suggest substantial, higher-than-estimated overall losses to the industry. This situation clarifies why credit limits are reduced even when credit decisions remain unchanged. The CFPB has effectively illustrated that medical debt strongly predicts expected losses for

[30] I am using industry nomenclature. To decrease by 10% means the value of accounts collectors are collecting, "liquidating", has fallen by 10%. I.e., Collectors receive less from accounts referred to them.

creditors. If this predictive factor is disregarded, losses may need to be mitigated by restricting credit access for all consumers or increasing the cost of credit.

The effect of this rule on other industries

72. The CFPB needs to study the effect a degradation in the quality of credit reports would have on the consumer finance lending industry. Currently, analysis has yet to be done on the end users of the credit reports and the potential consequences of removing the predictive information in the medical debt tradelines. Below are two case studies based on academic work.

Case Study: Medical Bankruptcy

73. A large part of the justification for eliminating medical tradelines is due to the work on medical bankruptcies by Elizabeth Warren and her co-authors.[31] The study by Himmelstein et al. (2009) examines the prevalence and characteristics of medical bankruptcies in the United States in 2007, building on a previous study from 2001. The researchers surveyed 2,314 bankruptcy filers and interviewed 1,032 of these people, identifying "medical bankruptcies" based on the filers' stated reasons, income loss due to illness, and the magnitude of their medical debts. They found that 62.1% of bankruptcies in 2007 were due to medical reasons, a significant increase from the 46.2% reported in 2001. Notably, 92% of these medical debtors had medical debts exceeding $5,000 or 10% of their pretax family income. Additionally, some debtors had mortgaged their homes or lost significant income due to illness, qualifying them as medical bankruptcies. Less than a quarter

[31] Himmelstein, D. U., Thorne, D., Warren, E., Woolhandler, S. (2009). Medical bankruptcy in the United States, 2007: results of a national study. *The American journal of medicine*, 122(8), 741-746.

of all debtors were uninsured when filing, but medical debtors more frequently experienced coverage lapses in the two years before filing.

74. Hospital bills were the largest single out-of-pocket expense for nearly half of the patients, with prescription drugs and doctors' bills contributing significantly. The period between the 2001 and 2007 surveys saw the enactment of the Bankruptcy Abuse Prevention and Consumer Protection Act (BAPCPA), which introduced more stringent requirements and procedural barriers for filing bankruptcy. The study found that BAPCPA's effects were nonselective, impacting both medical and nonmedical bankruptcies equally. The increase in medical bankruptcies was attributed not to BAPCPA but to the rising financial burden of illness, as evidenced by the growing number of underinsured Americans, which rose from 15.6 million in 2003 to 25.2 million in 2007. Overall, this study had an outsized impact on the policy community. Senator Elizabeth Warren is one of the authors.

75. However, Dobkin et al.'s (2018) critique of the widely held belief in "medical bankruptcies" challenges the existing evidence, primarily based on studies claiming that around 60% of U.S. bankruptcies were due to medical events. These studies relied on self-reported data from people who had declared bankruptcy, asking if they had experienced health-related financial stress. The critique argues that this method is flawed as it assumes a causal relationship between medical expenses and bankruptcy without considering the broader population who incur substantial medical debts but do not file for bankruptcy. The fundamental flaw in the logic can be illustrated by considering the example given by Dobson. Many tech billionaires are not college graduates, but it would be absurd to conclude that dropping out of college contributes to success in the tech industry. This analogy highlights the selection and causation problems in the previous literature on medical bankruptcies. Just as one cannot infer a causal

relationship between dropping out of college and becoming a billionaire based on a limited subsample of successful college dropouts, it is problematic to conclude that medical expenses cause most bankruptcies simply because a significant proportion of bankruptcy filers report having substantial medical debts.

76. Previous studies assumed a direct causal link between medical expenses and bankruptcy without considering the broader context. They focused only on those who went bankrupt and had medical expenses, ignoring the many people with significant medical debts who did not file for bankruptcy. This selection bias leads to overestimating medical expenses' role in causing bankruptcies. A more accurate approach would involve examining a representative sample of the population, including those with substantial medical expenses who did not go bankrupt, to truly understand the impact of medical costs on financial distress. A 2014 CFPB report noted that while about 20% of Americans have significant medical debt, less than 1% file for bankruptcy annually, suggesting the previous assumption is problematic.

77. To provide a more accurate estimate, they conducted a study using data from people hospitalized in California, tracking their credit reports and bankruptcy filings. The results showed an apparent but much smaller effect of hospital admission on bankruptcy. Hospitalizations were found to cause only 4% of bankruptcies among nonelderly U.S. adults, significantly lower than the previously reported 60% (Figure below shows the relationship). Even among the uninsured, hospitalizations accounted for only 6% of bankruptcies. This study excluded hospitalizations for children and the elderly and focused on non-childbirth-related conditions. It concluded that while hospitalization leads to some bankruptcies, the overall impact is much smaller than previously claimed, and overemphasizing medical bankruptcies could distract from understanding broader economic hardships.

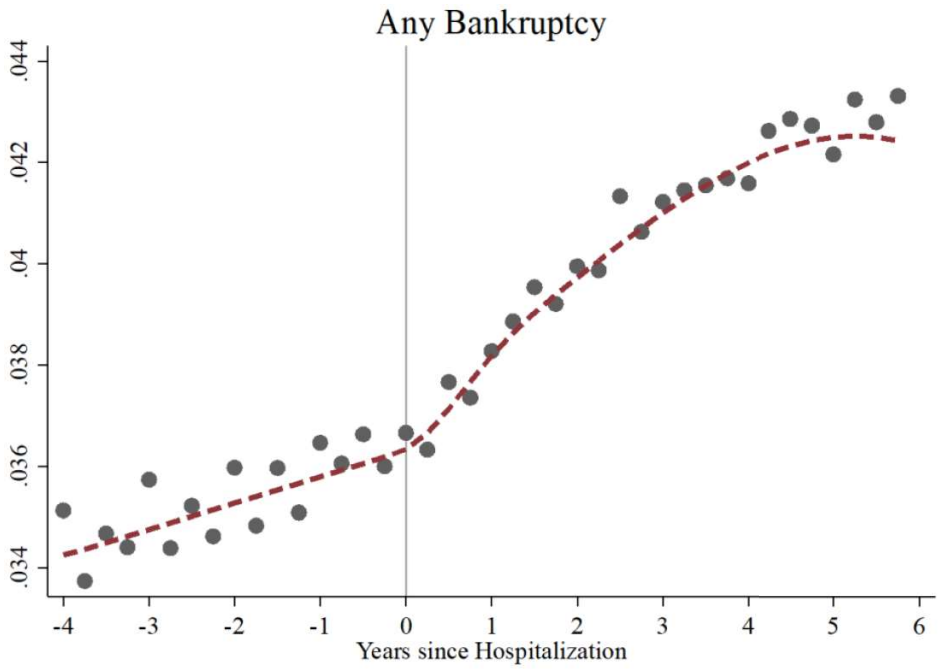


Figure 1. The Effect of Hospitalization on the Likelihood of Filing for Bankruptcy
The x axis shows time relative to the index hospital admission. Each data point represents the proportion of people who filed for personal bankruptcy between the year before the start of our credit-report data and the indicated date, after adjustment for any patterns in bankruptcy rates by calendar year. The dotted line shows the estimates from fitting a flexible, nonlinear function quantifying the relationship between the timing of hospital admission and the bankruptcy rate, again controlling for calendar-year trends. (More detail on the sample and estimators can be found in Dobkin et al. (2018)[4])

78. Contrasting with the 2009 study by Himmelstein et al., which asserted that 62.1% of bankruptcies were medically related, the new critique highlights methodological flaws in the earlier approach. Himmelstein's study surveyed bankruptcy filers and identified medical bankruptcies based on self-reported reasons, substantial medical bills, or income loss due to illness. They found that medical debtors often had lower incomes and experienced coverage lapses, with significant out-of-pocket expenses contributing to their financial distress. This study linked the increase in medical bankruptcies to rising healthcare costs and the growing number of underinsured Americans. In contrast, the newer analysis used hospital admission data to track the direct impact on bankruptcy filings, providing a more precise measurement of the causal relationship. This approach revealed a much lower percentage of bankruptcies caused by medical issues, suggesting that

while medical expenses contribute to financial distress, they are not as predominant a cause of bankruptcy as previously thought. Further, the current law has changed since the studies were conducted. However, a key implication is that the insurance and charity care system drive medical debt – not debt collection.

Case Study: Improved Credit Assessment

79. Few studies document how improving credit scoring affected lenders and lending. The Bureau is proposing to reduce the information value of credit reports, i.e., degrading, by removing predictive information about risks faced by potential consumers when lending to consumers. Einev et al. (2013)[32] studied the effects on a car dealership with a few locations that provided auto financing in a low-income, high-risk market.[33] This firm operates in a high default population where profitability depends on identifying consumer risk quality. Furthermore, the firm matches cars (high or low value) to consumers and offers customized lending terms. It is important to remember that computational, data-intensive, and readily available credit scores are a relatively modern phenomenon. Credit reports are ubiquitous today, but even 30 years ago, they were not commonly used. Credit reports' benefits to the financial markets are often taken for granted.

80. This firm went from a low to a higher information environment. The lender adopted credit scoring by the end of June 2001. Before this, employees made judgments on credit based on information they elicited out of the sales process. This firm began using credit reports and inputting the information into its

[32] Einav, Liran, Mark Jenkins, and Jonathan Levin. "The impact of credit scoring on consumer lending." *The RAND Journal of Economics* 44.2 (2013): 249-274.

[33] The author has an extra reason to like the study as one author shared a desk with me, the other two were professors of mine at Stanford. Professor Einev taught me Industrial Organization and Professor Levin taught me Advanced Game Theory. Afterwards Professor Levin became the Dean of The Graduate School of Business at Stanford and now he is the President of the entire University.

proprietary algorithms to assess risk. This is a case study of using data to make more informed decisions.

81. The effects of improved risk assessment are apparent. The firm was able to identify better risks and extend more credit to them to increase profitability. This was achieved by more accurately identifying customers as low or high risks. The company closed deals with less than half the high-risk customers than before. However, the default rate fell as the firm was better at avoiding bad risks. Additionally, as higher risks, they were required to put higher down payments for purchases. Credit became tighter for this population. The applicants identified as low-risk were able to take out bigger loans.

82. The Bureau's proposed rule is to take this process of improving lending through predictive credit information backward. The proposed rule changes would result in credit reports being less accurate, and consequently, lenders in consumer finance will be less able to assess default risks. The low-risk borrowers will be less able to signal their lower risk level and have access to credit constrained. Lenders will see a fall in profitability as they unwittingly take on risky borrowers. This will result in more credit for the risky borrowers. But more defaults.

Case Study: Data Privacy

83. There are few studies about how the restriction in the flow of data through privacy laws affects consumer financial markets. Kim and Wagman (2015) studied the effect of privacy on consumer finance at theoretical and empirical levels. They show that a firm's ability to sell consumer information can lead to lower prices, higher screening intensities, and increased social welfare. Empirically, they show their model is consistent with the fall in denial rates in home loans and refinancing in counties that adopted more stringent privacy regulations. Subsequently, these counties had higher foreclosure rates in the 2007-2008 financial crises. This issue

of unstable mortgage origination and high foreclosure during this exact crisis was the raison d'etre for establishing the CFPB itself.

84. The motivation for this academic work was the 1999 enactment of the Gramm-Leach-Bliley Act (GLBA), allowing a variety of financial institutions to sell, trade, share, or give out nonpublic personal information about their customers. In their model, financial institutions use data to reduce customer service costs. Market competition results in cost savings passed to consumers via price cuts or better financing terms. For this to be profitable, firms use the newly available information more heavily to screen applicants, and as a result, potentially high-risk borrowers are denied credit. Thus, the industry and borrowers accept applicants who would not have defaulted[34], benefit as consumer information increases.

85. The test for this theory was when three out of five counties in the San Francisco-Oakland-Fremont Metropolitan Statistical Area (MSA) adopted a privacy ordinance on January 1, 2003, requiring consumers to opt-in to releasing information under GLBA. Given most people's status quo bias, this effectively reduced the amount of private personal information lenders could access. By studying loan data of conventional home purchases at the census tract levels in these counties from 2001 to 2006, the study authors established market behavior before and after the enactment of the privacy ordinance.

86. The theoretical results are consistent with their empirical findings. The theory predicts that these stronger privacy laws that reduced access to borrower payment behavior information would result in less screening of mortgage applicants. This would result in a fall in loan denial rates because less information means less reason to deny a loan. The theory finally posits that as loan approvals

[34] Rejected applicants who would have defaulted would have benefited if the costs of default, e.g., foreclosure, is high.

rise based on incomplete information, foreclosure rates eventually also rise as less qualified borrowers are more likely to default.

87. Indeed, reality comports with the theory. When looking at the data, the census tracts with higher shares of 2003-04 originated loans in the counties that enacted the privacy opt-in had a higher foreclosure rate. As the authors put it:

> "The results in this paper give rise to the conjecture that privacy acts may have played some role in the subprime mortgage crisis by weakening lenders' incentives to screen loan applications."[35]

88. The Bureau's rule is essentially a privacy rule against medical debt tradelines. The Bureau has presented no evidence that suppression of medical tradelines would be any different from the suppression of data in the California counties discussed above. Like those California counties, the result of the proposed rule is a move to a lower information environment. Only if consumers voluntarily disclose their medical collections history will lenders have a complete picture. This will result in more credit being available to unqualified borrowers. Like the 2008-09 financial crisis, increases in improvident lending hurt not only lenders but society as a whole.

The impact of this rule on debt collection

89. To quantify the impact of these proposed changes on debt collectors, I have utilized a dataset provided by collection agency members of ACA International (ACA) in two waves. The first wave was conducted from November to December 2023, and the second wave was conducted in May 2024.

90. The first wave of data contains 1,615 client accounts (not consumers, but 1,615 creditor organizations) from 19 self-reported debt collection agencies. The

[35] Kim, Jin-Hyuk, and Liad Wagman. "Screening incentives and privacy protection in financial markets: A theoretical and empirical analysis." *The RAND Journal of Economics* 46.1 (2015): Pg. 7

second wave also has 19 self-reported debt collection agencies but with 935 client accounts. These data include the number of referrals, collections, and the estimated impact of the rule change on liquidation rates of referred debts to collectors (or writing off debt) due to the changes. This data reflected the restrictions on reporting medical debts under $500.[36] The Bureau proposes to restrict the consideration of all medical debt balances, which is a more drastic rule with more drastic consequences. This preliminary analysis focuses on one key market component—the debt collection process. However, this is more evidence of the proposed rule change's effects on the industry than the Bureau has conducted.

91. The data is disproportionately weighted toward California. California makes up 60.3% of the first wave sample. The second wave has 24.3% of the data being from California. Overall, California is 46.7% of the data, which is still over-weighted to California, but the second wave is more balanced. This is not a representative sample of the U.S. However, I split the data into the four regions defined by the Census Bureau: North-East, Mid-West, South, and West. Despite this aggregation, the general results will reflect the West and California.

