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RX FOR COSTLY CREDIT: DEFERRED INTEREST MEDICAL CREDIT CARDS DO MORE HARM THAN GOOD

ALLISON J. ZIMMON*

Abstract: Various health care providers offer patients medical credit cards that charge high rates of deferred interest. As the cost of medical care and patient responsibility for out-of-pocket costs continue to rise, patients have turned to medical credit cards for help footing the bill. Unfortunately, because they fail to pay off their balances before the end of the promotional period, many patients find themselves unexpectedly responsible for deferred interest charges at rates well above those associated with general-purpose credit cards. Medical credit cards fall outside the protection of many federal credit laws regulating consumer credit. This Note argues that the Consumer Financial Protection Bureau (CFPB) should ban deferred interest medical credit cards through the exercise of its rulemaking power. Short of a total ban on deferred interest medical credit cards, the CFPB should use its rulemaking power to expand the reforms it recently levied on GE CareCredit to the entire medical credit card industry.

INTRODUCTION

Sixty-eight-year-old Alice Diltz, a part-time hospital aide, needed five dental implants.¹ The Hillside Dental Care clinic in Queens, New York quoted her a price of \$7450 in October 2005.² Diltz's insurance would only pay \$200 towards the bill.³ Diltz and her retired husband lived on \$18,000 each year from her part-time job and social security benefits.⁴ Diltz managed to pay \$250 up front for her implants, and signed up for what she thought was a payment plan administered by the clinic.⁵ Instead, Diltz had signed an application for a GE CareCredit deferred interest medical credit card.⁶ Although the paper was

* Managing Editor, BOSTON COLLEGE JOURNAL OF LAW & SOCIAL JUSTICE 2014–2015.

¹ Brian Grow & Robert Berner, *Fresh Pain for the Uninsured*, BLOOMBERG BUS. WK. (Nov. 21, 2007), http://www.businessweek.com/printer/articles/296038-fresh-pain-for-the-uninsured?type=old_article.

² *Id.*

³ *Id.*

⁴ *Id.*

⁵ *Id.*

⁶ *Id.*

labeled as a credit card application, the print was so small that Diltz never saw it.⁷ Clinic employees never told her she was applying for a credit card.⁸

After having her teeth pulled in preparation for the implants, Diltz experienced heavy bleeding.⁹ Frightened, she left the office and cancelled the implants four days later.¹⁰ To her surprise, she received a \$7000 bill from GE CareCredit several weeks later.¹¹ Even though Diltz's implants were never completed, GE CareCredit had paid the dental clinic upfront, and wanted to be repaid.¹² The bills kept arriving from GE CareCredit, even after Diltz disputed the charge.¹³ As interest accrued, her debt grew to over \$10,000.¹⁴ GE CareCredit sued Diltz in state court to recover what it claimed she owed.¹⁵ Only after *BusinessWeek*, a major national publication, inquired into her case did GE CareCredit agree to forgive Diltz's debt and remove it from her credit report.¹⁶

Diltz's medical credit card experience is replicated in medical, dental, ophthalmology, and audiology clinics across the country.¹⁷ Patients who cannot afford necessary treatment are steered by office staff toward deferred interest medical credit cards available right in their health care providers' offices.¹⁸ Often, patients do not realize that they are applying for a credit card.¹⁹ Even if

⁷ *Id.*

⁸ *Id.*

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Id.*

¹² *Id.*

¹³ *Id.*

¹⁴ *Id.* When Diltz did not pay the first bill she received, her 0% interest rate jumped immediately to 26.99% annually; consequently, her balance quickly grew from \$7000 to over \$10,000. *Id.*

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ Jessica Silver-Greenberg, *Patients Mired in Costly Credit from Doctors*, N.Y. TIMES, Oct. 14, 2013, at A1.

¹⁸ See Jim Hawkins, *Doctors as Bankers: Evidence from Fertility Markets*, 84 TUL. L. REV. 841, 859 (2010) (explaining that deferred interest medical credit card purveyors supply medical providers with promotional materials and train medical staff in sales techniques designed to entice patients into applying for credit); Lauren Horwitz, Note, *Medical Credit Cards: A Clash Between Physicians' Interests and Patients' Rights*, 42 LOY. L.A. L. REV. 807, 808 (2009) (noting that "[t]he dentist's office manager can even help [patients] contact the credit card company, submit the application, and recommend repayment options"); Silver-Greenberg, *supra* note 17 (describing the "growing number of health care professionals [that] are urging patients to pay for treatment not covered by their insurance plans with credit cards and lines of credits that can be arranged quickly in the provider's office").

¹⁹ See Hawkins, *supra* note 18, at 877–78. "In some cases, the description of credit is so vague that patients do not even know they are signing up for credit at all . . . [They] thought they were signing up for a payment plan with their doctors, but in actuality were applying for credit from third-party lenders." *Id.* at 878; see also Silver-Greenberg, *supra* note 17 (describing an elderly patient who did not realize he signed up for a GE CareCredit card during a dental visit); Kelly Dilworth, *Medical Credit Cards: Treatment Today, Payment Headaches Tomorrow*, FOX BUS. (Mar. 25, 2013), <http://>

they do understand what they are applying for, patients are often not sufficiently informed about the terms and conditions of the cards.²⁰ Specifically, they are frequently unaware that the full cost of their treatment will be charged to the card up front or that they will be responsible for interest charges going back to the first day of treatment if their entire balance is not paid in full before the end of the promotional “no interest” period.²¹ Interest rates of up to thirty percent may then attach to patients’ balances; before they realize the gravity of the commitment, these patients are in significant debt with little hope of being able to repay what is owed.²²

Deferred interest medical credit cards were first introduced to the marketplace in the early 2000s as a way to finance elective and often cosmetic surgery.²³ Yet, as patients’ out-of-pocket medical expenses for non-elective medical care skyrocketed, deferred interest medical credit cards were marketed to patients and medical providers alike as an easy solution to these out-of-control costs.²⁴ As of 2014, more than four million patients used medical credit cards.²⁵ The cards are most often used to finance dental care but increasingly

www.foxbusiness.com/personal-finance/2013/03/21/medical-credit-cards-treatment-today-payment-headaches-tomorrow/ (stating that “some consumers may not even realize that they’re taking out a loan from a third party and may assume that it’s their doctor’s office that’s offering the loan”).

