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PULSE

Medical Debt Credit Reporting Rule Vacated by Federal Court

Health care providers and hospitals have received significant relief following a federal court ruling that completely nullified the Consumer Financial Protection Bureau's controversial medical debt credit reporting rule. This important decision protects the health care community from potentially devastating financial losses while preserving essential collection mechanisms.

On July 11, 2025, the U.S. District Court for the Eastern District of Texas delivered a decisive ruling in favor of health care providers by vacating the CFPB's medical debt credit reporting rule in its entirety. The court found that the rule:

- Exceeded the CFPB's statutory authority.
- Violated the Fair Credit Reporting Act.
- Was "contrary to law" under the Administrative Procedure Act.

The lawsuit, filed by Cornerstone Credit Union League and Consumer Data Industry Association in January 2025, successfully challenged the rule that would have removed medical debt information from consumer credit reports and prohibited lenders from using such information in credit decisions.

Massive Financial Impact Prevented

The stakes for health care providers were enormous. According to a commissioned report by Dr. Andrew Nigrinis for ACA International, the vacated rule would have caused:

- $24 billion in losses for medical providers in the first year alone.
- Potentially more than $972 billion in losses over 10 years.
- 8% decrease in medical account collections referred to third-party debt collectors.

This ruling prevents these catastrophic financial impacts from materializing, allowing health care providers to maintain essential revenue streams needed to continue providing patient care.

CFPB Abandons Related Advisory Opinion

In a related development, the CFPB has confirmed it will not reissue its problematic medical debt collection advisory opinion, which ACA had also challenged in federal court. The CFPB's filing acknowledged several fundamental flaws:

- **Lack of Clear Guidance:** The bureau admitted the advisory opinion provided only vague "examples" without clarifying compliance requirements. *Continued on pg 2*

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- **Improper Procedures:** The Office of Management and Budget determined the advisory opinion was actually a "major rule" requiring proper notice-and-comment procedures.
- **Costly Burden:** The CFPB recognized the guidance would impose "difficult and costly requirements" on medical debt collectors.

What This Means for Health care Providers

The problematic guidance that created compliance confusion has been permanently eliminated, and health care providers will avoid the "difficult and costly requirements" that the CFPB itself acknowledged.

Additionally, essential collection mechanisms remain intact, protecting health care providers' ability to recover legitimate debts.

The Path Forward

Health care providers should continue to monitor regulatory developments while taking comfort in knowing that proper legal challenges can successfully protect industry interests when agencies exceed their authority.

The complete repeal of the medical debt credit reporting rule represents a significant victory for health care providers and hospitals. By preserving essential collection mechanisms and preventing billions in losses, this ruling ensures that health care providers can continue focusing on their primary mission: delivering quality patient care while maintaining the financial stability necessary to sustain their operations.

The CFPB's acknowledgment of its regulatory overreach validates the importance of challenging improper agency actions and sets a positive precedent for future regulatory disputes affecting the health care industry.

Rhode Island Advances Medical Debt Collection Requirements

Note: This article was updated to correct the effective dates of the R.I. laws

Rhode Island Gov. Daniel McKee signed two measures on medical debt collection into law in July. The bills received overwhelming backing from the state legislature, passing with substantial majorities or unanimous approval.

Medical Debt Garnishment and Liens

Rhode Island joined other states focusing on medical debt legislation this year with the passage of S 0169/H 5184. The law takes effect Jan. 1, 2026.

Under the new law, debt collectors are prohibited from reporting medical debt to credit bureaus, garnishing a consumer's wages or salary, as well as issuing judgments against a consumer's primary residence based on medical debt.

Medical debt is defined in the law as "an obligation of a consumer to pay an amount for the receipt of health care services (as defined by Section 27-81-3), products or devices, owed to a health care facility or a health care professional (as defined by Sections 27-81-3 and 6-60-1)."

Medical Debt Interest

Rhode Island also passed an interest rate cap on medical debt, which carries the same definition as the law on medical debt credit reporting.

The law, S 0172, states, "Interest on medical debt shall be limited to the rate of interest equal to the weekly average one-year constant maturity Treasury yield, but not less than 1.5% percent per annum nor more than 4% per annum as published by the Board of Governors of the Federal Reserve System, for the calendar week preceding the date when the consumer was first provided with a bill."

The law took effect upon passage (June 26, 2025) but only applies to debts incurred after the effective date.

NEWS & NOTES

Insurers Rapidly Expanding Primary Care Ownership

Health insurers are significantly increasing their foothold in primary care delivery, particularly targeting Medicare Advantage markets, according to research published in Health Affairs Scholar. The study reveals that payer-operated practices now control 4.2% of the national Medicare primary care market by service volume in 2023, representing a five-fold increase from just 0.8% in 2016. This marks the first comprehensive analysis of insurer ownership patterns across physician practices nationwide. Researchers attribute this vertical consolidation to the profit potential of directing Medicare Advantage members to insurer-owned clinics, creating integrated delivery models that benefit plan sponsors.

Read more.