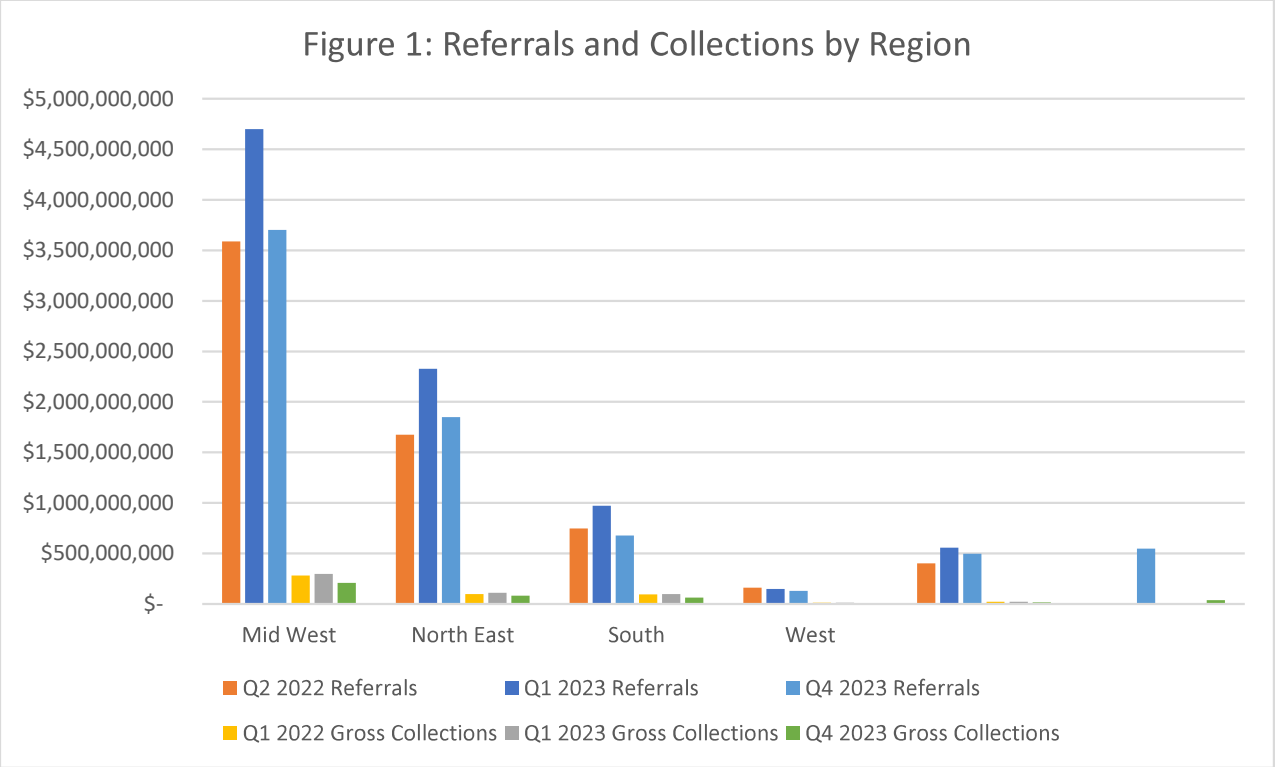
Table 1: Data by Region

region	Wave 1		Wave 2		Total	
	Freq.	Percent	Freq.	Percent	Freq.	Percent
Mid-West	193	14.89	363	46.42	556	26.76
North-East	30	2.31	41	5.24	71	3.42
South	113	8.72	136	17.39	249	11.98
West	960	74.07	242	30.95	1202	57.84
Total	1,296	100	782	100	2078	100.00

The remaining observations did not have an identified State and, thus, region.

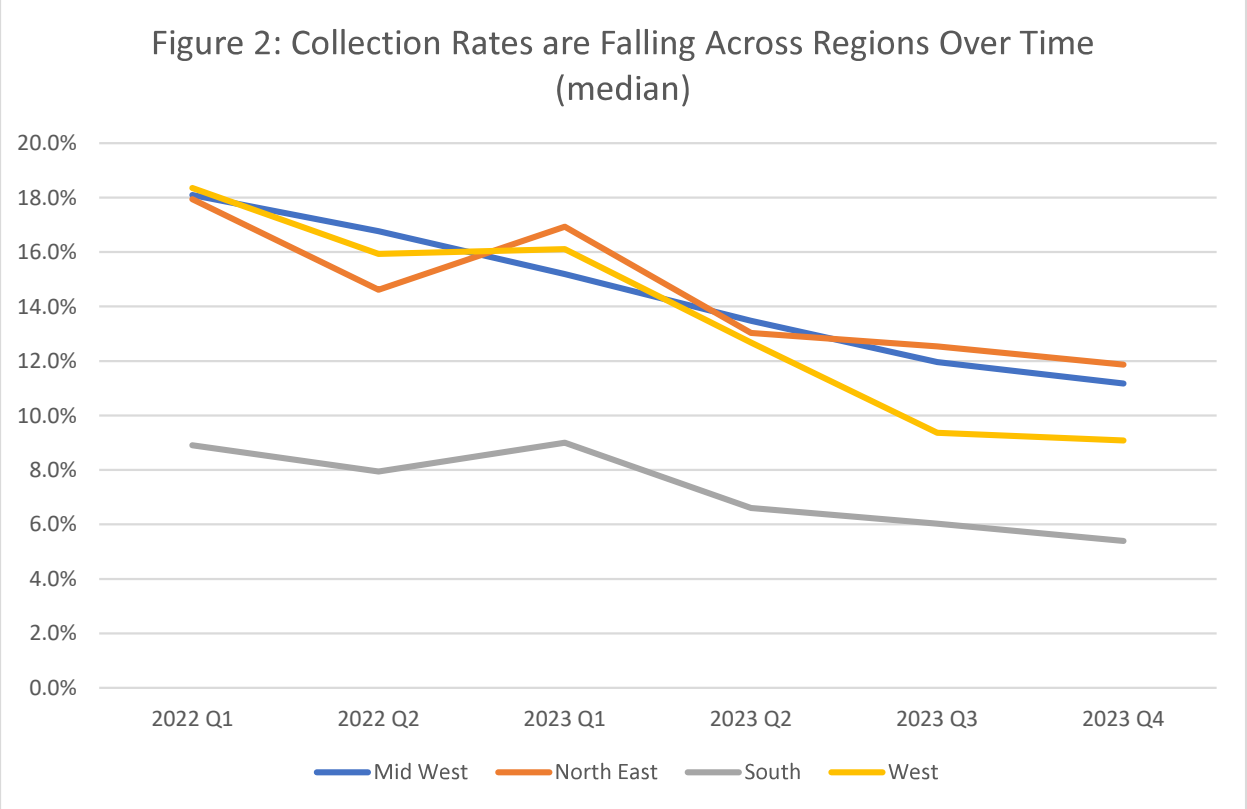
[36] This change went into effect April 1, 2023. The credit reporting agencies also took two other actions prior to that (removing paid medical debt, and delaying credit reporting for a year), none of which has been empirically studied for potential degradation of the lending environment.

92. The data includes referrals (amounts to be collected) and gross collections. I used the 2nd Quarter of waves 1 and 2 data for 2022 and 2023 and added the fourth quarter of 2023 data. Debts might not be collected in the quarter they are referred so this approach is an approximation. Figure 1 shows the referrals and collections for Q2 2022 and 2023 for the data collected by ACA. This data will be skewed by who submitted the data. Referrals to collect in the U.S. increased in 2023 compared with 2022. The cause of the increase in these referrals is unknown. However, this could result from providers receiving fewer payments for their medical services and consequently making more debt collection referrals. Gross collections remained stable from 2022 to 2023.



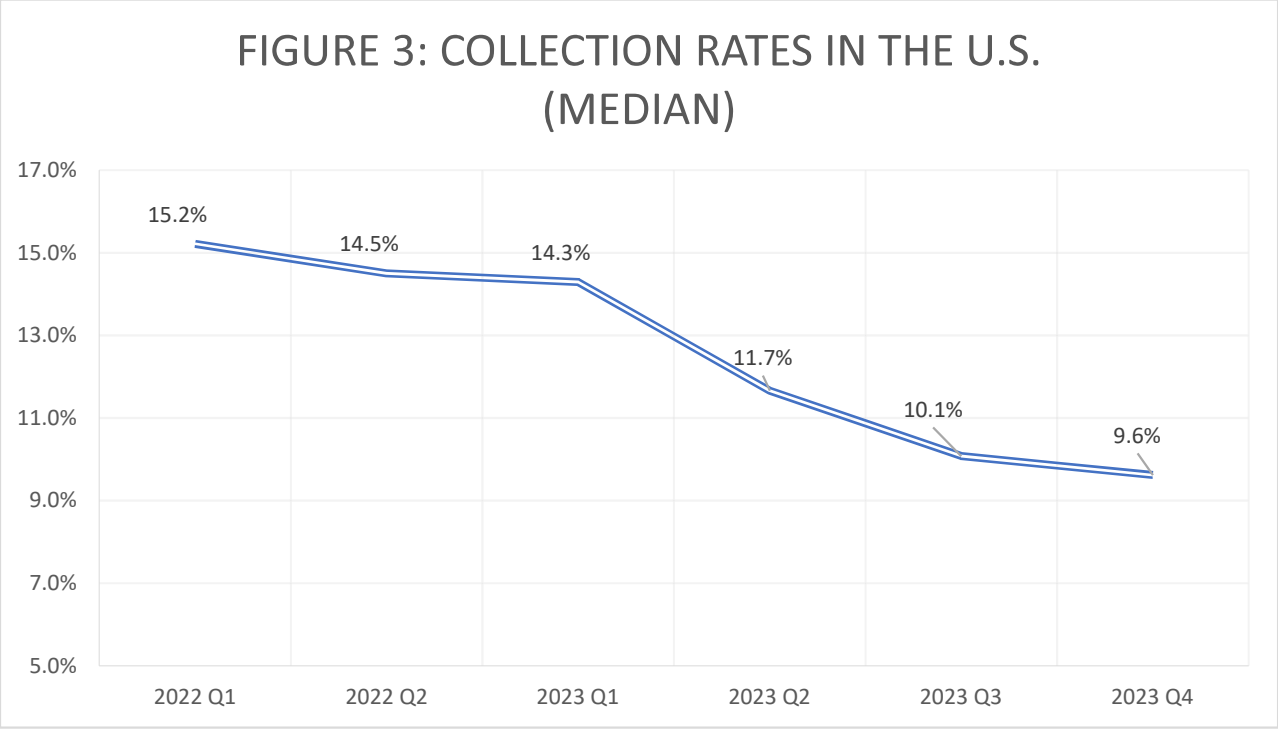
93. The geographic distribution of the data does not reflect the data overall. The West constitutes about 59% of the data, but most collections originate in the Mid-West.

94. The number of collections determines the size of the market, but the collection rate indicates whether payments are occurring. I find the collection rates by dividing gross collections by referrals for 2022 and 2023. The results by region are in Figure 2. Collection rates are between 18% and 5%, with the Mid-West in 2022 as a high outlier and the South as a low outlier. Due to outliers skewing the results, I use the median value. It is clear that across the U.S., collection rates are falling.



95. The data was collected after new rules limiting the ability to report medical debts came into effect. Thus, the fall in collection rates in Figure 2 may already reflect the reduction in creditors' rights these last few years and the evolving decrease of creditor's rights. The change in the collection rates by region suggests that the message behind the message is that medical debts do not need to be paid.

96. For the U.S., in Figure 3, the collection rate fell by 5.6%. However, this obscures meaningful differences within the U.S. In the regions where obstructions to the reporting of medical debt have spread, the North-East and West (mainly California), we see a slight increase in collections or no change in Q1 2023, and then it starts to fall again. However, overall, the trend is clear: there have been large reductions in the collections of medical debts. This could be an anticipatory effect of the belief that debts would not have to be paid. These amounts are large and could be a harbinger of future reduced collections for medical service providers created by the proposed rule change. A good metric would be to see the decrease in expected liquidation rates of referred debts to collectors that could be attributed to limits to credit reporting.



97. Other relevant data are estimates from industry professionals concerning the impact on liquidation rates from ceased, unreported, or non-consequential credit reporting. The ACA, therefore, has provided data that estimates if the rate of

liquidation of referred debts to collectors is caused by ceasing credit reporting. The data indicates that it will decrease.[37] The data submitted by the ACA members show the expectations of a decrease in liquidation of referred debts due to the proposed rule, see Table 2.

Table 2: Estimate of Change in Liquidation Percentage due to not Credit Reporting

	Wave 1		Wave 2		Total	
	Mean	Median	Mean	Median	Mean	Median
U.S.	-9.6%	-3.9%	-6.3%	-2.0%	-8.0%	-3.0%
U.S. less California	-10.8%	-4.0%	-5.5%	-2.0%	-7.6%	-2.5%
Mid-West	-12.6%	-7.5%	-4.8%	-2.0%	-6.1%	-3.0%
North-East	-7.3%	-3.5%	-5.7%	-2.0%	-5.9%	-2.0%
South	-9.6%	-3.5%	-5.1%	-1.0%	-6.8%	-2.0%
West	-8.9%	-3.0%	-8.5%	-5.0%	-8.7%	-4.0%

I present two sets of numbers, the mean and median response for each wave, and combine them. The mean/average is the best estimate for the actual value, but extreme values may skew it. The median is a more conservative number.

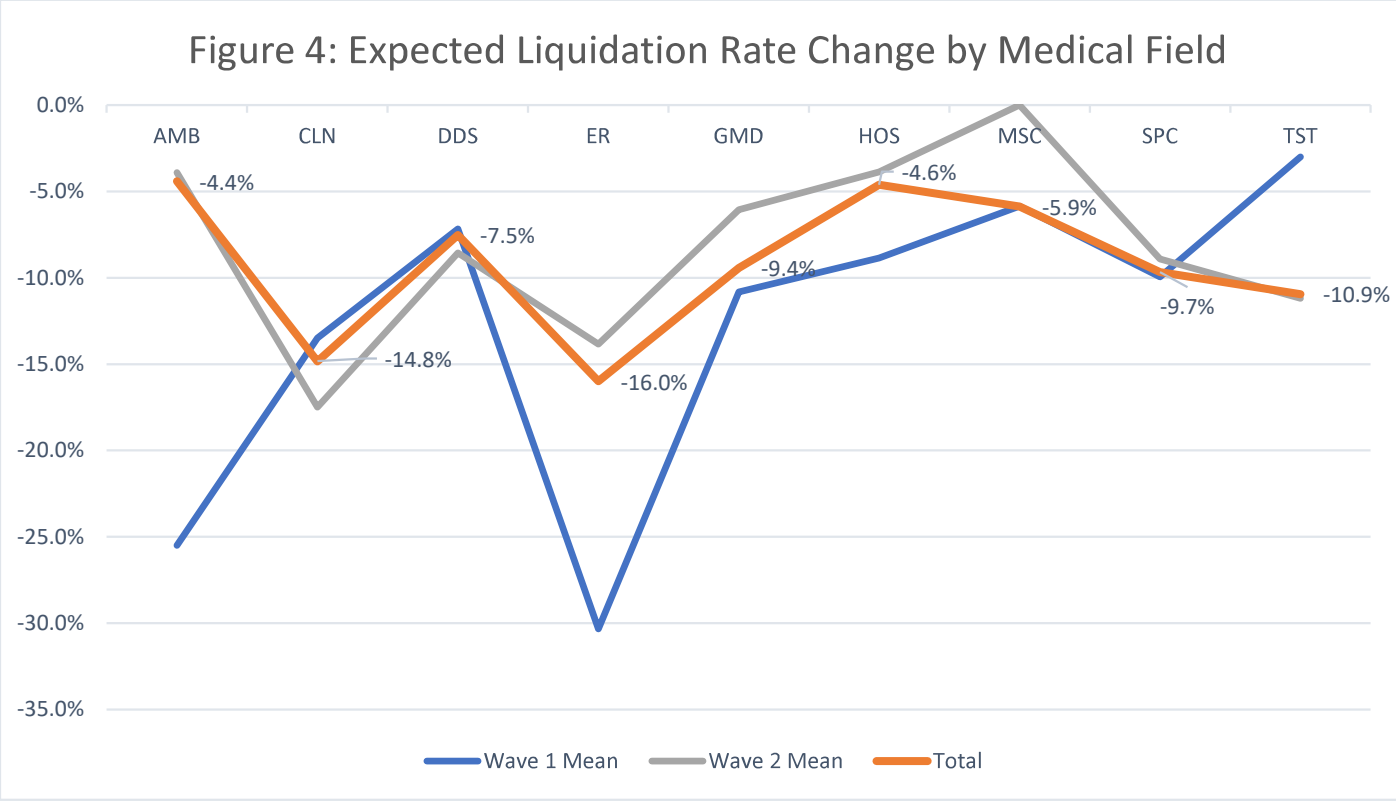
98. The effect of ending credit reporting on liquidation rates of referred debts to collectors varies by region. The overall amount decreases by 9.6% on average or a median of -3.9% in wave 1,- 6.3% mean, and -2.0% median for wave 2. Because the data is so heavily California-centric, I calculated the difference for the rest of the U.S. I get a rise in the average, the same median for wave 1, and a drop in the mean for wave 2. Wave 2 was surveyed in May 2024, when many of the changes were brought in by the consent of the credit scoring agencies. The lower response could result from changes already assumed by respondents. By region, the West will be most affected by the proposed rule changes—a shockingly high average

[37] I am using industry nomenclature. To decrease by 10% means the value of accounts collectors are collecting, "liquidating", has fallen by 10%. I.e., Collectors receive less from accounts referred to them.

decrease of 8.9% on average in wave 1 with a drop of 8.7% in wave 2. Even the more conservative median value is a 4% decrease.

99. **T**he median values align with what has been seen elsewhere. In an amicus brief filed by the Nevada Hospital Association (NHA), the NHA estimated that an increase of a "cooling off" period on reporting medical debts to 60 days would result in an expected loss of 1.5% to 5% for 2022[38]. This proposed rule differs because the "cooling off" period is permanent. Thus, the losses should be higher and align with the mean values reported in Table 2 (-8.7% in Western States). This is not proof but evidence that my estimates are reasonable.

100. I repeat the exercise of observing the estimated liquidation rates of referred debts to collectors by medical specialty in Figure 4. I graph the mean of the estimated rate over waves 1 and 2 and the total combined.