²⁰ See Hawkins, *supra* note 18, at 877–79 (describing how doctors recommend lenders to patients without ever discussing the terms of the credit offer); Horwitz, *supra* note 18, at 813–14 (describing the promotional literature provided by the medical credit card providers as “general and incomplete”); Silver-Greenberg, *supra* note 17 (describing findings by New York Attorney General’s Office that patients who applied for GE CareCredit cards were “misled about the terms of the credit cards”). Many patients report that they “don’t realize their debts are being shifted to . . . interest-charging middlemen[.]” and instead believe that the financing is being provided directly by their physician. Grow & Berner, *supra* note 1.

²¹ See Hawkins, *supra* note 18, at 877–80; Horwitz, *supra* note 18, at 815–16; Silver-Greenberg, *supra* note 17; Grow & Berner, *supra* note 1.

²² See Silver-Greenberg, *supra* note 17; Dilworth, *supra* note 19; Helaine Olen, *The Medical Credit Card Trap*, AM. PROSPECT, Aug. 15, 2007, <http://prospect.org/article/medical-credit-card-trap>.

²³ See Silver-Greenberg, *supra* note 17; Mary Pat Whaley, *Using Medical Credit Cards: The Ugly, the Bad and the Good*, MANAGE MY PRAC. (Dec. 16, 2013), <http://managemyppractice.com/using-medical-credit-cards-the-ugly-the-bad-and-the-good>.

²⁴ See *Overdose of Debt*, CONSUMER REPS., July 2008, at 14, 15. According to the Federal Centers for Medicare and Medicaid Services (CMS), out-of-pocket medical payments will rise from \$269 billion in 2007 to \$464 billion by 2017. *Id.* Older Americans who rely on Medicare or private insurance plans that do not always cover their basic health care needs are heavy users of the cards. Silver-Greenberg, *supra* note 17; see also Grow & Berner, *supra* note 1 (“The pool of self-pay patients is mammoth: Some are among the nation’s 47 million uninsured; others are among the 16 million whose plans offer scant coverage or have deductibles as high as \$10,000.”).

²⁵ U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-14-570, CREDIT CARDS DESIGNED FOR MEDICAL SERVICES NOT COVERED BY INSURANCE 1 (2014), available at <http://www.gao.gov/assets/670/664244.pdf>.

are being used to pay health insurance deductibles or to pay for medical care by individuals who lack health insurance entirely.²⁶

As the use of medical credit cards rose, complaints began to pour into state attorneys general offices and, following its creation, into the federal Consumer Financial Protection Bureau (CFPB).²⁷ Patients complained that they were misled during the enrollment process into believing that the cards were interest-free.²⁸ In addition, patients reported that they never received written copies of the credit card agreements and instead had to rely upon medical office staff's oral representations of the cards' terms.²⁹

In late 2013, the CFPB ordered GE CareCredit, the largest provider of medical credit cards, to change the way its cards were marketed and distributed.³⁰ In addition, GE CareCredit was ordered to make a restitution payment of over thirty-four million dollars to consumers who unexpectedly incurred interest charges.³¹ Currently, these reforms apply only to GE CareCredit; it is unclear how, if at all, they may be applied to the industry as a whole.³²

Part I of this Note describes patients' increasing reliance on credit cards to pay for health expenses. It also explains the rise of the deferred interest medical credit card industry and the terms and conditions associated with the cards. Part II discusses the legal landscape supporting the rise of medical credit card usage, reforms within the credit card industry, and the creation of the consumer-focused CFPB. Additionally, Part II examines the reforms required by the Consent Order imposed by the CFPB on the medical credit card company GE CareCredit. Part III argues that deferred interest medical credit cards should be banned through CFPB rulemaking. It further argues that in the ab-

²⁶ *Id.* at 2–3, 7.

²⁷ See Michelle Andrews, *Be Skeptical of Health-Care Credit Cards*, WASH. POST, Aug. 31, 2010, at E4; Blake Ellis, *GE Capital to Pay \$34 Million to Credit Card Customers*, CNN MONEY, (Dec. 10, 2013), <http://money.cnn.com/2013/12/10/pf/ge-capital-credit-card-refund/>; Press Release, Consumer Fin. Bureau, *CFPB Orders GE CareCredit to Refund \$34.1 Million for Deceptive Health-Care Credit Card Enrollment* (Dec. 10, 2013) [hereinafter *CFPB Orders GE*], available at <http://www.consumerfinance.gov/newsroom/cfpb-orders-ge-carecredit-to-refund-34-1-million-for-deceptive-health-care-credit-card-enrollment/>; Press Release, N.Y. State Att'y Gen., *A.G. Schneiderman Announces Agreement with GE Capital Retail Bank and CareCredit LLC, Stopping High-Pressure Tactics in Health Credit Card Sales to Consumers* (June 3, 2013), available at <http://www.ag.ny.gov/press-release/ag-schneiderman-announces-agreement-ge-capital-retail-bank-and-carecredit-llc-stopping>.

²⁸ See Andrews, *supra* note 27; Ellis, *supra* note 27; *CFPB Orders GE*, *supra* note 27.

²⁹ See Andrews, *supra* note 27; Ellis, *supra* note 27; *CFPB Orders GE*, *supra* note 27.

³⁰ See GE Capital Retail Bank, CareCredit LLC, File No. 2013-CFPB-0009, at 1 (CFPB Dec. 10, 2013) (consent order) [hereinafter *Consent Order*]; *CFPB Orders GE*, *supra* note 27.

³¹ *Consent Order*, *supra* note 30, at 7; *CFPB Orders GE*, *supra* note 27.