Individual Insurance Market Faces Major Contraction in 2026

The individual insurance market is poised for significant shrinkage starting in 2026 due to federal policy changes, HFMA reports. Despite recent growth driven by ACA enrollment surges — reaching a record 25.4 million people in nongroup plans by late 2024, including over 22 million subsidized enrollees — the market faces a dramatic reversal. Congressional Budget Office projected that over 8 million current marketplace enrollees could become uninsured by 2034, though this estimate may be slightly lower following recent legislative changes. This contraction threatens to reverse years of coverage gains and could significantly impact health care access for millions of Americans who rely on individual market plans.

Read more.

Digital Health Market Shows Strong Performance

Digital health venture capital funding reached $6.4 billion in the first half of 2025, demonstrating steady growth from $6 billion in H1 2024. Q2 alone generated $3.4 billion, exceeding the $2.6 billion quarterly average since early 2023, according to Fierce Healthcare. Despite economic uncertainty, the market shows maturity through key developments, including the IPO revival with Hinge Health and Omada Health going public, signaling renewed investor confidence. AI-enabled startups dominated funding, capturing 62% of venture capital dollars ($3.95 billion), reflecting strong investor enthusiasm for health care AI solutions and growing provider adoption of AI tools.

CMS Proposes Dual Conversion Factors for 2026 Physician Fee Schedule

The Centers for Medicare & Medicaid Services (CMS) unveiled its proposed 2026 physician fee schedule on July 14, introducing a significant structural change that will implement two separate conversion factors based on provider participation in alternative payment models.

Separate Rates for Different Provider Types

For the first time, according to Becker's Hospital Review, CMS will apply distinct conversion factors depending on whether physicians participate in qualifying alternative payment models (QPs). According to the CMS proposal, "QPs are clinicians who meet thresholds for participation in advanced APMs that promote quality and cost accountability."

The agency suggests increasing the QP conversion factor by 0.75%, while non-QP participants would see a more minor 0.25% increase. When combined with additional statutory adjustments, the QP conversion factor would reach $33.59, representing a 3.83% increase from the current $32.35. Non-QP providers would receive $33.42, marking a 3.62% increase.

Significant Policy Changes

Beyond payment adjustments, CMS proposes substantial modifications to service delivery and supervision requirements. The agency plans to streamline telehealth services by "removing the distinction between provisional and permanent status," focusing reviews solely on whether services can be delivered through real-time audio-video technology.

Additionally, CMS will permanently eliminate frequency limits on subsequent inpatient visits, nursing facility visits, and critical care consultations, providing greater flexibility for ongoing patient care.

Teaching Supervision Requirements Return

A notable change affects medical education settings. CMS proposes ending the temporary virtual supervision policy for teaching physicians, requiring in-person presence during key care components in metropolitan areas, while maintaining exceptions for rural areas.

DATAWATCH

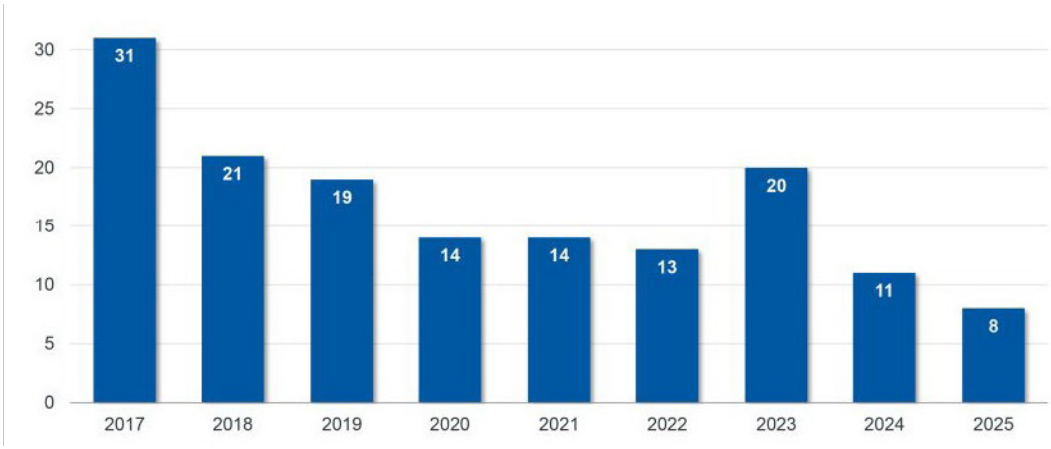
Hospital M&A Activity Slumps in Q2 Amid Policy Uncertainty

Health care consolidation activity remained subdued in the second quarter of 2025, with hospital and health system mergers and acquisitions continuing to face headwinds from policy uncertainty and economic pressures, according to a new report from KaufmanHall.

The second quarter saw eight announced transactions, representing a modest uptick from the five deals announced in Q1 2025. However, this activity level remains well below historical averages, reflecting ongoing market caution among healthcare organizations. Notably absent were any mega-mergers — transactions where the smaller party's annual revenue exceeds $1 billion. This absence pushed the average seller size down to $175 million, which Kaufman Hall characterized as "relatively low" compared to recent year-end averages.

Read the KaufmanHall report.

Number of Q2 announced transactions by year, 2018 - 2025



Source: *Kaufman, Hall & Associates, LLC*

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