[38] Brief for the Nevada Hospital Association as Amicus Curiae, *Aargon Agency, Inc. v. O'Laughlin*, 70 F.4th 1224 (9th Cir. 2023).

The biggest change is in the ER – Emergency Room. These are primarily family physicians and general practitioners. The fall in expected liquidations of referred debts is 16.0%. The largest category in terms of volume is GMD – General Medicine, which has a decline over the whole data of 9.4%. Thus, industry is expecting a large decline in the local physicians' ability to collect revenue. Additionally, we see a considerable reduction in CLN, clinical services, TST, testing and diagnostic services, HOS, hospital services, DDS, dental services, SPC, specialty medicine, and MSC, miscellaneous (for difficult-to-categorize services). The Bureau has not considered how the impact will vary by medical practice. However, few businesses operating under market principles can sustain such sudden drops in revenue by collectors that will pass them on to medical practices.

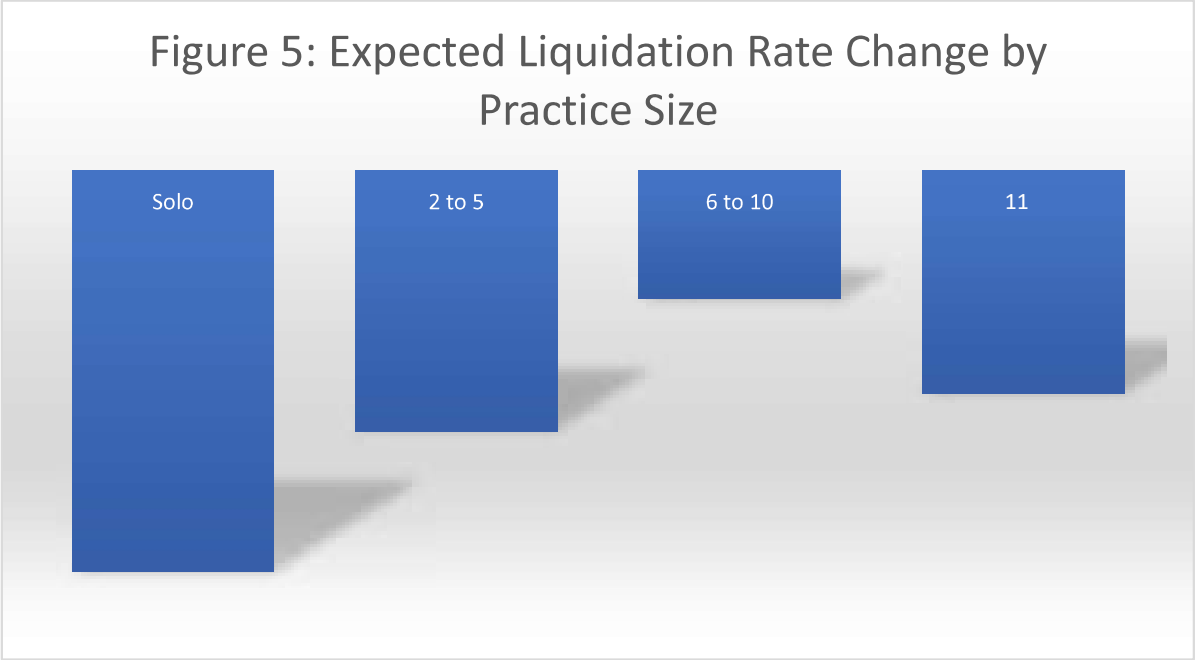
101. The impact on small businesses is substantial. Table 3 shows the data's decrease in expected liquidations of referred debts from small business clients[39]. The small business rate is slightly higher than the average for the U.S. The key takeaway is that this proposed rule change will drastically affect the ability of small business physician practices to collect revenue via collections.

Table 3: Small Businesses and Metro Area
Estimate of Change in Liquidation of
Referred Debts Percentage

	Mean
Small Business	-8.92%
Non-Metro	-8.16%
Metro	-7.98%

[39] I am using industry nomenclature. To decrease by 10% means the value of accounts collectors are collecting, "liquidating", has fallen by 10%. I.e., Collectors receive less from accounts referred to them.

102. The proposed rule will have a disproportionate impact on smaller practices. As can be seen in Figure 5, the largest fall in the estimated liquidation rates is with solo practitioners at 10.5%. The next largest fall is for practices with 2 to 5 doctors or dentists. Even large practices with over 11 medical practitioners face a drop in the estimated liquidation rates of 5.8%. Combined with Table 3, it is clear that the data shows the impact of this rule will fall heaviest on small businesses with small practices. This is potentially a bigger issue in rural areas, which rely more heavily on the small practice of a family doctor.



103. The impact disproportionately hurts rural physicians. The data was matched via zip codes to the Rural-Urban Commuting Area (RUCA) defined by the U.S. Census Bureau. These codes measure census tracts and zip codes and the flow of people living in that area into a primary metropolitan area. For example, Hoboken, N.J., is part of New York City. The code I used for a business to be included in a metro is 10% commuting or higher. This captures most suburban communities that use a metro area's medical facilities. Thus, my definition of non-metro is towns

sufficiently far away from metro areas, so commuting is uncommon. Physicians in non-metro zip codes have a more considerable decrease in expected liquidations of referred debts. 8.2% of these accounts represent a substantial loss of revenue to collections on behalf of rural physicians.

104. The impact on expected liquidation of referred debts in the data depends on whether a firm was already credit reporting delinquent accounts. Table 4 shows the fall in the expected liquidations of referred debts for non-credit reporting collection agencies, which is 3.3%, and 9.3% for credit reporters. This could be due to credit reporters being in States that severely limit their ability to report or collect debts, or it could be due to the type of medical debt collected. In the data, 75.2% of accounts are credit reporters; thus, the impact will be substantial if the proposed rule changes are implemented. This is consistent with the deterrent effect of credit reports. The removal of credit reporting causes a large decrease in liquidations. Firms that don't report to credit reporting agencies have already adjusted to this policy. However, non-credit reporters expect a fall of almost 3.3% since the message that medical debts need not be paid will be clear and well-known amongst borrowers.

Table 4: Credit Reporting and Usage of Legal System Estimate of Change of Liquidation of Referred Debts Percentage

	Mean
No Credit Reporting	-3.30%
Credit Reporting	-9.28%
Does not use legal collections	-8.48%
Uses legal collections	-5.88%

105. Using the legal system to enforce collections is an essential differentiator amongst collection firms, and consequently, the expected liquidation rate of

referred debts decreases due to non-credit reporting. In the deterrence section, I emphasized there were three levels of consequences for non-payment of debt. The first was not to have the debt reported or no consequence. The second was to report delinquency to the credit bureaus – the medium step. The third was to use legal collections. The data shows that 75.2% are credit reporters, but only 17.5% use legal collections.[40] Table 4 shows that collectors who do not use legal collections expect a fall of 8.5%, but firms that use legal collections expect only a 5.9% decrease. This difference cannot be known from this data, but presumably, this may be due to legal collectors planning to use the legal system to enforce their rights to receive payment. If some debts could be collected via credit reporting but now require legal action, this would entail a net social loss due to the costs of the legal system.

The impact of this rule on debt collectors

106. The implications of this rule on the debt collection industry are significant. Debt collection plays a vital role in financial markets, as it enforces the payment of contracts. This service, however, comes at a cost. The industry operates in a competitive environment, with fees aligning with costs. Therefore, any reduction in the effectiveness of collectors, as proposed in the regulation, will likely lead to an increase in collection costs or a decrease in collectible amounts. These changes will ultimately be passed on to the consumers of these services – the companies providing financing.

107. To provide a rough estimate of the potential impact of the proposed regulation on the Provider community, I have employed a specific calculation method. While this approach may not be precise, it should still offer an

[40] There is no limit to using credit reporting and legal collections. Given legal collections are more costly to initiate than a credit report, I assume legal collectors are credit reporters and that legal collections are an escalation in the collections process.

approximate estimate. I have taken a conservative stance to establish a lower bound for the proposed rule's cost, as detailed in Table 5 below. The health spending industry is valued at $4.4 trillion, with out-of-pocket spending accounting for 12.7% or $588.8 billion annually. The analysis considers two primary factors: the existing inventory of debt and the new debt entering collections each year. Given the rule's lack of a sunset clause or expiration date, it is assumed to continue indefinitely.

108. The Kaiser Family Foundation (KFF) estimated the inventory of medical debt to be $220 billion in 2021.[41] In contrast, the Consumer Financial Protection Bureau (CFPB) estimated the inventory of debt on credit reports to be $88 billion[42] in 2022. However, the CFPB's measurement only accounts for debt reported on credit reports.[43] According to the ACA survey, 75.22% of agencies report to credit bureaus. By adjusting the CFPB's number upward to account for this, we get $116.99 billion from the original $88 billion. The CFPB estimate thus represents only 53% of the KFF's estimate. Given that the KFF specializes in health economics research, I will use their estimate for a more accurate analysis.

109. Estimating the flow of debt is more challenging. Drawing from the results of Kluender et al. (2021),[44] which are based on survey data from 2020, 13% of the adult population incurs debt entering collections each year, with a mean value of $2,396. With 258.3 million adults in the U.S., new medical debt accrues at a rate of $80.46 billion per year. While this figure might seem surprisingly high, it is

[41] United States Census Bureau, U.S. Adult Population Grew Faster Than Nation's Total Population From 2010 to 2020, (August 12, 2021, available at https://www.census.gov/library/stories/2021/08/united-states-adult-population-grew-faster-than-nations-total-population-from-2010-to-2020.html/ , last accessed on June 17th 2024).

[42] I am not adjusting for the 2 years since these numbers are back of the envelope calculations.

[43] The CFPB only records the data from one credit reporting agency.

[44] Kluender, R., Mahoney, N., Wong, F., Yin, W. (2021). Medical debt in the US, 2009-2020. *Jama*, 326(3), 250-256.

reasonable. First, new debt accounts for 36.6% of the inventory of debt, which aligns with the continuous cycle of debt creation and retirement (through payment or write-off). Additionally, new medical debt represents 14.4% of total out-of-pocket expenditures.

110. To get the direct cost of this rule, I apply the decrease in the expected liquidation rates of 8% to the inventory and flow of medical debts. The proposed rule's cost due to the inventory of medical debt lost is expected to be $17.6 billion. The loss will be $6.44 billion when the rule comes into force. However, the annual loss will continue indefinitely. The actual loss to the industry will be the discounted sum of losses over time. I apply a standard discounting formula to the data. First, I choose a discount rate of the 1-year US treasury rate of 5.11%[45]. I also assume that medical debts grow with the growth of the healthcare industry at 4.1%.[46] This results in a total loss to the industry of **$637.27 billion plus** the loss of the sock of debt of **$17.6 billion** for a total cost of **$654.87 billion**. Second, I recalculate the values under the assumption that medical debts do not grow at all -- but stay constant at $6.44 billion per year. This assumption implicitly assumes a world where policy intervention, charity care, etc., allow health care to grow without the growth of medical debts by consumers. This produces a flow of losses of **$125.96 billion** and a total cost of **$143.56 billion**.

111. One might argue that using the 1-year US Treasury yield as a discount rate is inappropriate. To address this concern, I have recalculated using a discount rate of 10%, which is a reasonable approximation of the weighted average cost of capital (WACC). The WACC represents the average rate a business pays to finance its

[45] As of June 17th, 2024

[46] Centers for Medicare Medicaid Services, National Health Expenditures 2022, (December 13th, 2023, available at https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical/ , last accessed on June 17th 2024).

assets, which reflects the cost of financing the lost medical debt. In this revised calculation, I have applied the 10% discount rate and a 4.1% growth rate in health spending. Under these assumptions, the flow of medical debt loss increases to **$109.09 billion**, resulting in a total cost of **$126.69 billion**. Further, assuming no growth in medical debt per annum over the years reduces the value to **$64.36 billion** and a total cost of **$81.96 billion**.

Table 5: Cost of Proposed Medical Debt Rule for Providers

	Parameters	Billions
Health Spending		$ 4,400.00
Private spending	12.7%	$ 558.80
US population (Millions)	258.3	
Decrease in expected liquidation rates of referred debts	8%	
Growth in US health spending	4.1%	
US 1-year treasury yield	5.11%	
Outstanding Medical Debt		
KFF Outstanding Medical Debt		$ 220.00
CFPB Outstanding Medical Debt on Credit Reports		$ 88.00
Credit reporting from the survey	75.22%	
CFPB Outstanding Medical Debt - Adjusted		$ 116.99
Flow of Medical Debt		
Annual Percentage of Population with Medical Debt in Collections	13%	
Mean Medical Debt Conditional on Being in Collections	$ 2,396.00	
Annual Medical Debt		$ 80.46
Cost of Proposal		
Loss to Inventory of Medical Debt		$ 17.60
Loss to flow of Medical Debt in the first year		$ 6.44
Total Cost in the First Year (Backlog of debt plus one-year new debt)		**$ 24.04**
Value of loss flow of Medical Debt (Treasury Rate and Growth)		$ 637.27
Value of loss flow of Medical Debt (Treasury Rate and No Growth)		$ 125.96
Value of loss flow of Medical Debt (10% Discount Rate with Medical Debt Growth)		$ 109.09
Value of loss flow of Medical Debt (10% discount rate with No Medical Debt Growth)		$ 64.36

Total Cost of Regulation		**$ 654.87**
Total Cost of Regulation (No Growth)		**$ 143.56**
Total Cost of Regulation (10% Discount Rate with Medical Debt Growth)		**$ 126.69**
Total Cost of Regulation (10% Discount rate with No Medical Debt Growth)		**$ 81.96**

112. An additional objection might be that the KFF and Kluender et al. (2021) have overestimated the amount of medical debt outstanding and the flow. The CFPB's estimate of the inventory of medical debt was only 53% of the KFF's estimate. By deflating the inventory and flow of medical debt accordingly, the loss in the inventory of debt is **$9.3 billion,** and the flow is **$34.1 billion**, resulting in a total cost of **$43.4 billion**. Even according to the CFPB's numbers, this is a highly costly rule. I believe a conservative, lower-bound estimate of the rule's cost should use a 10% discount rate and assume no growth in medical debt. Under these assumptions, the debt inventory is expected to fall by **$17.6 billion** and the flow of medical debt by **$64.36 billion**, leading to a total cost of **$81.96 billion**.

I believe these estimates are too low. First, the influence of social media will likely spread the message that debt payment is voluntary, which could result in an 8% decrease in the expected liquidation rate. Additionally, the inventory of debt and expected losses were estimated during 2020 and later—a period characterized by various debt payment moratoriums, direct consumer payments from the government, and robust economic growth. Consequently, these estimates reflect lower inventories and flows of medical debt and higher payment rates. However, if the economy worsens, consumer distress will increase, and refusal to pay, especially without the use of medical trade lines data, will also rise. These factors will increase the cost of implementing this proposed rule. With industry revenues declining by **$81.96 billion**, some firms will leave the market, reducing

competition, employment, and options for collection companies and, by extension, healthcare providers.

The impact of this rule on medical providers

113. The struggles of debt collectors will be passed on to companies financing medical procedures and, ultimately, medical providers. Without efficient debt collection, medical providers would have to raise the cost of financing or cut consumers off from medical services. America has a market-based healthcare system, and with competitive pressures, systematically losing revenue cannot be written off. The data shows net losses in collections can be over 5-10% and concentrated in rural areas and general medicine. Given the competitive nature of this industry, much of these losses will be passed on to medical providers and subsequently – their patients. Further, this will be a systematic issue across the entire country. Unfortunately, there is no data documenting the losses to providers from the reduction in the ability to collect medical debts. Given that Americans pay co-pays, deductibles, and out-of-pocket expenses in market-based healthcare, this amounts to a large portion of provider's incomes being put at risk by the proposed Bureau rule change. However, in Figure 1, I have shown how referrals of debts for collections have increased. It is consistent with the data to hypothesize that the message consumers are getting is that they do not need to pay their medical debts. If true, this would result in providers receiving less compensation. This hypothesis should be studied before any new rules are promulgated because, ultimately, medical providers will need to protect themselves and deny care. This could result in heavier government or non-profit care usage or people going without medical treatments, goods, or services.

The impact of this rule on medical consumers

114. The final stakeholder who will ultimately lose is the consumer of medical services. Consumers who gain by having their medical debt records removed or never reported will potentially suffer from worse financing terms or the inability to access health care and, ultimately, debt financing. Consumers who diligently pay their medical debts will not get credit for doing so but potentially lose access to medical access. A market-based health system without financing would be a terrible equilibrium.