³² See *Consent Order*, *supra* note 30; see also M. Elizabeth Magill, *Agency Choice of Policymaking Form*, 71 U. CHI. L. REV. 1383, 1386 (2004) (explaining that an agency can choose whether or not to engage in rulemaking, adjudication, or guidance and select the parties that will be impacted by its actions).

sence of a ban, current federal credit law must be amended. Lastly, Part III encourages the CFPB to educate physicians and medical providers about the financial products they offer to their patients.

I. PATIENTS AND PHYSICIANS LOOK FOR HELP IN THE FACE OF RISING OUT-OF-POCKET COSTS

The cost of medical care in the United States has risen steadily since the 1970s.³³ Over time, patients have assumed responsibility for a larger share of their health care costs.³⁴ Patients and health care providers, while searching for ways to finance patients' out-of-pocket expenses, have turned to medical credit cards for assistance.³⁵ The majority of medical credit cards are offered on a deferred interest basis.³⁶ If a patient is able to pay off the balance before the end of the promotional period, the patient can avoid interest charges.³⁷ Patients who are unable to pay off their entire balance before the end of the deferred interest promotional period often find themselves unexpectedly on the hook for high interest charged retroactively for the entire bill, regardless of the amount of the balance that the patient has already paid.³⁸

A. Medical Expenses Lead to Mounting Debt

Since Blue Cross and Blue Shield introduced health insurance in the first half of the twentieth century, the American health care landscape has been in flux.³⁹ As the system continues to evolve, one thing remains constant: both

³³ See generally SARA ROSENBAUM ET AL., *LAW AND THE AMERICAN HEALTH CARE SYSTEM* 199–205, 218–40 (2d ed. 2012).

³⁴ Mitch Patridge & Doug Barry, *Compassionate Patient Financing Can Cure a Hospital's Financial Ills*, 32(4) *J. HEALTH CARE FIN.* 88, 88–90 (2006); Alyssa Brown, *Costs Still Keep 30% of Americans from Getting Treatment*, GALLUP (Dec. 9, 2013), <http://www.gallup.com/poll/166178/costs-keep-americans-getting-treatment.aspx?version=print>; Olen, *supra* note 22; Silver-Greenberg, *supra* note 17; Amy Taub & Catherine Ruetschlin, *The Plastic Safety Net: Findings From the 2012 National Survey on Credit Card Debt of Low-and Middle-Income Households*, DEMOS 15–16, <http://www.demos.org/sites/default/files/publications/PlasticSafetyNet-Demos.pdf>.

³⁵ See Silver-Greenberg, *supra* note 17; Whaley, *supra* note 23.

³⁶ See Consent Order, *supra* note 30, at 3; *Overdose of Debt*, *supra* note 24, at 16; Silver-Greenberg, *supra* note 17.

³⁷ See Dilworth, *supra* note 19; Olen, *supra* note 22; Silver-Greenberg, *supra* note 17.

³⁸ See Dilworth, *supra* note 19; Olen, *supra* note 22; Silver-Greenberg, *supra* note 17.

³⁹ See ROSENBAUM ET AL., *supra* note 33, at 199. Hospitals and physicians established state-based, nonprofit corporations to sell health insurance plans open to all. *Id.* Hospitals created Blue Cross and physicians created Blue Shield. *Id.* Physicians and hospitals set the prices to be paid by Blue Cross and Blue Shield on behalf of patients. *Id.* After World War II, employment-based health insurance rose in prominence, and in 1965, Medicare and Medicaid were established to provide government-sponsored health insurance for the elderly and poor. *Id.* at 200, 202. The passage of the Patient Protection and Affordable Care Act of 2010 (ACA) ushered in more changes to the health care insurance and delivery system, and those changes continue to be implemented. *Id.* at 218–40; see also

insured and uninsured patients are responsible for a substantial portion of out-of-pocket health care costs.⁴⁰ Rising premiums and deductibles, coupled with reduced levels of coverage, require patients to reach deeper into their pockets to self-fund the care that they need.⁴¹ Out-of-pocket health care spending amounted to just over \$300 billion in 2011.⁴² Despite the increase in the number of Americans who will receive health insurance coverage in the coming years through the reforms made by the Patient Protection and Affordable Care Act (ACA), out-of-pocket health care spending is projected to rise to just under \$450 billion annually by 2021.⁴³ Patients are currently responsible for between

Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified in scattered sections of 42 U.S.C.).

⁴⁰ *National Health Expenditures Projections 2011–2021*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf> (last visited Mar. 31, 2015).

⁴¹ Partridge & Barry, *supra* note 34, at 88–90; Brown, *supra* note 34; Olen, *supra* note 22; Silver-Greenberg, *supra* note 17; Taub & Ruetschlin, *supra* note 34, at 15.

⁴² *National Health Expenditures Projections 2011–2021*, *supra* note 40.

⁴³ *Id.*; see also Patient Protection and Affordable Care Act, 42 U.S.C. §§ 300gg–300gg-28, 18001–18121 (2012). The ACA enacts several reforms that should make health care more affordable and accessible for many Americans. See 42 U.S.C. §§ 300gg–300gg-28, 18001–18121; Karen Pollitz, et al., *Medical Debt Among People with Health Insurance*, HENRY J. KAISER FAM. FOUND. 19 (2014) <http://kaiserfamilyfoundation.files.wordpress.com/2014/01/8537-medical-debt-among-people-with-health-insurance.pdf>. Health insurance providers under the ACA are no longer allowed to reject people with pre-existing conditions and dependents will be covered under their parents' plans until age twenty-six. 42 U.S.C. §§ 300gg–300gg-28, 18001–18121. The ACA also requires that certain insurance plans cover ten categories of essential health benefits (EHBs), which, while determined on a state-by-state basis, will include hospitalization, ambulatory care, rehabilitative and habilitative services, mental health care, and prescription drugs. *Id.* The ACA will also require health insurance plans to remove annual dollar limits on covered benefits. *Id.*

In addition to making patient-friendly changes to health insurance plans, the ACA also revises the tax code in ways that may reduce some patients' medical debt. 26 U.S.C. § 501(r) (2012). The revisions require non-profit hospitals to conduct community health needs assessments (CHNAs) every three years and make their plans to address those needs public, with hospitals that fail to meet their CHNA requirements subject to an annual \$50,000 tax. *Id.* §§ 501(r)(3), 4959. The new revisions also require hospitals to establish financial assistance policies that are widely publicized in the community served by the hospital. *Id.* § 501(r)(4)(A). Hospitals must also commit to providing emergency care without discriminating against patients eligible for financial assistance. *Id.* § 501(r)(4)(B). Hospitals will also no longer be allowed to charge patients who are eligible for financial assistance more than what they would charge a health insurance provider for the same care. *Id.* § 501(r)(5).