115. The health insurance industry relies on cross-subsidization to function effectively. When the Affordable Care Act (ACA) was passed, there was significant concern about the possibility of the industry entering a "death spiral." This concept, grounded in the asymmetric information theory of insurance economics, revolves around the uncertainty of whether young and generally healthy individuals would purchase insurance.

116. Young and healthy people are less likely to need medical services, but there is always a chance they might. They may opt not to buy insurance if they can receive treatment without paying or facing negative credit repercussions. The likelihood of a healthy person in their 20s needing medical care is low. Without these low-risk consumers in the health insurance pool, costs would rise for everyone else. This cost increase would lead to more people exiting the health insurance market, thereby making the pool of insured individuals riskier and driving costs even higher, perpetuating a cycle of exits and escalating costs. In extreme cases, this can lead to the unraveling of the health insurance market. This possibility of unraveling health insurance markets underscores that the proposed rule has significant and explicit consequences.

Ensuring Research and Transparency: The CFPB's Mandate

117. In 2024, the Research, Monitoring Regulations budget amounts to $79.7 million[47], supporting the employment of numerous PhD economists. Despite these substantial resources, there has been a notable absence of a comprehensive cost-benefit analysis regarding the proposed rules. Such an analysis is crucial for estimating and modeling the potential costs incurred by American consumers, taxpayers, and the consumer finance industry. Given the considerable expertise and resources at its disposal, the agency should prioritize conducting thorough cost-benefit analyses before implementing sweeping changes that could significantly impact a $4.5 trillion industry. Further, according to the CFPB:

> "At the CFPB, we leverage the full potential of data to meet our mission. This means proactively and securely acquiring, analyzing, and publishing high quality data and research to keep pace with statutory mandates and an evolving data-driven economy. Data is a fundamental driver of our mission to ensure people have access to fair, transparent, and competitive markets for consumer financial products and services. The CFPB is committed to improving transparency and accessibility by providing the public with timely and reliable data that will enable them to make informed decisions." [48]

118. The CFPB has yet to release any data or conduct a comprehensive analysis regarding the impact of medical debts, which account for approximately 50% of debt tradelines, on consumers and industries. Transparency and data-driven decision-making are paramount, considering the significant implications of medical debts on financial lives. The absence of peer-reviewed research and the lack of transparency regarding data and codes raise concerns about the credibility of the CFPB's findings. To make evidence-based decisions, the CFPB should

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[47] CFPB, *Annual Performance Plan and Report, and Budget Overview,* (February 2023, available at https://files.consumerfinance.gov/f/documents/cfpb_performance-plan-and-report_fy23.pdf, last accessed on June 17th 2024).

[48] https://www.consumerfinance.gov/data/

subject its research to public scrutiny and provide industry stakeholders access to all relevant data and codes for verification. Furthermore, there is a pressing need for studies examining the implications of the proposed rule on consumer financial markets. If the proposed rule, costing a conservative estimate of **$81.96 billion,** were passed by legislation, the Congressional Budget Office would have to address the estimated impact on the US economy. The CFPB, a self-purported 21st-century agency, has failed to meet the rigorous standards of the CBO. Specifically, investigations should assess the impact on medical debt payment behaviors, the response of medical providers to changes in collections, and the broader ramifications for industries reliant on consumer credit reports for risk assessment. In the CFPB's proposed rule,[49] the phrase "CFPB requests data" occurs eight times, the phrase "The CFPB requests further information" appears six times, "CFPB does not have data" occurs 15 times, and "CFPB does not have information" occurs five times, despite the CFPB's budget and legal authority to collect data. The Bureau's research falls short of addressing these critical concerns in a comprehensive and evidence-based manner. By fostering transparency and accountability, the CFPB can ensure that its regulatory decisions are based on sound evidence and serve the best interests of consumers and industry stakeholders.

[49] 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)

Andrew Nigrinis

Andrew Nigrinis, Ph.D.

July 8th, 2024

EXHIBIT 2

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

ACA INTERNATIONAL and SPECIALI ED COLLECTION SYSTEMS, INC., Plaintiffs, v. CONSUMER FINANCIAL PROTECTION BUREAU; and ROHIT CHOPRA, in his official capacity as Director of the Consumer Financial Protection Bureau, Defendants.	Case No. 4:25-CV-00094

SWORN DECLARATION OF ANDREW NIGRINIS IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I. INTRODUCTION

1. I, Andrew Nigrinis, am an economist at Legal Economics LLC, a consulting firm specializing in economic and statistical analysis. Prior to joining Legal Economics, I was the sole enforcement economist at the Consumer Financial Protection Bureau's ("CFPB" or "Bureau") enforcement division.

2. I am over 18 years old and have personal knowledge of the facts sworn to herein and if called to testify, I could and would competently so testify. I submit this Declaration in

support of ACA International ("ACA") and Specialized Collection Systems Inc.'s ("SCS") (collectively, "Plaintiffs") Motion for Preliminary Injunction.

3. If the CFPB's Final Rule, *Prohibition on Creditors and Consumer Re orting Agencies Concerning edical Information Regulation* , issued on January 7th, 2025 and published in the Federal Register at 90 Fed. Reg. 3276 (the "Rule"), becomes effective on March 17, 2025, the American credit markets will be irreversibly harmed with no opportunity for recompense. The CFPB failed to study and measure major foreseeable effects of this Rule and did not study and measure relevant data to understand the actual benefits of the Rule. Additionally, healthcare providers, creditors, debt collectors, and consumers will all face significant economic harm.

4. Compliance with the Rule will fundamentally change the nature of the credit reporting industry and all those who rely on it to facilitate an efficient credit market. The Rule must be enjoined from taking effect or the accuracy and usefulness of the credit reporting system will be irrevocably damaged.

A. Professional Expertise

5. I earned a Ph.D. in Economics from Stanford University. I completed a master's degree in economics at Queen's University in Canada and my bachelor's degree at the University of Alberta in Canada. I won the economics medal at the University of Alberta. I was a Carmichael Fellow at Queens University and a Stanford Institute for Economic Policy Research Fellow at Stanford.

6. Throughout my career, I have managed investigations related to allegations of unfair or deceptive practices, fair lending, disputes between financial services providers and lenders, allegations of mortgage and student loan servicing issues, credit card fees, debt collections, and dark patterns. I have also provided economic analysis of consumer financial

regulations and policies and have extensive experience with sampling and big data.

7. While at the CFPB, I led the Bureau's economic analysis and evaluation of over 70 cases. Additionally, I have worked with State Attorneys General, the Department of Justice ("DOJ"), and Office of the Comptroller of Currency ("OCC") officials on various matters.

B. Summary of High Level Conclusions Regarding the Final Rule

8. I was originally hired by Brownstein Hyatt Farber Schreck, LLP, counsel for ACA, to provide my opinion concerning the possible economic impact of a potential rule restricting medical debt credit reporting on the consumer finance industry and medical providers, including small businesses during the Small Business Regulatory Enforcement Fairness Act ("SBREFA") process convened in October 2023. That opinion, *Economic Analysis of the Consumer Financial Protection Bureau s FCRA Rule Pro osals*, was completed on November 6th, 2023, and is attached hereto as **Exhibit A** (hereinafter **Exhibit A**).

9. Brownstein also asked me to provide my opinion concerning the economic analyses and empirical evidence used by the Bureau in the then-Proposed Rule on the Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information (Regulation V), issued on June 11th, 2024 and published at 89 Fed. Reg. 51682 ("NPRM"). That opinion, *Economic Analysis of the Consumer Financial Protection Bureau s Prohibition on Creditors and Consumer Re orting Agencies Concerning edical Information Regulation* , was completed on July 8th, 2024, and is attached hereto as **Exhibit B** (hereinafter **Exhibit B**). Additionally, both of my comments reviewed other literature and studies produced by other economic professionals.

10. Because the CFPB did not alter its economic analysis between the NPRM and the Final Rule, my studies apply equally to the Rule, now in its final form.

11. To conduct my analysis, I started with the common sense logical chain that if it is harder to collect debt, then fewer debts are paid. This leads to losses to collectors, which are then

passed on to providers, which are similarly passed on to consumers and the like. My analysis and data interpretation sought to quantify the first step: namely the impact on debt collection due to the Rule.

12. In both the SBREFA and notice and comment processes, I reviewed data compiled by ACA and its members regarding the economic impact of limits on credit reporting. I studied the impacts on the collection industry, medical providers, consumers, and the economy as a whole. In doing so, I did not account for growth in healthcare costs in an effort to be conservative with my cost estimates. Similarly, I did not account for indirect costs, such as increased litigation or reduced consumer welfare. I wanted to remain extremely conservative in my estimates to quantify the impacts of the Rule, and not accounting for these factors served that goal.

13. My analysis showed that the CFPB did not provide a valid economic analysis of the impact of the Rule in several key areas. As it related to small businesses in particular, I outlined in **Exhibit A** some critical aspects of the problem created by the proposed Rule that the CFPB failed to analyze:

a. The CFPB did not study whether providers will respond to reduced collections by refusing to provide credit and thereby cutting off access to healthcare services for consumers.
b. The CFPB did not study whether healthcare providers will respond to the Rule by raising prices for all consumers.
c. The CFPB did not study whether providers might request cash up-front for co-pays and deductibles, and whether this might result in disadvantaging consumers who cannot afford to pay these amounts all at once.
d. The CFPB did not study the impacts to patient health from this Rule.
e. The CFPB has also not examined how rural and underserved communities operating on thin margins could be impacted;
f. Furthermore, the CFPB must evaluate whether changes in the ability to recoup payment causes shifts to a concierge model, which could further reduce access for low-income community members.

14. My analysis also showed that the Rule would have many foreseeable economic

impacts—each of which the CFPB failed to evaluate. These Rule changes all stand to make fundamental changes to the credit ecosystem and, as a result, the economy at large. As outlined in **Exhibit A**, these include:

a. There would be increased uncertainty in consumer finance as predictive information is removed from credit reports;

b. Restricting the use of accurate information about valid debts would cause increased financing for unqualified borrowers. There is a strong possibility of more lending of the type that precipitated the financial crises;

c. There would be decreased access to credit for credit-qualified borrowers;

d. There would be an increase in difficulty in meaningfully repairing credit scores;

e. Medical providers would suffer a loss of income from non-payment of services. My very conservative estimate of direct losses in the first year is estimated to be $24 billion. My estimated range for the losses over time ranges from $82 billion to $655 billion;

f. There is a likely increase in litigation costs for medical providers to collect debts, including increased costs to consumers facing that litigation;

g. There is potential to harm consumers, including those without health insurance and many in protected classes;

h. There is a risk of health insurance markets entering a death spiral if young and healthy consumers who infrequently use health care forgo insurance due to not needing to pay for medical treatment.

15. In sum: the CFPB proposed, and now enacted, a Rule with major impacts on consumers, lenders, small businesses, and the broader market that relies on credit reporting. All of this should have been studied—extensively—when the Rule was working its way through notice and comment procedures.

16. The CFPB failed to study and measure major foreseeable effects of this Rule and did not study and measure relevant data to understand the actual benefits of the Rule. The result is a Rule that irrevocably damages the credit ecosystem.

II. THE CFPB IGNORED CLEAR EVIDENCE OF THE USEFULNESS OF MEDICAL DEBT IN CREDIT UNDERWRITING

17. The CFPB justifies the final Rule saying: Research has shown that medical debt

has limited predictive value for credit underwriting purposes. 90 Fed. Reg. 3297–98.

18. The CFPB relies on a 2014 Model that "has raised questions about the predictive value of medical debt " to justify its Rule. This statement by the CFPB has two problems. First, the research into the predictive problems of medical debt has serious methodological issues. Second, the Bureau has misinterpreted the research's conclusion to justify its rulemaking.

19. Methodologically, the CFPB's 2014 Model fails to effectively isolate the effect of medical debts on delinquency (or, their measure of risk). The research design assigned consumers into one category: medical (MM) debt and non-medical debt (MNM). Consumers were then stratified further: paid medical debts (MPM) and unpaid (MUM). The CFPB then studied delinquency by credit score for the MM and MNM groups over time. The problem is that an MM and a MNM are a mixture of credit lines. This is not a clean test of the effect of medical tradelines on a credit report at the margin.

20. Without data on the composition of the groups, it is impossible to make an apples-to-apples comparison. We do know that medical debt is not random in the U.S. population. Medical debt falls most heavily on low-income counties with a high percentage of uninsured people. *See* Ex. B, 45, fn. 18. The CFPB's 2014 study does not use standard statistical controls for economic research. The effect of medical debt may be confounded by the income and healthcare policies of the states in which the people of the sample reside. But this analysis was not performed. Further, the CFPB's study is not published. Before using research to make major policy changes, the CFPB should open its code and data to the public for scrutiny.

21. Even if we took the results at face value, the conclusion that medical debt tradelines can be removed with little impact on credit scores is false. The CFPB's own data shows an estimated credit score difference of 16 to 21 points for medical debts versus non-medical debts.

But in their example, the credit score of a consumer with medical debt tradelines is still almost 100 points lower than their score prior to the tradeline deletion, implying a large impact from the removal of medical debt tradelines under the Rule. There are methodological issues that make the estimates suggestive but not definitive. But the Bureau's work, on which they base policy, concludes that medical debts have a predictive value that their removal from credit reports would lose. The conclusion that medical debt has no predictive value is wrong.

III. THE CFPB IGNORED EVIDENCE OF THE HARMS AND PROVIDED CONTRADICTORY JUSTIFICATIONS

22. In my report, I stated that, with fewer repercussions for medical debt, consumers would not pay their medical debts under the proposed rule. Ex. B, 22–25. This revenue loss has multiple consequences: price increases, closures of practices with tight margins, and providers asking for prepayment in advance of services.

23. The CFPB dismisses these results as unlikely because "CFPB expects that the reduction in health care provider revenue under the rule would be equal to no more than 2 percent of their total costs." 90 Fed. Reg. 3328. This analysis was not provided in the NPRM, nor did the CFPB provide further analysis or citations in the final Rule.

24. But the CFPB's determination of a 2 percent increase in healthcare costs equates to $97.33 billion per year. Total Health Consumption Expenditures reported by CMS were $4.866 trillion in 2023.[1] Even if the 2 percent figure were limited to only hospital bad debt, this amounts to $30.39 billion per year based on 2023 CMS data. This figure is substantial and very likely to impact market behavior.

[1] https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical_:_:text_U.S.%20health%20care%20spending%20grew,For%20additional%20information%2C%20see%20below.

25. Moreover, the CFPB contradicts its own analysis in the Rule when elsewhere the CFPB estimated a $900 million reduction in recoverable medical debt over 10 years under the rule. 90 Fed. Reg. 3322. Over ten years, the same 2 percent increase in costs estimated above is $973.30 Billion—not even accounting for yearly growth in healthcare costs. In sum, the CFPB has purported to study the costs of the rule to healthcare providers and arrived at figures that vary over ten years by over $972 billion.

26. At no point has the CFPB conducted analysis of how consumers of private market healthcare providers can finance healthcare services under the Rule. The CFPB has yet to study whether providers will respond by refusing to provide credit and cutting off the consumers the Bureau purports to be helping from health services or whether healthcare providers will respond by raising prices on all consumers and hurting everyone, or if they will respond by requesting cash up-front for co-pays and deductibles, hurting low-income community members who can't afford to pay those all at once, thereby reducing their access to health care. The CFPB also failed to study whether any healthcare providers would be forced to exit the market due to decreased revenues.

27. I summarized key findings regarding the economic impacts of the NPRM in **Ex. B**, 3 as follows:

a. The research shows that improved accuracy of credit reports, which this rule undermines, leads to an expansion of lending to reasonable risks and a reduction in poor risks. This is done by providing more credit at better terms to low-risk consumers while reducing access and raising costs for lower-risk consumers. Overall, this benefits businesses as profitability rises;

b. Medical account collections referred to third-party debt collectors will decrease by 8%, thus reducing revenue for medical service providers;

c. There will be increases in write-offs at the provider level as more patients interpret the message behind the message that medical debt should take a back seat to the priority of paying other debts;

d. The CFPB failed to assess whether the burdens associated with regulations could result in market exits for small medical care providers and debt collectors;

e. Medical debt disproportionately impacts the South and Mid-West States;

f. The CFPB, in their technical appendix, shows that medical debt is predictive of expected losses the credit card industry faces. But the CFPB used a faulty methodology and did not properly interpret or chose to ignore the results showing the harm removing medical debts would have on the credit system.

28. I specifically reviewed the impact this Rule would have on the debt collection industry. To do so, I used a data set contributed directly to me by collection agency members of ACA. Ex. B, p. 50. These data contain 1,615 client accounts (not consumers, but 1,615 creditor organizations) from 19 self-reported debt collection agencies. This data include the number of referrals, collections, and the estimated impact of the rule change on liquidation rates of referred debts to collectors (or writing off debt) due to the changes. This data reflected the restrictions on reporting medical debts under $500—of course, the Rule restricts reporting of all medical debt balances.