The ACA depends on individual states expanding their Medicaid programs to extend coverage to all low-income non-elderly adults with family incomes below 138% of the federal poverty line. *How Will the Uninsured Fare Under the Affordable Care Act?*, HENRY J. KAISER FAM. FOUND. (Apr. 7, 2014), <http://kaiserfamilyfoundation.files.wordpress.com/2014/04/8531-how-will-the-uninsured-fare-under-the-aca.pdf>. As of August 28, 2014, only twenty-seven states and the District of Columbia have expanded their Medicaid programs. *Status of State Action on the Medicaid Expansion Decision*, HENRY J. KAISER FAM. FOUND. (Aug. 28, 2014), <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>. Twenty-one states have refused to expand their programs and two states are actively debating whether to participate. *Id.* In states that fail to expand their Medicaid programs, non-elderly, low-income adults will continue to lack insurance coverage

twenty and thirty-five percent of every dollar of health care services they receive.⁴⁴

The rise of out-of-pocket medical costs has occurred alongside an explosion of the credit card industry.⁴⁵ According to the U.S. Census Bureau, 156 million Americans held credit cards in 2009.⁴⁶ Thirty percent of Americans pay only the minimum monthly balance due on their credit cards.⁴⁷ In 2012, the average credit card debt among low- and middle-income households was just over seven thousand dollars.⁴⁸ In 2012, forty percent of low- and middle-income families used credit cards to pay for basic living expenses, including housing, food, and utilities.⁴⁹ Credit card use is high across all age brackets, but Americans age sixty-five and older carry the highest average balance: over nine thousand dollars.⁵⁰

Unsurprisingly, patients often resort to using their general-purpose credit cards to pay for out-of-pocket medical expenses.⁵¹ In 2010, Americans charged almost forty-five billion dollars in health care costs to their general-purpose credit cards.⁵² This amount is expected to rise to \$150 billion by 2015.⁵³ Almost fifty percent of families carried debt from out-of-pocket medical expenses in 2012, averaging \$1678 per household.⁵⁴ Medical debt, either charged to credit cards or owed directly to physicians or medical providers, is a significant driver of personal bankruptcies.⁵⁵ Sadly, those with medical debt are less likely to obtain necessary medical care due to the fear of falling deeper into

through Medicaid. *How Will the Uninsured Fare Under the Affordable Care Act?*, *supra*. More than sixty percent of America's working poor live in states that have refused to expand Medicaid. Sabrina Tavernise & Robert Gebeloff, *Millions of Poor Are Left Uncovered by Health Law*, N.Y. TIMES, Oct. 3, 2013, at A1.

⁴⁴ See Whaley, *supra* note 23. A patient's responsibility for health care costs under an insurance plan regulated by the ACA fluctuates depending on whether the person gets the plan through an employer or through the individual market, the employee's income level, and the plan level chosen (for example, bronze, silver, or gold level plans). Jayne O'Donnell & Paul Overberg, *Medical Debt Will Persist Despite Health Law*, U.S.A. TODAY, Jan. 15, 2014, at B1.

⁴⁵ See Oren Bar-Gill, *Seduction by Plastic*, 98 NW. U. L. REV. 1373, 1373, 1383 (2004).

⁴⁶ U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES, TABLE 1188, at 740 (2012).

⁴⁷ Taub & Ruetschlin, *supra* note 34, at 13.

⁴⁸ *Id.* at 6.

⁴⁹ *Id.* at 9.

⁵⁰ *Id.* at 6.

⁵¹ *Overdose of Debt*, *supra* note 24, at 15; Silver-Greenberg, *supra* note 17.

⁵² *Overdose of Debt*, *supra* note 24, at 15; Silver-Greenberg, *supra* note 17.

⁵³ *Overdose of Debt*, *supra* note 24, at 15.

⁵⁴ Taub & Ruetschlin, *supra* note 34, at 16.

⁵⁵ David U. Himmelstein et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED. 741, 741 (2009). In 2007, illness or medical bills contributed to sixty-two percent of all bankruptcies. *Id.*

debt.⁵⁶ In 2012, half of all households with medical debt reported forgoing medical treatments and tests and filling prescriptions.⁵⁷

Health care providers have long been keenly aware of the financial difficulties that patients face.⁵⁸ Until recently, most health care providers attempted to assist their patients by routinely offering long-term payment plans for expensive treatments.⁵⁹ These payment plans, administered by the doctor's office, allowed patients to stretch out their payments over time, without incurring fees or interest.⁶⁰ Yet these plans proved expensive for providers, who assumed the cost of administering the payment plans and associated billing and record-keeping.⁶¹ Doctor-administered payment plans can cost medical practices at least three dollars per bill, and thus physicians often lose money attempting to recover what is owed.⁶² Hospitals who hire collection specialists to collect long overdue debts often only recover around ten cents on every dollar owed and end up paying the collection companies between thirty and forty percent of what is collected.⁶³ In addition, providers are often reluctant to engage collection agencies to collect debts from patients because once they do so, the providers often lose these patients.⁶⁴ Short of resorting to collections, however, providers find themselves without the means to collect what they are owed.⁶⁵

B. The Advent of Medical Credit Cards

Patients' need to finance their out-of-pocket health care costs and providers' dissatisfaction with collecting debts from their patients created an oppor-

⁵⁶ Melissa B. Jacoby & Mirya Holman, *Managing Medical Bills on the Brink of Bankruptcy*, 10 YALE J. HEALTH POL'Y L. & ETHICS 239, 247 (2010); Taub & Ruetschlin, *supra* note 34, at 16.

⁵⁷ Taub & Ruetschlin, *supra* note 34, at 16.

⁵⁸ Pamela Lewis Dolan, *Collecting the Patient Portion: Being Proactive, Early and Often*, AM. MED. NEWS, Apr. 2, 2007, at 18, 19. A practice management professional noted that "[b]ecause a doctor can't un-fix a patient, medical bills are often the last to get paid . . ." *Id.*

⁵⁹ Hawkins, *supra* note 18, at 847–50 (describing how many physicians extend credit to patients by allowing them to pay for treatments over an extended period of time); Dave Hansen, *Giving Credit to Get What's Due: How Doctors Can Help Patients Pay the Bill*, AM. MED. NEWS, Jan. 21, 2008, at 15, 15. As Hansen points out, "[w]ith more Americans uninsured or in high-deductible plans, experts say collecting the payment portion of bills is getting more important—and challenging—for physicians' practices. One solution many recommend to avoid the high cost and hassle of collection is setting up payment plans for patients." *Id.*

⁶⁰ Hawkins, *supra* note 18, at 848.

⁶¹ Dolan, *supra* note 58, at 19; Pamela Moore, *Billing and Collections: Playing Hardball*, PHYSICIANS PRACTICE, Apr. 1, 2008, at 57, 61.

⁶² Dolan, *supra* note 58, at 19.

⁶³ Hansen, *supra* note 59, at 15; Grow & Berner, *supra* note 1.

⁶⁴ Dolan, *supra* note 58, at 19.

⁶⁵ See Dolan, *supra* note 58, at 19; Hansen, *supra* note 59, at 15–16; Moore, *supra* note 61, at 57 (noting that "[a]s overdue patient accounts stack up, more physicians feel like they're playing the patsy").

tunity for a new kind of financing: deferred interest medical credit cards.⁶⁶ Big names in the finance industry, including General Electric, Citibank, and Capital One, first offered medical credit cards in the early 2000s to help patients finance elective procedures such as cosmetic surgery.⁶⁷ Those same companies saw that patients who were experiencing difficulty financing non-elective care were an untapped market.⁶⁸ Accordingly, these creditors stepped in and began heavily marketing medical credit cards to providers and patients alike.⁶⁹ Providers were quick to embrace this new service because doctors who offer a third-party medical credit card to their patients no longer bear the burden of providing a self-financed payment plan.⁷⁰

Signing up for a medical credit card is simple.⁷¹ When patients indicate that they will have difficulty paying for proposed medical treatments or services, medical office staff can assist them with applying for a medical credit card right in the office.⁷² The application process often runs through the office's own computer system and patients receive immediate approval, frequently without a credit check.⁷³ In just minutes, the health care provider brokers a deal for the patient with a third-party creditor—usually without the patient communicating with anyone from the credit card company—and subsequently casts off all responsibility for collecting fees from the patient.⁷⁴

⁶⁶ See Hansen, *supra* note 59, at 16; Moore, *supra* note 61, at 59; Silver-Greenberg, *supra* note 17; Whaley, *supra* note 23.

⁶⁷ See Silver-Greenberg, *supra* note 17; Grow & Berner, *supra* note 1; Whaley, *supra* note 23.

⁶⁸ See *Overdose of Debt*, *supra* note 24, at 14–15; Silver-Greenberg, *supra* note 17; Grow & Berner, *supra* note 1.

⁶⁹ See *Overdose of Debt*, *supra* note 24, at 15–16; Silver-Greenberg, *supra* note 17; Grow & Berner, *supra* note 1.

⁷⁰ See Hawkins, *supra* note 18, at 865–66; Partridge & Barry, *supra* note 34, at 90; Moore, *supra* note 61, at 58 (citing consultant Judy Capko: “If a patient does owe you money, try to have him put his balance on a credit card or use a credit agency such as CareCredit that extends credit lines to patients. You get paid in full, and the patient can work out his troubles with someone else.”); *Overdose of Debt*, *supra* note 24, at 18 (noting that “31 state medical and veterinary associations and 11 national groups, including the American Dental Association, American College of Eye Surgeons, American Society of Plastic Surgeons, [and] American Society of Bariatric Physicians” endorse GE CareCredit); Silver-Greenberg, *supra* note 17; Grow & Berner, *supra* note 1.

⁷¹ See Hawkins, *supra* note 18, at 860; Horwitz, *supra* note 18, at 808, 814; Silver-Greenberg, *supra* note 17; Dilworth, *supra* note 19.

⁷² See Hawkins, *supra* note 18, at 860; Horwitz, *supra* note 18, at 808, 814; Silver-Greenberg, *supra* note 17.

⁷³ See Silver-Greenberg, *supra* note 17; Dilworth, *supra* note 19.

⁷⁴ See Consent Order, *supra* note 30, at 4. Some patients apply for the cards outside of the health care provider's office by enrolling through GE CareCredit's website directly. *Id.*; Hawkins, *supra* note 18, at 866; Horwitz, *supra* note 18, at 814; Silver-Greenberg, *supra* note 17.