29. From this data, I reviewed the estimated change of liquidation of referred debts due to not credit reporting. **Exhibit B** contains a more complete analysis of the data, but the topline result is clear: the impact of the Rule on small businesses is substantial. *See* Ex. B, 89–105. Small collection agencies will suffer as the result of this Rule. The data is clear: smaller collection agencies will find it harder to collect.

30. The struggles of debt collectors will be passed on to companies financing medical procedures and, ultimately, medical providers. The Rule will drastically affect the ability of small business physician practices to collect revenue via collections. This will have far-reaching implications. Small physician practices may resort to litigation to collect on lost revenue, or they may simply stop serving the same communities the CFPB claims to be protecting. Neither result is productive; both are the inevitable result of this Rule on a market-based healthcare system.

31. My analyses also showed that the impact disproportionately hurts rural physicians.

Based on my analysis of the data, physicians in non-metro zip codes will experience a more considerable decrease in expected liquidations of referred debts. 10.4% of these lost accounts represent a substantial loss of revenue to collections on behalf of rural physicians.

32. My analysis makes two things clear. First, the Rule has an outsized impact on small businesses, both collection businesses and small medical providers. The Rule makes it harder for collectors to collect—and harder for providers to get paid. Second, the CFPB should have conducted extensive analysis on that point. The impact on small businesses is so substantial that the CFPB cannot justify avoiding this analysis.

33. As part of my broader analysis of the Rule, I evaluated collection dates (based on the data provided by ACA) when the new rules limiting the ability to report medical debts were already in effect. I noted in my report that the collection rates continued to fall as time went on. *See* Ex. B, 5. My conclusion from this trend is that, while the initial impact of the reporting rule may have been baked into the data, the continued change in the collection rates by region suggests that the message behind the message is that medical debts do not need to be paid.

34. This data paints a clear picture: the initial impact of limits on medical debt reporting have negatively impacted the collection of medical debt. Those trends have continued and showed no signs of slowing down.

35. The CFPB shrugged off the impact of the Rule on debt collectors, critically relying on the fact that debt collectors could still bring litigation against consumers to collect on this medical debt. See generally 90 Fed. Reg. 3276, 3329 at VII.E.4. But during the SBREFA Panel, the CFPB completely dismissed increased litigation as a non-issue. This complete change of position did not allow stakeholders such as ACA to properly study the impact of increased litigation costs under the Rule.

36. As I stated in my report, *see generally* **Exhibit B**, the research in the arena of information relied upon for underwriting credit decisions irrefutably demonstrates facts and outcomes that advise against the implementation of the Rule.

IV. THE CFPB FAILED TO CONSIDER CURRENT AND PROPER ECONOMIC DATA

37. Despite the evidence presented regarding the massive change this Rule will bring to the credit ecosystem as a whole, the CFPB failed to adequately consider relevant economic data showing the scope of the impact. The easily predicable results of the Rule (which are outlined above) are clear enough to any rational observer. Yet, the commentary and analysis supporting the Rule failed to provide any quantitative or empirical evidence addressing these readily predictable results of the Rule.

38. The Bureau relies on internal research that fails to predict or shed light on the expected consequences of its proposed rule. Specifically, the Bureau points to a 2014 study titled "Data Point: Medical Debt and Credit Scores," which suggests that medical debts are not as predictive as other types of unpaid. My specific concerns with this finding are discussed *su ra*, 16–20.

39. The other problem with this study, however, is that it uses data collected from October 2011 to September 2013 that predates significant policy changes such as the Medicaid expansion of the Affordable Care Act. As shown by the Urban Institute, this expansion notably decreased the percentage of uninsured people, a factor that significantly drives medical bills. Therefore, updating the data for any policy analysis today is crucial to ensure its relevance and accuracy. *See* Ex. B 47, fn. 19. Additionally, this work predates the changes to Regulation F and the No Surprises Billing Act that reduced medical debt tradelines on credit reports.

40. The changes to Regulation F and the passing of the No Surprises Billing Act are

particularly relevant as, by the author's admission:

> "The account-level information that is included in the credit records comprising the CCP allows us to identify which debts reported by third-party collection agencies were from medical or non-medical bills. While we can identify those collections that were from medical bills, nothing in the data reveals anything about the identity of the medical service provider, the type of institution that provided the service, or the nature of the services that were performed."

This analysis cannot distinguish between medical debts that would have been removed by the No Surprises Billing Act and Regulation F. Given that these laws and regulations were intended to eliminate or regulate expensive emergency healthcare services, out-of-network charges, and debt misreporting, the remaining medical debts may be equally predictive as non-medical debts. This underscores the urgent need for further studies and consideration with data that is not a decade old. Without these, there is no way to tell.

41. Further, the CFPB's research has not been subjected to rigorous peer review, nor has its results been scrutinized or validated. Opening its findings to public scrutiny is imperative for an institution that seeks to base its decisions on evidence. In economics, this is typically done through the publication of results. At the very least, the CFPB should grant industry stakeholders access to all data and codes, enabling them to verify the Bureau's results.

42. By failing to do so, the CFPB sidesteps what is typically part of a normal—and healthy—scientific process. Peer review, especially review of data that will form the basis of enforceable regulations, is critical.

43. The Bureau also heavily relies on a "Technical Appendix," frequently referencing it to justify their conclusion that removing medical debts from credit reports will not have negative consequences. This analysis is presented unusually, as it is not a report, blog post, or peer-reviewed study. The CFPB is presenting work that has not undergone a peer review process to verify its validity, nor have they allowed the industry to review the data or code used to generate the results.

Consequently, there is no way to validate these results, which, as I show in my report, Ex. B 60–71, have serious methodological issues. Given the implications of this work, the CFPB should be more transparent in its research.

44. As an example of the issue with its approach, the CFPB used an inappropriate model in the technical appendix, resulting in biased outcomes. Their research relies on regression discontinuity (RD), which is based on a straightforward concept: a threshold variable determines on which side of the "quasi-experimental" treatment an observation falls. When applied correctly, this methodology enables causal analysis. The CFPB applied 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. While similar to RD, RDiT analyzes effects over time. However, this application of RDiT by the CFPB is inappropriate, leading to biased results.

45. The CFPB acknowledges its work's limitations and potential biases, particularly with regression discontinuity in time designs when it states that such designs "can be biased if observations far from the threshold period are included for identification, possibly due to autoregressive properties or unobservable confounders." 90 Fed. Reg. 3357. Moreover, academic literature highlights concern about bias when consumers improve their credit behavior during the threshold period, subsequently applying for credit and maintaining improved behavior. The severity of this bias cannot be accurately assessed because the CFPB has not released the data and code to independent researchers for scrutiny and verification.

46. The CFPB also states, "The key assumption of a regression discontinuity analysis is that nothing is changing discontinuously across the threshold besides the treatment." 90 Fed. Reg. 3357. Surprisingly, the CFPB would utilize a methodology requiring stability. The period

from 2017 to 2022 (which spans the data of the appendix) was marked by *significant instability* in the medical debt collection environment, including the COVID-19 crisis, student loan debt moratoriums, government cash payments, and the implementation of Regulation F at the federal level, alongside numerous state-level changes.

47. The CFPB's heavy reliance on the Technical Appendix is but another instance of the CFPB failing to study and measure major foreseeable effects of this Rule.

V. THE FINAL RULE IRREPARABLY DAMAGES THE AMERICAN ECONOMY

48. The Final Rule negatively impacts the credit market as a whole, collectors of debt, healthcare providers, and consumers. The CFPB has ignored the significant and catastrophic economic impacts that will follow from the implementation of this Rule. This harm will be irreparable.

A. Impact on Credit Markets

49. In a capitalist system, the healthy functioning of credit markets is critical to the nation's economic well-being. Policies that erode confidence in the credit system are destabilizing. This Rule is just that. If the ability of creditors to utilize and rely on medical debts is eliminated, some consumers will not pay those debts (and in some cases may even be unaware they exist). When these consumers fail to make timely payments, they may be pursued through litigation. Unfortunately, the social costs of litigation will be increased and borne by consumers. As more debt collectors and healthcare providers turn to the legal system, the consumers the Rule is intended to benefit will be forced to pay for litigation and court expenses. Litigation is a more expensive method to transfer resources from debtors to creditors than through informal resolutions like settlement agreements to pay contractual obligations outside the court system.

50. Ultimately, if there is an increase in litigation, all consumers may face increased

financing costs or experience providers refusing patients who rely on credit, resulting in losing access to healthcare and making them net losers if the proposed regulation is enacted.

51. Additionally, credit reporting is an extremely important tool to educate potential lenders. Medical debt may be unpleasant but it remains debt. Limits on reporting will result in unqualified borrowers obtaining access to lines of credit. This instability and increased faulty lending standards could cause another Great Recession-style collapse of the financial sector.

B. Impact on Collectors of Debt

52. The implications of this Rule on the debt collection industry are significant. Debt collection plays a vital role in financial markets, as it enforces the payment of contracts. This service, however, comes at a cost. The industry operates in a competitive environment, with fees aligning with costs. Therefore, any reduction in the effectiveness of collectors, as can be anticipated by this Rule, will likely lead to an increase in collection costs or a decrease in collectible amounts. These changes will ultimately be passed on to the consumers of these services—the companies providing financing.

53. In **Exhibit B**, I walk through calculations on the cost of the Rule. The Rule's cost due to the inventory of medical debt lost is expected to be $17.6 billion. The annual loss will be $6.44 billion when the Rule becomes effective. In addition, the Bureau conducted a separate analysis that "bad debt" costs would rise 2 percent, which is as much as $ 97.3 billion annually. Moreover, the annual loss will continue indefinitely. This will result in a monumental amount of money lost.

C. Impact on Healthcare Providers

54. It should be made clear: America has a market-based healthcare system, and with competitive pressures, systematically losing revenue cannot be written off. Losses for debt collectors will become losses to medical providers—and subsequently, their patients. Rational,

profit-maximizing firms will likely need to restrict financing or increase the cost of financing medical services based on easily verifiable data. This process is already underway, with many hospitals and medical providers requiring upfront payments.

55. My data illustrates how referrals of debts for collections have increased. It is consistent with the data to hypothesize that the message consumers are getting is that they do not need to pay their medical debts. If true, this would result in providers receiving less compensation. This hypothesis should have been carefully studied before any new rules are promulgated because, ultimately, medical providers will need to protect themselves and deny care. This could result in heavier government or non-profit care usage or people going without medical treatments, goods, or services.

D. Impact on Consumers

56. Consumers, ultimately, will lose out. Consumers who gain by having their medical debt records removed or never reported will potentially suffer from worse financing terms or the inability to access health care and, ultimately, debt financing. Consumers who diligently pay their medical debts will not get credit for doing so but potentially lose access to medical access. A market-based health system without financing would be a terrible equilibrium.

57. While I respect the CFPB's attempts to protect consumers, this Rule does just the opposite. Consumers may not like medical debt—but they also need medical services. These medical services must be paid for.

Pursuant to Local Rule, I declare under penalty of perjury that the foregoing is true and correct.

Executed on January 17, 2025.

Andrew Rodrigo Nigrinis

Digitally signed by Andrew Rodrigo Nigrinis
Date: 2025.01.17 19:48:02 -05'00'

Dr. Andrew Nigrinis

EXHIBIT
3

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

ACA INTERNATIONAL and SPECIALIZED COLLECTION SYSTEMS, INC., Plaintiffs, v. CONSUMER FINANCIAL PROTECTION BUREAU; and ROHIT CHOPRA, in his official capacity as Director of the Consumer Financial Protection Bureau, Defendants.	Case No. 4:25-cv-00094

SWORN DECLARATION OF ANITA MANGHISI
IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I.
INTRODUCTION

1. I, Anita Manghisi, am the owner of Independent Recovery Resources, Inc. ("IRR"). I am the former President of the New York State Collectors Association, the former Legislative Chairwoman for the New York State Collectors Association, a former Board Member of ACA International, as well as a former member of ACA International's Federal Affairs Committee.

2. I am over 18 years old and have personal knowledge of the facts sworn to herein and if called to testify, I could and would competently so testify. I submit this Declaration in support of ACA International and Specialized Collection Systems Inc.'s ("SCS") (collectively "Plaintiffs") Motion for Preliminary Injunction.

3. If the CFPB's Final Rule regarding Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information (Regulation V), published in the Federal Register at 90 FR 3276 (the "Rule") becomes effective on March 17, 2025, my business and my personal financial situation will be irreversibly harmed with no opportunity for recompense.

A. Summary of Testimony that Supports Vacating the Final Rule

4. The Rule must be enjoined from taking effect or my business and I will face losses that can never be recovered. My testimony provides the below facts in support of Plaintiffs:

- **Restricts Speech.** The Rule cuts off my firm's only means to communicate accurate information about the medical debts it collects to creditors via the credit reporting agencies ("CRAs"). It infringes upon my First Amendment right to convey and receive accurate information about facts that are important to my business.

- **Harm to Health Care Providers**. The Rule removes an incentive for people to pay my clients who are healthcare providers as well as my non-healthcare provider clients whose accounts I will also stop furnishing.

- **Medical Debts are Accurate.** The Rule is based on a fallacy that medical bills are "plagued with inaccuracies." In my experience, medical bills are seldomly invalid or incorrect. Rather, consumers need one-on-one conversations with my collections staff to better understand their bills and their payment obligations.

- **Consumers Already Have Protections.** The Rule is unnecessary because my policies and procedures under the Fair Debt Collection Practices Act ("FDCPA") and Fair Credit Reporting Act ("FCRA") provide consumers the right to understand the medical debts they owe, and dispute amounts they do not believe they owe. My firm is legally required to correct errors under the FDCPA and FCRA. The Rule is unnecessary because the No Suprises Billing Act helps alleviate the out of network expenses consumers have faced in the past.

- **Harm to the Healthcare System.** The Rule will cause medical providers to lose revenue, which causes a host of trouble. It will harm access to healthcare, especially in small and rural communities. It disincentivizes payment for healthcare services and may disincentive people from paying for health insurance.

- **Harm to Consumers**. When IRR stopped furnishing medical debt information in New York state, IRR's collections decreased significantly. Thus, IRR had to increase telephone contacts, mailing services, and litigation to ensure that healthcare clients were fairly paid for their services.

- **Harm to Access to Credit.** This Rule will diminish the accuracy and value of credit report information. Thus all the gains American consumers—especially low-income consumers—have received from the democratization of credit will be reversed.

- **Now Cash Up-Front will Be Required.** My healthcare clients will stop providing medical services prior to payment, thus more people will need to pay upfront for healthcare services.

- **Will Cause Bad Underwriting.** The Rule suppresses accurate information about accounts that help creditors make ability-to-repay assessments—thus it will contribute to the same faulty underwriting that led to the 2007 Financial Crisis.

B. Independent Recovery Resources Collects Medical Debt for Healthcare Clients

5. I am the president and chief executive officer of IRR. I opened this small business in March of 1996. IRR, a certified Woman Owned Small Business ("WOSB") based in Patchogue, New York, operates as a full-service debt collection agency and employs a staff of five. IRR is a dues-paying member of ACA.

6. IRR's principal purpose is the collection of debts owed or due, or asserted to be owed or due, to another. It is a "debt collector" under the FDCPA and a "covered person" under the Consumer Financial Protection Act. As a debt collector, IRR relies on accurate credit reporting to assess the value of accounts, individuals' propensity to repay, and other important financial data.

7. Many of IRR's clients are healthcare providers who offer and deliver services to Americans prior to those individuals paying for services. This allows people to obtain medical care without paying the full price of the care upfront. IRR has accounts across the United States, and it's agents regularly communicate with consumers for those accounts, including through calls, emails, and text messages. In addition, IRR initiates lawsuits to collect on past due medical debts, which ensures that physicians and hospitals are fairly paid for their services.

8. IRR regularly seeks to recover unpaid past due amounts for services rendered—including for medical and hospital care. IRR's clients rely on my firm to help recover their outstanding debt so that they can continue operating and providing quality healthcare to the communities and consumers they serve. IRR works with its healthcare clients to answer consumer questions, resolve disputes, and arrive at achievable resolutions, including settlements and payment plans. Over the nearly thirty years that IRR has been in business, we've found that our clients appreciate our willingness to work with consumers and also our understanding that a consumer may need additional flexibility on a specific account.