Medical credit cards differ from general-purpose credit cards.⁷⁵ Most may only be used at the medical provider's office or hospital where services will be performed.⁷⁶ In addition, most medical credit cards present patients with a choice of two payment plans: traditional fixed payment plans, where interest attaches if the balance is not paid in full, and deferred interest, or promotional, plans.⁷⁷ Deferred interest plans offer a temporary no-interest promotional period, generally from six to eighteen months, during which patients can pay off their balances without incurring any interest or fees.⁷⁸ If patients continue to carry a balance once the no-interest period ends, the credit card provider charges interest retroactively to the original day of the charge for the entire amount originally charged, even if a portion was already paid.⁷⁹ The interest rates charged on deferred interest plans are often extremely high, ranging from twenty-five to thirty percent.⁸⁰ In addition, patients are subject to late fees and penalties that often include an increase in the already high interest rates.⁸¹ Generally, medical credit cards allow and encourage health care providers to charge patients for the entire projected cost of treatment upfront.⁸² Patients are therefore responsible for paying interest on the entire cost of their care, sometimes before the care is even administered or completed.⁸³

⁷⁵ See *Risk Management Examination Manual of Credit Card Activities*, FED. DEPOSIT INS. CORP. 12–14 (Mar. 2007), https://www.fdic.gov/regulations/examinations/credit_card/pdf_version/ch2.pdf (defining “general purpose” credit cards as ones that “can be used at a variety of stores and businesses”). Medical credit cards are considered to be “proprietary cards.” *Id.* at 13–14.

⁷⁶ See *id.* at 13. Medical credit cards are also known as “private label cards.” *Id.* Private label cards have lower credit limits and higher interest rates than general-purpose cards. *Id.* Also, private label cards are often made available to borrowers who pose a higher risk to creditors. *Id.*

⁷⁷ See Consent Order, *supra* note 30, at 3; *Overdose of Debt*, *supra* note 24, at 16; Silver-Greenberg, *supra* note 17.

⁷⁸ See Consent Order, *supra* note 30, at 3; *Overdose of Debt*, *supra* note 24, at 16; Silver-Greenberg, *supra* note 17.

⁷⁹ See Silver-Greenberg, *supra* note 17; Dilworth, *supra* note 19; Olen, *supra* note 22.

⁸⁰ See Silver-Greenberg, *supra* note 17; Dilworth, *supra* note 19; Olen, *supra* note 22.

⁸¹ See CONSUMER FIN. PROT. BUREAU, CARD ACT REPORT 32 (2013), http://files.consumerfinance.gov/f/201309_cfpb_card-act-report.pdf [hereinafter CARD ACT REPORT]. The prevailing interest rate for general-purpose credit cards in 2012 was 12.9%. *Id.*; see also Silver-Greenberg, *supra* note 17.

⁸² See *Overdose of Debt*, *supra* note 24, at 16 (citing GE CareCredit brochure received by a New York area dentist urging him to “offer the plan so [he could] get immediate payment”); Silver-Greenberg, *supra* note 17 (noting that medical credit card companies promote upfront payment in their marketing materials to medical providers). “[T]he transformation of medical bills into consumer debt means quicker cash for medical providers . . .” Grow & Berner, *supra* note 1.

⁸³ See *Overdose of Debt*, *supra* note 24, at 16–17 (describing how a dentist encouraged a mother to apply for a medical credit card to pay for her daughter's dental work; the work was subsequently cancelled but the dentist took months to refund the money to the mother); Silver-Greenberg, *supra* note 17 (describing how a dental clinic encouraged an elderly patient to apply for a medical credit card, charged the full amount of the patient's dentures on the card, and never provided functional dentures to the patient); Grow & Berner, *supra* note 1 (describing how a dentist encouraged an elderly

Although medical credit card providers are eager to tap into the vast market of patients who need financial assistance, they do not pay for market access.⁸⁴ Instead, health care providers pay credit card providers to offer the cards to their patients.⁸⁵ While regular retail merchants pay a processing fee or a merchant discount rate of less than 2% of each charge, health care providers pay a great deal more, often over 13% per charge.⁸⁶ Health care providers pay less, however, when they steer patients to arrangements that benefit the creditor.⁸⁷ For example, if a patient agreed to a no-interest, eighteen-month payment plan with a GE CareCredit card, a health care provider would pay a processing fee of 13.5%.⁸⁸ If that same patient instead agreed to an extended-payment plan over two to five years with an annual interest rate of 11.9%, a more lucrative plan for the creditor, the health care provider's processing fee is reduced to 5%.⁸⁹ This arrangement encourages health care providers to promote self-interested payment plans regardless of whether that plan is the most prudent choice for that particular patient.⁹⁰

Aside from the savings gained from shifting the financing, billing, and collection burden to medical credit card providers, health care providers reap additional tangible and intangible benefits from medical credit cards.⁹¹ The availability of easy financing makes patients more likely to agree to costly treatments that they would not otherwise be able to afford.⁹² Unlike health insurance or out-of-pocket payment, medical credit cards remit the entire charge to the health care provider within a day or two, even if the care or treatment has yet to be provided.⁹³ Finally, the medical credit card companies provide

patient to apply for what she thought was an installment plan administered by the dentist's office but was in fact a medical credit card, then charged the card for the full amount for dental implants despite the patient cancelling the remaining work).

⁸⁴ See Hawkins, *supra* note 18, at 864; *Overdose of Debt*, *supra* note 24, at 16.

⁸⁵ See Hawkins, *supra* note 18, at 864; *Overdose of Debt*, *supra* note 24, at 16.

⁸⁶ See *Overdose of Debt*, *supra* note 24, at 16.

⁸⁷ See *id.*

⁸⁸ See *id.*

⁸⁹ See *id.*

⁹⁰ See *id.* Doctors can recruit more patients by paying medical lenders to provide credit to potential patients. Hawkins, *supra* note 18, at 865.

⁹¹ See Hawkins, *supra* note 18, at 864–65; *Overdose of Debt*, *supra* note 24, at 15; Silver-Greenberg, *supra* note 17.

⁹² See Hawkins, *supra* note 18, at 865 (noting that creditors appeal to doctors by emphasizing the increase in business that will result from offering medical credit cards and that doctors who offer the cards do report a substantial increase in sales); *Overdose of Debt*, *supra* note 24, at 15 (noting that one medical credit card provider, ChaseHealthAdvance, promotes its cards to medical providers by promoting the cards' tendency to influence patients to "book full comprehensive treatment plans") (internal quotations omitted); Silver-Greenberg, *supra* note 17 (stating that medical providers are motivated to promote the medical credit cards because patients will then choose to undergo procedures and products that are not covered by insurance that they would otherwise forgo).

⁹³ See *Overdose of Debt*, *supra* note 24, at 14; Silver-Greenberg, *supra* note 17.

sales and marketing training for medical office staff, promotional materials explaining the cards, and application software to the health care providers at no charge.⁹⁴

Aside from these financial benefits, health care providers often accrue goodwill from patients who are grateful for the availability of easy credit.⁹⁵ Although bills were formerly issued directly by the health care provider, medical credit card bills come from the financial institution.⁹⁶ Patients interact with staff from the financial institution when they have billing questions.⁹⁷ Medical office staff and, by extension, medical providers are no longer seen in the patient's eyes as a bill collector to be avoided and loathed.⁹⁸ Although the level of intangible benefit to the health care provider is difficult to quantify, medical credit cards certainly change the relationship between patient and provider.⁹⁹

C. Side Effects of Medical Credit Cards

Although to health care providers medical credit cards seem like a winning solution, the picture is not always as rosy from the patient's perspective.¹⁰⁰ Unlike a typical consumer situation, where a customer may open a credit card at a retail store, patients are often in pain, anxious, and in desperate need of health care when they apply for medical credit cards.¹⁰¹ Many of these

⁹⁴ See Hawkins, *supra* note 18, at 859; Horwitz, *supra* note 18, at 813–14. For example, Capital One trained fertility clinic staff to present loans in ways designed to increase patient interest. See Hawkins, *supra* note 18, at 859. In particular, staff were encouraged to present monthly payment amounts to patients rather than use larger, more daunting, figures. *Id.*

⁹⁵ See Hawkins, *supra* note 18, at 860; Silver-Greenberg, *supra* note 17; Dilworth, *supra* note 19.

⁹⁶ See Hawkins, *supra* note 18, at 866; Moore, *supra* note 61, at 58.

⁹⁷ See Hawkins, *supra* note 18, at 866; Moore, *supra* note 61, at 58.

⁹⁸ See Hawkins, *supra* note 18, at 854, 866.

⁹⁹ See *id.* at 866; Silver-Greenberg, *supra* note 17.

¹⁰⁰ See *Overdose of Debt*, *supra* note 24, at 14, 16; Silver-Greenberg, *supra* note 17; Dilworth, *supra* note 19; Grow & Berner, *supra* note 1.

¹⁰¹ See Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 650–53 (2007–2008) (quoting Raymond Tallis, *Commentary: Leave Well Alone*, 318 BRIT. MED. J. 1756, 1757 (1999)). Tallis described the vulnerable state of many patients as follows:

Someone who is ill and seeking help—unlike someone who is purchasing a pair of socks or a pound of sausages—is often vulnerable, certainly worried, sometimes uncomfortable, and frequently frightened. [The term c]ustomer, like the other obvious choices—clients, consumers, and users—erases something that lies at the heart of medicine: compassion and a relationship of trust.

Id.; see also *Overdose of Debt*, *supra* note 24, at 15; Silver-Greenberg, *supra* note 17; Dilworth, *supra* note 19; Grow & Berner, *supra* note 1. Credit card contracts may be considered to be adhesion contracts in that they are “drafted unilaterally by a business enterprise and forced upon an unwilling and often unknowing public for services that cannot readily be obtained elsewhere.” *Jones v. Dressel*, 623 P.2d 370, 374 (Colo. 1981). Contracts of adhesion often impose terms on a “take it or leave it” basis

patients are also elderly and less able to make complex financial decisions due to the effects of aging.¹⁰² Moreover, many Americans, regardless of age, have very little understanding of how credit works.¹⁰³ In their vulnerable state, patients are even less likely than the average consumer to comprehend the terms of medical credit cards.¹⁰⁴ Faced with the need to receive treatment, these patients are unlikely to shop around and consider other sources of financing.¹⁰⁵ Moreover, because medical office staff, whose primary expertise is not in credit card services, explain the terms of medical credit cards, many patients walk away confused or ignorant about their newly assumed responsibility.¹⁰⁶ It is telling that many patients who applied for medical credit cards reported that they did not even realize that they were applying for credit provided by a third-party; instead they believed they were requesting a payment plan provided by the doctor's office.¹⁰⁷

Aside from medical credit cards, consumers often make irrational credit choices.¹⁰⁸ For example, consumers often carry balances on high-interest credit cards while keeping money in the bank earning minimal interest.¹⁰⁹ As patients, consumers often replicate this irrational behavior.¹¹⁰ Patients are often unreasonably optimistic about their ability to repay their debts before the no-interest period ends.¹¹¹ As a result many patients decide to take out loans, disregarding eventual interest rates because they do not believe they will continue to carry a balance past the no-interest period.¹¹²

and are often considered to be unfair. *Id.* Under certain circumstances, courts will refuse to enforce adhesion contracts for reasons of public policy. *Id.*; Fredric S. Newman, § 8.06[A] *Characteristics of Contracts of Adhesion*, in *COMMERCIAL CONTRACTS: STRATEGIES FOR DRAFTING AND NEGOTIATING* 8-1 (Vladimir R. Rossman & Morton Moskin, eds., 2014).

¹⁰² See Silver-Greenberg, *supra* note 17.

¹⁰³ See Oren Bar-Gill & Elizabeth Warren, *Making Credit Safer*, 157 U. PA. L. REV. 1, 27 (2008) (citing *Frequency Questionnaire*, CTR. FOR AM. PROGRESS ET AL. 8 (2006), http://cdn.americanprogress.org/wp-content/uploads/kf/DEBT_SURVEY_FREQUENCY_QUESTIONNAIRE.PDF) (explaining that “[A] recent study by the Center for American Progress and the Center for Responsible Lending found that 38% of consumers believe that ‘[m]ost financial products such as mortgage loans and credit cards are too complicated and lengthy for [them] to fully understand.’”).

¹⁰⁴ See Hall & Schneider, *supra* note 101, at 650; Hawkins, *supra* note 18, at 875–76; Silver-Greenberg, *supra* note 17.

¹⁰⁵ See Hall & Schneider, *supra* note 101, at 652; Hawkins, *supra* note 18, at 876; Grow & Berner, *supra* note 1.