II.
THE RULE IS UNNECESSARY, WILL DAMAGE THE ECONOMY, AND HARM PEOPLES' HEALTH

A. The Rule's Restriction of Speech Directly Harms Me and IRR

9. Under the Rule, no creditor can get information about consumer medical debts.

(1) The Rule Restricts My Truthful Speech

10. IRR will stop furnishing medical debt information to CRAs due to this Rule.

11. The Rule stops IRR from conveying truthful speech about past due medical accounts to creditors in the United States.

12. The Rule, as applied, also stymies speech about non-medical debt. Because my system of record cannot distinguish between healthcare and non-healthcare debt, IRR must stop credit reporting all types of accounts to avoid violating the Rule. Now, CRAs are considering IRR's inability to report accurate data on non-medical accounts as a breach of contract, exposing us to additional litigation risk. This has caused us to be at risk of losing the future ability to furnish accurate reporting about non-medical debt.

(2) The Rule will have Direct Financial Costs to IRR

13. In states with laws similar to the Rule, the inability to provide truthful information about past due debts to CRAs has severely damaged my business.

14. When consumers do not experience any consequences for unpaid accounts, they are less likely to pay. This not only hurts my revenue, it means that healthcare providers are not being compensated for their services. Or, as discussed below, litigation is more likely to be used as a method to collect on accounts.

15. IRR sends accounts to litigation. Because the prohibition on credit reporting in certain states removes a consequence for nonpayment, unpaid accounts in those states are moving to litigation more quickly and at higher volumes than in previous years.

16. Because the Rule will increase collection through litigation, there are many negative consequences. Namely, collecting debt through litigation is the most expensive, most embarrassing, and least efficient method of collecting on past due obligations. It also burdens society at large, who must pay for the court system or have their own legal resolutions delayed because the courts are overburdened.

17. The cost to IRR to collect a hypothetical $ 1,500 account in New York state courts is $500 in filing fees alone. That cost is included in the amount owed by the consumer, and therefore increases the total amount due from the consumer. The cost of collection increases as the amount of unpaid debt increases, as I must file in a different court with more expensive filing fees and may require the assistance of counsel.

18. The recovery of the judgment also incurs costs. Once IRR receives a judgment, we may garnish wages or bank account funds. This is not a voluntary process for consumers. In contrast, if a consumer made a payment arrangement during a typical collections conversation,

that consumer would have several choices about payment timing and amounts. The Rule eliminates that option, which harms my business, the clients we serve, and the consumers they serve.

B. IRR Collects Accurate Medical Debt in Compliance with the FDCPA and FCRA

19. IRR collects medical debts that are accurate and fairly owed. It has policies and procedures to ensure that medical debt accounts are accurate, consumers are receiving accurate statements, that agents on calls are providing accurate information, and credit reporting is accurate.

20. In my experience, when a patient disputes a medical debt, they usually are incorrect and merely need a better understanding of their records. In my 36 years of experience in the account receivables industry, less than 1% percent of the consumers disputes that IRR receives are valid disputes about inaccurate medical debt. In most cases, consumers simply need guidance understanding the bills and how they work under their policies.

21. Relatedly, the CFPB cannot rely upon a mere count of "disputes" or "complaints" about medical debt to assess whether medical collection accounts have errors. Disputes and complaints do not indicate actual inaccuracies. The CFPB should only base policy on proven instances of inaccurate data.

C. Consumers Already Have Adequate Protections

22. I have studied, received training, and provided training on Confidentiality, Health Insurance Portability and Accountability Act ("HIPAA"), 501(r), the FDCPA, the Gramm-Leach-Bliley Act ("GLBA"), the Fair Credit Reporting Act ("FCRA"), Regulation F, Identity Theft, Red Flags, Accuracy & Integrity, Bankruptcy, and other regulatory requirements that impact my agency. IRR complies with all these laws. The FDCPA, FCRA, GLBA, HIPAA, Regulation F, several other privacy laws, and many state laws already address the CFPB's concerns related to reporting of inaccurate information and protecting consumer privacy.

23. The FCRA already requires furnishers to report only complete and accurate data to the CRAs. The Rule's supposed rationale in combatting "inaccurate" medical debt tradelines is thus already addressed by existing law. Similarly, the FCRA requires IRR to reinvestigate disputed information about medical debt. When IRR receives a medical debt dispute, IRR's process is as follows: upon receiving a consumer dispute, IRR immediately suspends the account from further collections. Then we seek validation and supporting documentation from the original healthcare provider. If we obtain that validation, we send the appropriate documents to the consumer and restart the collection process. If IRR is unsuccessful in obtaining validation from the original provider, IRR closes the consumer account and returns it to the client. IRR then removes the tradeline from the consumer's credit report, and advises the consumer that it has been removed and that we could not validate the debt.

24. Relatedly, the No Surprises Billing Act ("NSBA") went into effect on January 1, 2022, which has already, and will continue to, reduce the level of emergency services costs and out-of-network insurance bills. This law further protects consumers from unexpected expenses and provides a consumer friendly appeal process if a consumer receives a bill for which they believe they should not be responsible. Thus, the NSBA provides a two-fold protection system for consumers, making the CFPB's Rule here unnecessary.

25. Regulation F also prevents inaccurate information from being furnished to CRAs, and states a debt collector must not furnish to a CRA information about a debt before the debt collector: (i) Speaks to the consumer about the debt; or (ii) Places a letter in the mail or sends an electronic message to the consumer about the debt and waits a reasonable period of time to receive a notice of undeliverability. 12 CFR § 1006.30(a)(1). Consumers may dispute the accuracy of an account with the debt collector before account information is furnished to a CRA. This provision

became effective January 19, 2021. The Rule, which relies on studies that predate this period, does not account for changes in practices that address this accuracy concern and already prevent inaccurate medical debt credit reporting.

26. IRR complies with the requirements of the FCRA and Regulation F. If IRR is unable to obtain debt validation and verify the account, it deletes the tradeline. Even if IRR was delayed in responding to a consumer's FCRA dispute, the CRAs themselves automatically delete the tradeline without further inquiry if they don't receive prompt verification from IRR.

D. The Rule will Hurt the Medical Care System in Multiple Ways

(1) Harm to Healthcare Creditors and Collectors Who Are Not Paid

27. The Rule creates a direct disincentive for consumers to not pay their medical debts. People want to pay their debts so that they are attractive to lenders and qualify for superior credit offers. Many consumers believe that if a debt is not reflected on their report, it is not owed. And even for those that do understand they have an obligation to repay, there is no incentive to pay their medical debts if it will not go on their consumer report and impact their future eligibility for and access to credit. After recent credit reporting maneuvers by the CFPB and some states, many consumers have started questioning or refusing to pay medical debts because there is little consequence to that course of action. The Rule will exacerbate this trend.

28. I have personally observed decreased collections of medical accounts in states that have banned medical debt reporting. Specifically, when the New York restriction came into effect, my collections dropped 40% percent, and I expect this number to increase over time.

29. Relatedly, many healthcare providers with whom I do business are now choosing not to send accounts to collections at all. They are writing the unpaid accounts off as bad debt and taking the loss on their balance sheets instead. The lost business has forced IRR to try and evolve into other areas of business in a very short timeframe, which has been challenging.

(2) The Rule Will Cause Consolidation in Healthcare Providers

30. When healthcare providers lose revenue due to this Rule, it will hurt the availability of medical care as fewer physicians are attracted to the profession and fewer hospitals and clinics open for business. My healthcare clients, including physicians, have consolidated with other firms when they are not earning sufficient revenue. It is not uncommon for small towns to only be served by a few medical providers. If small providers cannot get paid, these businesses must close or merge with a large company, leading to further market consolidation. In rural parts of America, there is a dearth of healthcare access already. This Rule will make it harder for patients in rural areas to receive medical care.

31. Where a consumer might have previously had better access to care, they are now dependent on large companies that may not have a meaningful presence in their community. Even for those who still have physical access to care, reduced market competition drives up consumer pricing, preventing some from accessing care because of increasing consumer costs.

(3) The Rule may Disincentive People from Obtaining Health Insurance

32. Consumers who see no negative consequences for skirting medical debts may stop paying for health insurance. People who pay an out-of-pocket premium on health insurance may choose to no longer carry health insurance if medical debt is no longer credit-reported. Even individuals who qualify for Medicaid may not see the value of taking time to apply if there is no impact of nonpayment on their credit score. The unintended consequence may be a large reduction in insurance dollars to hospital systems, leading to a reduction in services or staff available to patients (including those who do pay their medical debts).

E. Harm to Consumers

(1) Reduced Access to Credit and Health Care Services

33. While my healthcare clients currently allow patients to receive services prior to payment, this option will be eliminated in favor of pre-payment. If doctors and other healthcare workers are unable to collect payment after services have been rendered, they will stop offering services in advance and will only provide services to those who can pay for them beforehand. I have personally observed this with my clients who provide elective services, and anticipate that this practice will likely spread to non-elective services as a consequence of this Rule.

34. Prepayment requirements could create dire consequences: (a) People may not seek and receive preventative care; (b) People who cannot afford out-of-pocket costs for care will be forced to use high-cost financing methods like credit cards, or worst case, forgo medical treatment altogether; and (c) People who cannot pay for a procedure upfront will be denied access to care. What may have been a small or preventable issue could grow into a life-threatening emergency. Not only are these peoples' health more at risk, but the cost of care will increase.

35. Because hospitals are not able to turn away life threatening emergencies, those providers are forced to absorb even higher costs of care (which otherwise could have been prevented) which will be passed onto society in the form of higher healthcare costs generally.

(2) Reduced Access to Information about Obligations

36. Consumers are also harmed by incomplete and inaccurate credit reports. Consumers often leave mail unopened or are unsure if an initial written collection notice accounts for insurance payments. It often takes the straightforward communication of seeing an item on a credit report to incentivize a patient to address an issue with their insurance company, act to avoid future litigation, or act before a provider drops them as a patient in their practice.

37. By removing the option of credit reporting for learning about financial obligations: (a) Patients may miss important insurance deadlines and be forced to pay out-of-pocket for medical care that could have been covered by insurance or charity care and (b) Patients will be surprised about more serious and expensive consequences of unpaid debt, such as a lawsuit.

F. The Rule Will Cause Bad Underwriting Because the Credit and Debt Collection Industries Rely on Accurate and Complete Credit Reporting Information

38. By prohibiting my use of medical debt information, I am unable to fully evaluate accounts from my clients, assess propensity to pay, and otherwise understand the consumer's financial profile in a way that allows IRR to successfully recover unpaid debts for my clients.

(1) Inaccurate Assessment of Ability to Repay Will Harm Everyone

39. A Rule that prevents agencies from accurately reporting the amount of debt owed by a consumer and prevents lenders from issuing credit based on an accurate assessment of a consumer's finances fails to meet the needs of commerce for consumer credit and results in a system that is unfair and inequitable to consumers. In my experience, when creditors do not accurately assess the default risk of consumers, the result will be: (a) consumers take out more credit than they can repay; (b) consumers default on obligations; (c) this results in collection, litigation, or bankruptcy. When this happens on a large scale, it disrupts the economy—as it did for years after the 2007 financial crisis.

(2) Inability to Predict Defaults Restricts Credit for Consumers

40. Imagine a consumer with an "Excellent" credit score who secretly owes $ 50,000 in medical debt. That person may take out loans for cars or get a new credit card based on that excellent credit score, but soon after file for bankruptcy protection due to the invisible medical debt. This type of repeated pattern will decrease the efficacy and reliability of credit reports and credit scores for all borrowers in America.

41. When creditors are unable to effectively predict a consumer's propensity to pay or risk of default, the creditor is less likely to offer credit. If they do offer credit, it is on more expensive terms to offset the unknown default risk. The inability of creditors to predict the risk of default results in restricted credit access for consumers.

42. This leads to the exclusion of certain groups and people that can no longer set themselves apart through their historically positive payment behaviors, further harming those consumers who do honor their payment obligations. The financial penalties imposed by creditors to offset the unknown risk of default will be assessed against *all* consumers – even those with high credit scores and no outstanding medical debt. Thus, the Rule penalizes responsible hardworking consumers for no fault of their own. It also increases the risk that lenders and creditors are forced to rely on statistical information that may further promote systemic biases in the financial markets, further excluding individuals who would otherwise have been offered credit.

43. Finally, not only does this reality harm consumers who have been financially responsible; it also creates a direct disincentive for consumers to pay their medical debts. If all the money poured towards paying off their medical debt is invisible to lenders, consumers may reason that there is no point to making payments at all. A reasonable consumer would elect to spend that money elsewhere, paying down other debts, or putting it in savings.

III.
THE RULE WILL CAUSE IRREPARABLE HARM TO IRR AND MY RIGHTS

44. If the Rule is not enjoined, IRR will face substantial and irreparable harm. To comply with the Rule by March 17, 2025, IRR must expend significant money and time to make compliance changes, including rewriting policies and procedures, re-negotiating contracts with medical clients, employee training, and system updates. There will also be the cost of hiring legal

counsel if it becomes more difficult to collect, and there is a need for increased litigation. Hiring in-house or outside law firms, and the cost of litigation will likely exceed $10,000 dollars a year.

45. We may need to update computer programs and software, invest in different technologies, and renegotiate contracts with vendors and third parties to accommodate the changing nature of each and how they are covered by the FCRA. These all incur additional costs.

46. The Rule is set to take effect on March 17, 2025. The Rule represents a massive change, so small entities will need as much time as possible to take necessary measures to comply. It will be impossible for many small businesses, including my agency, to achieve full compliance with the Rule by that deadline and we will be at risk of fines, penalties, and enforcement action.

47. The Rule interferes with our ability to conduct efficient collections at the same volume as IRR currently collects, and therefore will also result in a reduction of revenue. IRR experienced a 40 % revenue drop when medical debt credit reporting was banned in New York State. To offset the limitations imposed by the Rule, I anticipate increased call campaigns. Under CFPB's Regulation F, it is possible to make seven calls in seven days. Many agencies, like mine, are currently under that limitation because we use a variety of tools to connect with consumers.

48. The Rule's limitation on options that have proven successful in delivering information to consumers will result in a focus on only calling or litigating. I anticipate hiring additional staff to make more phone calls and send more letters. In an environment where employment hiring is extremely challenging, it will be difficult to increase my staff within two months. I am concerned about attrition in current staff, by having limited resources due to loss of ability to collect. I need ample time to prepare my company and clients for such a large change.

49. All of the outlined compliance and costs burdens are exacerbated for small businesses, like mine, who have fewer staff and less in-house legal counsel. In some instances,

very specific client bases will be disproportionally impacted, and fewer resources will be available to devote to duplicative compliance requirements. As the CFPB has acknowledged, nearly 93% of companies in the debt collection industry fall within the definition of a "small business." It cannot be overstated that the Rule will have extremely detrimental effects for the debt collection industry and those they serve, including doctors and other healthcare providers.

50. For many small businesses, the Rule will result in their reduction or elimination. When compliance costs or revenue reduction become too burdensome, small businesses pay the highest price. They are often forced to reduce offerings or cut entire business lines and products. In the worst-case scenarios, they either go out of business completely, or are acquired by a larger company that can absorb the compliance burdens. This causes market and industry consolidation, where only the biggest companies, who already utilize vertical integration, can survive. Small businesses that operate using many vendors and third parties will simply be unable to compete.

51. Even for those small businesses and providers that survive, they may have insufficient staff or funding to be open full time. Consumers are the ultimate losers in this situation.

52. Finally, consumers will also be hurt by a system that allows them to overleverage themselves. When any type of creditor evaluates the creditworthiness of a potential borrower, they don't only observe repayment history and spending behaviors. They also look to understand the totality of a consumer's financial liabilities. If a payment obligation is not reflected in a consumer report, the debt-to-income ratio will be artificially deflated.

53. If there is no litigation over medical debts, the Rule would make medical debt payment voluntary. Given that litigation is expensive for all parties (including debt collectors), if litigation is never used as a substitute for the loss of credit reporting, the result would be a voluntary

payment system. Some consumers will pay their debts, as there are strong cultural norms for honoring debts. But lack of good consequences would quickly unravel the medical debt market.

54. If health providers cannot expect to be paid for their services, they will react to protect themselves by raising prices to account for losses due to uncollectable medical debt or refusing to seeing patients who require financing. They may require collateral or reject financing for patients whose credit scores are below a certain threshold. It's realistic to expect some mixture of these options to unfold in the market. Each scenario is inefficient and bad for consumers.

55. To reduce the risks and offset the costs created by the Rule, many small businesses, including IRR will likely reduce or restrict product and service offerings. For example, IRR has taken steps to reduce its collection of accounts that it receives after default, and is considering removing its offering of those services altogether. Given the regulation in this area, including the Rule, IRR is only able to meaningfully service first party accounts that it receives prior to default or that otherwise do not fall within the purview of the FDCPA.

56. Finally, my First Amendment rights will be irrevocably denied if this Rule is allowed to go into effect. I have a protected right to communicate truthful and accurate information. This Rule denies me that right.

57. The Rule's departure from existing standards creates significant hardship for IRR. It will both cost time and money when implemented, and will cost money to maintain, draining the finite resource of IRR staff time and funds.

Pursuant to Local Rules, I declare under penalty of perjury that the foregoing is true and correct.

Executed on January 17, 2025

/s/ Anita Manghisi
Anita Manghisi, President & CEO
Independent Recovery Resources, Inc.

EXHIBIT
4

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

ACA INTERNATIONAL and SPECIALIZED COLLECTION SYSTEMS, INC., Plaintiffs, v. CONSUMER FINANCIAL PROTECTION BUREAU; and ROHIT CHOPRA, in his official capacity as Director of the Consumer Financial Protection Bureau, Defendants.	Case No. 4:25-CV-00094

SWORN DECLARATION OF MEGAN HEBERT IN SUPPORT OF PLAINTIFFS' MOTION ON APPLICATION FOR PRELIMINARY INJUNCTION

I. INTRODUCTION

1. I, Megan Hebert, am the President and Chief Executive Officer of Specialized Collection Systems, Inc. ("SCS") based in Houston, Texas. SCS is a female-owned, 100% female-staffed small collection business specializing in the collection of medical debt. We at SCS believe medical debt collection is about informing patients of the existence of their account, providing account details, being a resource to answer questions, and offering them options to resolve their account. The Rule makes that work more burdensome and difficult.

2. I am over 18 years old and have personal knowledge of the facts sworn to herein and if called to testify, I could and would competently so testify. I submit this Declaration in support of ACA International and SCS's ("Plaintiffs") Complaint under the Administrative Procedure Act.

3. If the Consumer Financial Protection Bureau's ("CFPB") Final Rule regarding Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information, published in the Federal Register at 90 FR 3276 (the "Rule") becomes effective on March 17, 2025, my business will be irrevocably harmed. Those harms will, unfortunately, pass on to my healthcare provider clients and the patients and consumers that we ultimately serve.

A. <u>Summary of Testimony that Supports Vacating the Final Rule</u>

4. The Rule must be enjoined from taking effect on my business or I will face financial and asset losses that can never be recovered. My testimony provided here establishes the following facts in support of ACA and SCS:

- **Harm to Healthcare Providers**. Some of SCS's harms are passed onto healthcare providers who do not receive full payment for services rendered. This will affect all medical providers, but is especially true for specialties who often to not have contact with the patient during their treatment, such radiology, pathology, and anesthesiology. This creates adverse implications for providers and the healthcare system.

- **Harm to the Healthcare System.** The Rule will increase the number of medical accounts that go unpaid. Medical providers will lose revenue, which will ultimately increase the cost of healthcare. Practices with tight margins may close down or consolidate due to an increase in outstanding accounts receivable that cannot be recovered. This would be especially harmful to rural areas where there are not multiple medical providers. If those providers are forced to close down, there will be geographical areas with no immediate access to healthcare.

- **Now Cash Up-Front will Be Required.** The Rule will require healthcare providers to make up for that lost revenue by creating and implementing new operating procedures such as new payment requirements on patients. My healthcare clients will stop providing medical services prior to payment. Thus require more people to pay upfront for healthcare services.

- **Harm to Consumers**. Our Patient Payment Advisors work with consumers to establish reasonable and practical payment plans. The Rule restricts our ability to effectively and efficiently communicate with consumers.

B. Overview of Specialized Collection Systems, Inc.

5. SCS was founded in 1976 by Ken and Diane Akre, my parents. In founding SCS, my parents set out to provide collection services to often overlooked, smaller balance physician groups, such as radiology, pathology, and anesthesiology. My parents were committed to the idea of building a unique kind of collection service—one that empowers patients through respectful communication while addressing their experiences with understanding and care. That tradition continues today.

6. Our core healthcare specialties, radiology, pathology, and anesthesiology—continue to serve as the foundation of our client portfolio. Over time, we've expanded to support a wide range of specialties, including cardiology, medical centers, family practices, dermatology, and behavioral health, among others. From its founding, SCS has only ever been 100% medical collections—meaning we only collect on medical debt. Nothing else. We are a trusted resource for medical collections for hundreds of healthcare providers.

7. I am the sole owner of SCS after purchasing it from my father in 2017. I lead a wonderful team of 11—all of whom are women. My 100% female team is comprised of almost entirely working mothers. I am proud to share that my team has an average tenure of 15 years, demonstrating our deep expertise and unwavering commitment to excellence in our field.

8. SCS started offering credit reporting as part of our standard operating procedures in approximately 1989. In SCS's early years, letters in the mail and credit reporting were the only two outbound forms of communication SCS employed. This is different from most of the collection industry. At SCS, we do not make outbound calls. We never have.

9. As technology has advanced, we have added additional digital communication tools

to our operations while maintaining our weekly credit reporting updates. We strongly believe that it is our job to inform patients about their accounts and then allow the patient to select the communication channel that best fits their current need and situation. This allows patients to resolve their debt in a respectful nature. Our no-outbound-calling paired with credit reporting approach to collections has long been a distinguishing feature and a key factor in why providers select SCS as their trusted collection partner. Healthcare providers love knowing my team and my collection activity invites communication on the patient's schedule, yet still delivers positive results.

10. SCS has never hired a "collector." We named our call center team "Patient Payment Advisors." When patients call SCS, most of the conversation is spent educating patients about their account. A number of SCS accounts are resolved before SCS furnishes any credit report information. In these instances, consumers review their mail and respond in a short timeframe to either resolve the account or exercise their validation rights under the Fair Debt Collection Practices Act. Typically, the debt remains unpaid because there is confusion about the debt including: the patient has never personally interacted with the provider listed on the statement, the patient's contact information has changed since services were rendered, the patient mistakenly believes insurance covered the entire cost of the services provided, or there was a disconnect in the patient data transfer.

11. Our Patient Payment Advisors work to bridge any gaps in understanding between the patient and hospital billing or professional physician billing. Our Patient Payment Advisors inform patients about their responsibilities after third-party payors and other interventions (like charity assistance) occur and then work to settle the bill with the patient. Importantly, our Advisors are not compensated with a collection commission plan. In other words: what is collected does not

determine the financial success of any SCS employee. Our team's number one goal is to (1) provide information and then (2) resolve the account.

12. As my father would say: we prefer passive, yet effective, communication. But the Rule would eliminate that passive communication. The Rule will have devastating impacts on our business. First, we will lose the opportunity to directly and efficiently communicate with consumers through their credit reports and associated monitoring services. In many cases, the first meaningful and actionable interaction with a patient occurs when they proactively choose to review their credit report. Losing that vital communication channel will ultimately make the collection of the debt harder—which directly impacts our bottom line. Second, because we are losing such a major communication device, we will need to explore additional options to communicate with patients. This strikes at the heart of what makes SCS unique and will increase operational expenses. We pride ourselves on respecting a patient's autonomy by utilizing passive—rather than active—forms of communication. The Rule makes that much more difficult.

13. The Rule threatens SCS's bottom line and derails our business overnight. The economic impact is incalculable. Decades of standard operating procedures will need to be undone and retooled. This will require staff time and resources. The impact on our brand and reputation is even harder to predict. Our unique approach will be more difficult and more limited—and as a result, healthcare providers may choose to abandon the passive yet effective SCS method.

14. The impact on our business as a result will be irreparable. And it begins immediately. We will need to begin in earnest to make all of the changes I mentioned, expending money and resources immediately to attempt compliance with the Rule.

II.
THE RULE IS UNNECESSARY AND DIRECTLY HARMS SCS, PROVIDERS, AND CONSUMERS

A. The Rule's Restriction of Speech Directly Harms Me and SCS

15. In the simplest terms possible, the Rule will forbid SCS's longstanding practice of communicating about medical debt to consumers via the credit reporting channel. In addition, the Rule stops me and SCS from conveying truthful speech about past due medical accounts to creditors in the United States. The Rule thus violates my First Amendment right to convey truthful and accurate information both to consumers and other creditors. If this Rule is allowed to go into effect, the loss of my First Amendment rights will be both substantial and ongoing.

16. In every instance, SCS communicates with patients by email or letter (collectively "mail") before it furnishes information about medical debt to credit reporting agencies. But many consumers are unmotivated by mail for a variety of reasons, which may include:

a. Patients receive by mail a deluge of confusing information with multiple pages and fine print from providers and insurance companies, thus become trained to not view such mail as important or informative;

b. Patients often ignore (or do not open) bills and letters that explain their payment responsibility;

c. Providers and insurance companies may address correspondence to a patient instead of the responsible party;

d. Patients may not recognize the name of the provider because it is not their primary caregiver (e.g., radiologists or pathologists);

e. Patients may simply procrastinate until there is a clear consequence for non-payment.

17. For the subgroup of consumers who do not respond to mail, reporting the

outstanding debt to the credit reporting agency is a powerful, efficient, and passive tool to motivate a consumers' communication with SCS. When the debt is reported, the consumer is able to see—with their own eyes—the debt amount and understand quickly that it must be repaid. The reporting does not require SCS to make numerous calls to patients; nor does it require SCS to contact patients at work or at home. Instead, we are able to efficiently pass information from us to the patient in an established and regulated channel: the credit report.

18. Once patients see their debt, they can quickly and easily contact an SCS Patient Payment Advisor who can explain to them what the bill is and how the bill can be resolved. As I have explained, during patient calls, most of the call time is spent explaining the patient's responsibility and how insurance and other benefits were applied. Once we have established that information, our Advisors then guide the consumer through the process of settling the account.

19. If the Rule takes effect, SCS can no longer communicate with patients through credit reports. That avenue of communication will be entirely foreclosed. We will have fewer communication options, most of which may be more burdensome on the patient. Patients will be less likely to pay on debts that never hit their credit reports—meaning SCS is less likely to collect.

20. This impacts our bottom line. As of now, 63% of SCS's active clients—in other words, a majority of our business—rely on credit reports to communicate with consumers. For a rough estimate (and acknowledging that more work must be done to understand the Rule's impact on our business), I believe the Rule will result in a 20% decrease in collections, with greater decreases in certain specialties.

B. SCS Collects Accurate Medical Debt in Compliance with the FDCPA and FCRA and All Other Statutes and Regulations

21. The CFPB's primary rationale for the Rule is based on unsubstantiated information about patient complaints and disputes. Complaints and disputes do not prove that medical debt is

plagued with inaccuracy. For example, the Rule states that "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." Even if the data from the survey is reliable, the CFPB's conclusions from the survey do not take into consideration that many patients' belief that there is an error does not mean there is actually an error on their bill. This is especially true when patients receive a bill from a provider that works independently within a hospital system and the patient has no personal interaction with the provider.

22. SCS collects medical debts that are accurate and fairly owed. We have policies and procedures to ensure that medical debt accounts are accurate. Additionally, we have further policies to ensure that all patient communications reflect accurate account information, that our Patient Payment Advisors who communicate with consumers do so with accurate information, and that the information reported to credit bureaus is also accurate.

23. In my experience, when a patient disputes a medical debt, they usually need a better understanding. That is why our Advisors play such an important role. Common conversations between my Patient Payment Advisor and the consumer includes:

a. "This charge is separate from the hospital. The hospital charges for the use of the facility and the taking of the test. Your account with us is for the professional interpretation of the test."

b. "Your CT Scan has to be read by a board-certified Radiologist. Your primary care doctor cannot read results of your CT Scan; they are not trained or certified to do so."

c. "This account is from <doctors/provider group name>, they bill separately for their professional services."

d. "This account was not part of the bill you received from the Hospital, this is separate."

e. "Your insurance has already reviewed the charges, determined them to be valid, and paid their portion. The remaining balance is patient responsibility."

f. "It looks like the insurance has processed this, BCBS was $X, they paid $X and adjusted $X which left a patient responsibility of $X."

g. "I see that your insurance was billed and did process the claim but the balance of $X was applied towards your deductible or coinsurance."

24. Patient confusion is a common theme during calls across all healthcare specialty accounts. However, we see an increase in these instances when collecting for providers who, due to the nature of their field of medicine, may not have direct interactions with the patients they are treating and contributing to their care plans. For example, when a biopsy is conducted and a pathology report is run, the patient's surgeon or primary care provider may go over the results with the patient. But it is a pathologist who studies the disease and makes a diagnosis. Patients, though, may never know their pathologist's name. There is natural confusion when a bill comes from a physician that the patient is not familiar with, and that bill is often tossed aside. That's where SCS comes in. When the bill is not paid, we are brought in to help inform the patient of their obligations—even to doctors they may not know. Often, this simple act of education is enough to resolve the account.

25. In fact, less than 1% of SCS's disputed medical debts are actually inaccurate after an investigation following a patient dispute or inquiry.

26. Due to this experience, I do not find the CFPB's reliance upon counts of disputes

or complaints to be informative about accuracy problems in medical debt. Most consumers who complain are simply confused or misunderstand their accurate bill.

C. The Medical Debt Reporting Rule is Unnecessary

27. The FCRA already requires furnishers to report only complete and accurate data to the consumer reporting agencies. The FCRA also requires SCS to reinvestigate disputed information about medical debt. In addition, the credit reporting agencies also impose their own requirements and monitor credit furnishers for trends in the inaccuracy of reporting such as valid disputes. SCS has policies and procedures implementing these requirements that are laid out in an internal document made available to staff. The instructions include: "If an item is determined to be inaccurate, incomplete, or unverifiable, modify or delete the item in the consumer report or permanently block the reporting of that item."

28. Relatedly, the No Surprises Billing Act went into effect on January 1, 2022, which has already, and will continue to, reduce the level of emergency services costs and out-of-network insurance bills. This law further protects consumers from unexpected expenses and provides a consumer friendly appeal process in the event a consumer does receive a bill for which they believe they should not be responsible. Thus, the No Suprises Billing Act provides a two-fold protection system for consumers, making the CFPB's Rule here unnecessary.

29. Regulation F—which implements the FDCPA—also prevents inaccurate information from being furnished to CRAs. Regulation F says a debt collector must not furnish to a CRA information about a debt before the debt collector: (i) Speaks to the consumer about the debt; or (ii) Places a letter in the mail or sends an electronic message to the consumer about the debt and waits a reasonable period of time to receive a notice of undeliverability. 12 CFR § 1006.30(a)(1). Thus consumers may dispute the accuracy of an account with the debt collector before account information is furnished to a credit reporting agency.

30. This provision became effective January 19, 2021. Therefore the Rule, which relies on studies that predate this period, does not account for changes in practices that address this accuracy concern and that already prevent inaccurate medical debt credit reporting.

31. SCS complies with the requirements of Regulation F, and therefore consumers have adequate existing protection, making the Rule unnecessary.

32. Even if a consumer does not open mail or act to validate a debt prior to reporting, consumers have protections against inaccurate reporting under the FCRA. If SCS is unable to obtain debt validation and verify the account, it deletes the tradeline. And even if SCS was delayed in responding to a consumer's FCRA direct dispute, the CRAs themselves automatically delete the tradeline without further inquiry if they don't receive prompt verification from SCS.

D. SCS's Harm Will Be Passed On to Healthcare Providers

33. The credit system is a cohesive ecosystem—meaning few actions impacting one part of that ecosystem remain siloed. Instead, actions that impact collection will also impact healthcare providers. Unfortunately, this means that the harms the Rule imposes on SCS will eventually be passed onto our healthcare provider clients.

34. Patient billing begins with their insurance provider. If patients are unaware that their insurance company has already reviewed and processed the bill, they may overlook or delay payment to the healthcare provider. Many conversations between our Patient Payment Advisors and patients start with the common statement, "I thought my insurance covered this." This Rule would significantly limit our ability to educate patients and effectively resolve accounts on behalf of our clients. As previously mentioned, due to the complexities of healthcare, patient information may be incomplete or outdated. In such cases, utilizing an established and regulated channel like the credit report becomes a valuable tool for effective communication and account resolution.

35. SCS works with these physicians to explain to patients who these doctors are, what

services they provide, and how the patients can pay the debt. Because the Rule makes communicating with patients—or motivating their communication with SCS—harder for SCS, it follows that our clients will also suffer. These physicians who rely on SCS to explain who they are and what they do will be negatively impacted when SCS has its communications avenues blocked and collections curtailed.

36. The results may be far-reaching. If there is no recourse to unpaid debt, my medical provider clients will suffer—and so will their ability to provide lifesaving services. Take one of my (oncology) radiology providers. It costs over one million dollars to maintain, update, and replace an MRI scanner. Not having the operational funds to maintain and upgrade healthcare equipment could make the difference in a proper vs improper diagnosis. I have personally discussed with my clients how they spend the money they receive from SCS's services. These funds directly affect the quality of services that patients receive.

37. Moreover, if patients know there are no credit-based repercussions to not paying for healthcare services rendered, then providers will not have the revenue to staff their teams accordingly. This will cause delays in patient care because providers will not have sufficient staffing. That will impact office staff, nurses, and eventually physicians.

E. <u>The Rule Will Hurt the Same Consumers the Rule Seeks to Protect</u>

38. Ultimately, the harms from the Rule that start with SCS will wind up at the feet of patients. These harms will manifest in (1) reduced access to credit and healthcare services and (2) reduced access to information regarding patient obligations.

39. SCS has previously lost healthcare clients who determined they would rather charge upfront than collect payment after services are performed. This is a rational, market-based reaction to reduced revenues arising from patients' failure to pay.

40. I expect that many healthcare providers who currently allow their patients to receive

services prior to payment will change their policies in favor of pre-payment. If doctors and other healthcare workers are unable to collect payment after services have been rendered (or have their efforts substantially impaired or costs to collect increased), they will stop offering services in advance and will only provide services to those who can pay for them beforehand.

41. Prepayment requirements could create dire consequences:

a. People may not seek and receive preventative care;

b. People who cannot afford the out-of-pocket costs for care will be forced to use high-cost financing methods like credit cards, or worst case, forgo medical treatment altogether;

c. People who cannot pay for a procedure upfront will be denied access to care. What may have been a small or preventable issue could grow into a life-threatening emergency.

42. Not only are these people's health more at risk, but the cost of care will increase:

a. Because hospitals are not able to turn away life threatening emergencies, those providers are forced to absorb even higher costs of care (which otherwise could have been prevented);

b. These costs are passed onto society in the form of higher healthcare costs generally.

43. Contrary to the Rule's stated goal of reducing some of the healthcare burdens, the result of the Rule will exacerbate the issues that already exist in the healthcare industry.

44. Additionally, patients will be injured when a previously open avenue of communication about their payment obligations is foreclosed. We at SCS understand that no one wants to be in the position of owing medical debt. But our experience tells us that in most cases,

medical debts can be cleared through an informative conversation and a payment strategy. Credit reporting prompts those conversations and advances that strategy.

45. Patients may also see their settlement options dissipate. Due to increased costs of collection and reduction in remedies under the Rule, healthcare clients and agencies will likely reduce offerings for discounts and settlements.

III.
THE RULE WILL CAUSE IRREPARABLE HARM TO MY BUSINESS AND MY RIGHTS

46. If the Rule is not enjoined, SCS will face substantial and irreparable harm. To comply with the Rule by the implementation date, SCS must expend significant money and time to make compliance changes and communicate the nature and impact of these changes to our medical clients.

47. The Rule disrupts SCS's ability to conduct collections efficiently, in alignment with our core values, business model, and the expectations of our clients. Providers choose SCS for our unique service offerings, commitment to excellence, and proven collection processes and results. By removing a key communication and collection tool essential to healthcare collections, the Rule could result in up to a 20% decrease in collection activity across all active providers, with certain specialties experiencing even greater impact.

48. SCS will need to adjust its strategies to address this loss in revenue. Currently, the majority (63%) of SCS clients rely on credit reporting as an effective tool to communicate with and collect from their patients. The implementation of this Rule would cause an immediate decline in patient account resolutions, potentially even before its effective date. SCS has already started to field questions from patients who are now even more confused about what is happening with their account and what their responsibilities are to their provider. Patients who were previously motivated to fulfill their financial obligations may disengage, and SCS will lose a critical, safe,

and effective communication channel. As a result, I would be forced to make immediate reductions in payroll expenses, including potential layoffs or furloughs. My team is invaluable, demonstrating immense dedication to SCS, our clients, and the healthcare industry as a whole. Such measures would be devastating for the entire SCS team. I would also need to pursue significant reductions in operational expenses, including scaling back the use of key collection tools, removing certain patient communication channels from our collection portfolio, and downgrading to less effective technology—all in an effort to remain profitable. However, these measures would limit my ability to serve both providers and patients at the high level of effectiveness and quality we deliver today. Over the long term, this would hinder my ability to invest in technology upgrades and advanced collection tools, reduce opportunities for educational training for both myself and my team, and limit my capacity to hire highly qualified employees.

49. These harms begin now and do not wait for the implementation of the Rule. As I have said, immediate changes are necessary to comply with the Rule's short implementation timeline. This includes programming changes, payroll reductions, and procedural adjustments.

50. At a minimum, SCS would incur costs of $105,000 to implement procedures to comply with the Rule by March 17, 2025. These costs would include:

a. Programming to identify, sequester, and remove accounts from current credit reporting agencies.

b. Custom programming to ensure ongoing compliance of this Rule for all future accounts placed with SCS.

c. Removal of all refences to credit reporting from all patient communications; this includes all letter templates, text, emails, Chat Bot scripts, and patient payment portal notices.

d. Attorney approval of all outbound communication updates, and renegotiation to account for increase in E&O insurance cost and coverage.

e. Strategy meetings with third-party consultants and attorneys on how to try to maintain performance and service to clients, as well as exploration of collection

litigation as a credit reporting replacement strategy.

f. Third-party strategy meetings with collection law firms in various states to potentially contract with for clients that are forced to move to litigation as a collection tool.

g. Meet and contract with third-party telephone platform systems in anticipation of the need to start making outbound patient calls.

h. Modify and create new marketing materials removing Credit Reporting as a service offering.

i. Restructure and rewrite our entire policies and procedures to adapt collection strategies to remove credit reporting as a tool. Attorney approval of updated policies and procedures.

j. Create new training materials and training the entire SCS staff on SCS's new collection practices, new internal and external rules, policies and procedures.

k. Web design time to remove all mentions of credit reporting as a Patient communication tool and service available for SCS Clients and Prospects.

l. Formal communication to all clients, including travel expenses to Client to discuss the ramification of the new rule and consult on new collection strategies to assess loss of revenue and other potential strategies.

m. Training for SCS's billing partners and other revenue cycle teams that SCS partners with.

n. Time spent on the implementation of compliance with this Rule by myself, outside counsel, and compliance consultants.

51. Making matters worse, the Rule's implementation timeline is impossibly short. The Rule is set to take effect on March 17, 2025. The Rule represents a complete overhaul of collection strategies, so small entities like SCS will need as much time as possible to take necessary measures to comply.

52. Finally, my First Amendment rights will be irrevocably denied if this Rule is allowed to go into effect. I have a protected right to communicate truthful and accurate information. This Rule effectively limits my ability to do so. I also have a right to receive truthful and accurate communications (in the form of credit reports). This Rule denies me both of those

rights.

Pursuant to Local Rules, I declare under penalty of perjury that the foregoing is true and correct.

Executed on January 23, 2025.

/s/ Megan Hebert
Megan Hebert, President & CEO
Specialized Collection Systems, Inc.

EXHIBIT
5

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

ACA INTERNATIONAL

and

SPECIALIZED COLLECTION SYSTEMS, INC.,

Plaintiffs,

v.

CONSUMER FINANCIAL PROTECTION BUREAU; and ROHIT CHOPRA, in his official capacity as Director of the Consumer Financial Protection Bureau,

Defendants.

Case No. 4:25-CV-00094

SWORN DECLARATION OF SCOTT PURCELL
IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

1. I, Scott Purcell, am the CEO of ACA International ("ACA"). As CEO, I am responsible for ensuring that ACA serves the needs and interests of the membership pursuant to ACA's Bylaws and as directed by its Board of Directors, which is the primary policy-setting body of ACA. Additionally, I ensure that the programs, activities, and services of ACA directly benefit the members, the credit-and-collection industry, policymakers, and consumers.

2. I am over the age of 18 and have personal knowledge of the facts sworn to herein and if called to testify I could and would competently testify. I submit this Declaration in support

of ACA's and CBS's ("Plaintiffs") Motion for a Preliminary Injunction and Temporary Restraining Order.

3. If the CFPB's Final Rule regarding Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information, published in the Federal Register at 90 Fed. Reg. 3276 (the "Rule") becomes effective on March 17, 2025, ACA and ACA's creditor members will be irreversibly harmed with no opportunity for recompense.

4. ACA is a Minnesota corporation with offices in Washington, D.C. and Minneapolis, Minnesota. Founded in 1939, ACA represents approximately 1,600 members, including creditors, third-party collection agencies, law firms, asset-buying or debt-buying companies, and vendor affiliates. ACA provides a wide variety of products, services, and publications, including educational and compliance-related information; and articulates the values of the credit-and-collection industry to businesses, policymakers, and consumers.

5. ACA's primary purpose is to promote and maintain the highest standards of professionalism in the credit-and-collection industry. To that end, ACA represents its members' interests in the legislative and regulatory processes and addresses regulatory issues that are critical to members' success.

6. As the CEO of ACA, I frequently consult with members, and I am aware of federal and state laws and regulations that affect their credit-and-collection businesses, as well as the products and services, and publications, including educational and compliance-related information, that ACA provides to its members. In my tenure as CEO of ACA I have personally spent hundreds of hours learning about the businesses of our members, how their companies operate, the concerns of our members, and the challenges posed by regulations such as the Rule at issue in the instant lawsuit.

7. ACA's creditor members include many of the nation's largest banks and credit unions, among many other members that issue their own business-specific lines of credit. A comprehensive list of ACA creditor members is at: https://www.acainternational.org/directory/?t=creditor

8. ACA's creditor members rely on consumer reports (also known as credit reports) created by credit reporting agencies ("CRAs") when underwriting loans and other extensions of credit. Underwriting is a critical component of the credit process. It allows creditors to determine whether an individual is capable of paying back the extended credit. A complete, accurate view of an individual's credit is thus essential to the financial health of ACA's creditor members.

9. The CFPB claims that creditors' underwriting models will be minimally impacted by the Rule. But I know that many of ACA's creditor members use proprietary underwriting models that they keep well-guarded. The types of products that ACA members offer range widely, for example: mortgages, auto loans, appliance and technology financing, credit cards, utilities and telecommunications. Every creditor's underwriting model varies for the product, loan term, prepayment life-cycle, consumer risk pool, and ability of the creditor to tolerate losses, among countless other variables. Given the virtually unlimited permutations in underwriting models used by U.S. creditors, it is a vast overgeneralization and lacks credibility for the CFPB to say it thinks all underwriting models will be unaffected by the loss of medical debt information from their underwriting.

10. Because the Rule obstructs the reporting of accurate, truthful information regarding consumer medical debt, ACA's creditor members are unable to receive that information and use it to make underwriting decisions. The unfortunate result is that ACA's members will no longer have a holistic view of an individual's credit before extending lines of credit. This is bad for creditors

and bad for consumers.

11. For creditors (ACA's creditor members included), the Rule's limitations on accurate financial information regarding medical debts will introduce unnecessary risk when extending lines of credit. In effect, the Rule muddies the waters; it does not eliminate medical debt, it merely hides it. Creditors who extend credit to consumers they believe can repay the debts (but in fact cannot due to hidden medical debts) will be harmed when payments go unmade. These creditors will react in predictable ways designed to protect their institution's financial well-being: they will restrict credit, raise interest rates, and more aggressively pursue deficient consumers through default litigation.

12. Many creditors, including ACA creditor members submitted comments objecting to the Rule that explain in more detail my statements above. E.g., Cmt. CFPB-2024-0023-0996 from Iowa Credit Union League (Creating a prohibition that prevents Iowa credit unions from accessing medical debt information is detrimental to their operations); Cmt. CFPB-2024-0023-0347 (Comment from Community Bankers Association of Illinois opposing the Rule); Cmt. CFPB-2024-0023-0742 (opposing the Rule due to concern about faulty underwriting); Cmt. CFPB-2024-0023-0752 (same); Cmt. CFPB-2024-0023-0868 (same).

13. Moreover, the underwriting models used by ACA's creditor members to make underwriting decisions are not simplistic formulas that can be modified without expense. These models are proprietary pieces of information—often, they are the most valuable propriety information a creditor possesses. The models require fine-tuning and careful monitoring in order to ensure offers of new credit can be afforded by the borrower. Requiring creditors to change these models, by eliminating medical debt altogether, in 60 days requires significant resources and money.

14. ACA's creditor members must begin now to expend resources and money to bring their operations into compliance by the Rule's fast-approaching implementation date. The harms this Rule inflicts on ACA's creditor members thus begins now.

15. For consumers, the Rule will mean individuals who may appear to be capable of repaying debts (with no medical debt listed on their credit reports), are actually over-extended and cannot make the payments. These consumers will face default and the devastating consequences that follow.

16. ACA's collector members will lose revenue from medical accounts that are no longer placed with them. For example, one commenter explained:

> 1) Since the 3 credit reporting agencies stopped credit reporting balances under $500, my smaller medical clients (dental offices, private practices) have seen a BIG deduction in collections
> 2) For one particular client, we calculated that collections went from 43% to 12% in one year. This dental office is looking to merge with a larger group as they cannot keep taking hits to their ability to get paid.
> 3) In NY, we now have no consequence for not paying your medical bills: we can get a judgment, but cannot get a lien or garnish wages. We have heard multiple times that there are no consequences for not paying their medical bill, so they do not pay. We actually know of people that are discontinuing their health insurance since there is no consequence! THIS IS PROBLEMATIC!!!
> 4) There are multiple sources on TikTok and Instagram advising consumers that in NY since they do not credit report, there is no consequence for not paying their medical bill. The more people get away with not paying a bill, the more they will just not pay. Cmt. CFPB-2024-0023-0404.

17. This Rule may put many ACA debt collector members out of business entirely, which has a direct effect on ACA's revenue.

18. None of this is inevitable; all of this is caused by the Rule.

19. The Rule endangers the financial health of ACA's members and infringes on their First Amendment right to receive accurate commercial speech. To alleviate the harms inflicted, the Rule must be enjoined from taking effect.

Pursuant to Local Rules, I declare under penalty of perjury that the foregoing is true and correct. Executed on January 24, 2025.

/s/ Scott Purcell

Scott Purcell, CEO

ACA International

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF TEXAS, HOUSTON DIVISION

ACA INTERNATIONAL and SPECIALIZED COLLECTION SYSTEMS, INC. Plaintiffs, v. CONSUMER FINANCIAL PROTECTION BUREAU; and ROHIT CHOPRA, in his official capacity as Director of the Consumer Financial Protection Bureau, Defendants.	Case No. 4:25-cv-00094

ORDER FOR PRELIMINARY INJUNCTION

THIS MATTER comes before the Court on the Motion on Application for Preliminary Injunction ("Motion") filed by Plaintiffs ACA International ("ACA") and Specialized Collection Systems, Inc. ("SCS") (collectively, "Plaintiffs"). The Motion seeks an Order from the Court preliminarily enjoining Consumer Financial Protection Bureau ("CFPB") and its Director (combined "Defendants") from enacting and enforcing the Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information (the "Rule"), published in the Federal Register at 90 Fed. Reg. 3276, upon its effective date on March 17, 2025.

After consideration of the Motion and the Complaint, the Court determines that:

1. Pursuant to Fed. R. Civ. P. Rule 65(b), Plaintiffs have the express right to seek temporary injunctive relief from a court of competent jurisdiction pending hearing before a Judge;

2. Plaintiffs have alleged that immediate and irreparable injury, loss, and damage is threatened by the actions of Defendants, and Plaintiffs will suffer irreparable injury if the injunction is not granted;

3. The threatened injury to Plaintiffs outweighs any damage the injunction may cause Defendants;

4. The issuance of the injunction will not be adverse to the public's interest;

5. There is a substantial likelihood that Plaintiffs will prevail on the merits of their claims against Defendants;

6. Plaintiffs are prepared and capable of providing security for the requested relief. However, no such security is required;

7. Plaintiffs have notified Defendants of their request for a permanent injunction by personally serving Defendants and Defendants' counsel with a copy of Plaintiffs' Motion on Application for Preliminary Injunction; and

8. The order sought seeks to maintain the status quo between the parties by enjoining the enactment and enforcement of the Rule regarding Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information, published in the Federal Register at 90 Fed. Reg. 3276 until such time as the permanent application can be heard and issued.

Plaintiffs are therefore entitled to a preliminary injunction against Defendants until such time as this Court orders otherwise.

IT IS HEREBY ORDERED, ADJUDGED AND DECREED THAT:

1. A Preliminary Injunction issue immediately.

2. Defendants, their officers, agents, heirs, servants, employees, successors and assigns, and those persons in active concert, participation, or privity with them, or any of them, are enjoined from bringing any action under the standards proscribed by the Rule;

3. The Preliminary Injunction shall remain in place until an order dissolving such injunction is issued by this Court.

4. Plaintiffs are granted leave to commence discovery in aid of permanent injunction proceedings before the Court.

5. Defendant shall show cause before this Court on _____ day of _____, 2025 at _____ o'clock __a.m., or as soon thereafter as counsel may be heard, why a Permanent Injunction should not be ordered according to the terms and conditions set forth above.

DATED:_____, 2025

BY THE COURT:

_____
United States District Court Judge