¹⁰⁶ See Hawkins, *supra* note 18, at 877–79; Horwitz, *supra* note 18, at 813–14; Silver-Greenberg, *supra* note 17; Grow & Berner, *supra* note 1.

¹⁰⁷ See Hawkins, *supra* note 18, at 877–78; Silver-Greenberg, *supra* note 17; Dilworth, *supra* note 19.

¹⁰⁸ See Bar-Gill & Warren, *supra* note 103, at 21, 35.

¹⁰⁹ See *id.* at 35.

¹¹⁰ See Hawkins, *supra* note 18, at 875–76, 880.

¹¹¹ See Bar-Gill & Warren, *supra* note 103, at 34; Hawkins, *supra* note 18, at 880.

¹¹² See Bar-Gill & Warren, *supra* note 103, at 34; Hawkins, *supra* note 18, at 880.

Consumers' inherent irrationality in making financial decisions is exacerbated by their innate trust in their medical providers.¹¹³ Unlike a consumer shopping for a car, a patient in a doctor's office does not have his or her guard up against being taken advantage of financially.¹¹⁴ Patients form close attachments to their physicians and are highly susceptible to any suggestions their office may make, financial or otherwise.¹¹⁵ Health care providers are not legally required to disclose to patients what their relationship is to the medical credit card companies and how they stand to gain from patients selecting different types of payment plans.¹¹⁶

According to their proponents, medical credit cards provide a way for patients to finance their care without paying interest or fees.¹¹⁷ Indeed, GE CareCredit reports that eighty percent of borrowers pay off their debts before they incur interest.¹¹⁸ Consumer advocates, however, have grown increasingly concerned that medical credit cards may trap patients into deferred interest payment plans for over-priced care at exorbitantly high interest rates that can imperil both their financial stability and credit scores.¹¹⁹

II. THE LEGAL LANDSCAPE SUPPORTING MEDICAL CREDIT CARDS

As medical credit cards proliferated in the marketplace, the existing federal laws governing consumer credit, namely the Truth in Lending Act (TILA) and Section Five of the Federal Trade Commission Act (FTC Act), proved insufficient to regulate the new cards.¹²⁰ In 2009, after the economic collapse, Congress passed the Credit Card Accountability and Disclosure Act (CARD Act).¹²¹ The CARD Act instituted a number of reforms of the credit card indus-

¹¹³ See Hall & Schneider, *supra* note 101, at 651–52; Hawkins, *supra* note 18, at 876; Horwitz, *supra* note 18, at 830–31; *Overdose of Debt*, *supra* note 24, at 16; Silver-Greenberg, *supra* note 17.

¹¹⁴ See Hawkins, *supra* note 18, at 875–76.

¹¹⁵ See Hall & Schneider, *supra* note 101, at 652–53; Hawkins, *supra* note 18, at 875.

¹¹⁶ See Hawkins, *supra* note 18, at 886; Horowitz, *supra* note 18, at 823; Dilworth, *supra* note 19.

¹¹⁷ See Hawkins, *supra* note 18, at 866; Silver-Greenberg, *supra* note 17; Dilworth, *supra* note 19.

¹¹⁸ See Silver-Greenberg, *supra* note 17.

¹¹⁹ See Hawkins, *supra* note 18, at 877; *Overdose of Debt*, *supra* note 24, at 15; Silver-Greenberg, *supra* note 17 (quoting Ellen Cheek who provides legal aid to the elderly: “[T]his credit facilitates a bad financial decision that will haunt a patient because it adds to indebtedness . . .”). Mark Rukavina, founder of healthcare consulting group Community Health Advisors, warns that if patients are “already financially squeezed . . . a high-interest card that promises an interest-free promotional period upfront could just delay the pain . . . and potentially create deeper problems down the road.” Dilworth, *supra* note 19.

¹²⁰ Truth in Lending Act (TILA), 15 U.S.C. §§ 1601–1693r (2012); Federal Trade Commission Act (FTC Act), 15 U.S.C. § 45 (2012); see CARD ACT REPORT, *supra* note 81, at 10.

¹²¹ Credit Card Accountability Responsibility and Disclosure Act of 2009 (CARD Act), Pub. L. 111-24, 123 Stat. 1734 (2009) (codified as amended in scattered sections of 15 U.S.C.).

try.¹²² Following the CARD Act's passage, in July 2010 Title X of the Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank) created the CFPB.¹²³ The CFPB has oversight over all federal consumer financial law; in 2013 the agency clamped down on the medical credit card industry's largest provider, GE CareCredit.¹²⁴

A. Before the Financial Collapse: Credit Laws Allow for Growth of Medical Credit Cards

The existing laws and regulations governing consumer credit cards are insufficiently robust to police medical credit cards, especially as the cards continue to gain influence.¹²⁵ When medical credit cards first emerged as an option for patients, a patchwork of existing federal laws and agencies oversaw the banking and credit industry.¹²⁶ Two major controlling laws at the time were TILA and the FTC Act.¹²⁷ These laws, however, did not curtail the medical credit card industry's use of deferred interest rate plans.¹²⁸ Both laws authorized various agencies, known as prudential regulators, to engage in consumer protection activities; however, this work was overshadowed by their more central functions of protecting the "safety and soundness" of the banking industry.¹²⁹

1. TILA Creates Disclosure Obligations for Credit Card Providers

TILA, passed in 1968 as Title I of the Consumer Credit Protection Act, requires banks to disclose credit terms to make it easier for consumers to compare offers and make informed choices about them.¹³⁰ The Federal Reserve

¹²² *Id.*

¹²³ Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank), 12 U.S.C. §§ 5301–5641 (2012). The CFPB was first proposed by Elizabeth Warren in a widely publicized article in which she called for the creation of the Financial Product Safety Commission modeled after the United States Consumer Product Safety Commission. Elizabeth Warren, *Unsafe at Any Rate*, DEMOCRACY J. 8, 16 (2007).

¹²⁴ Dodd-Frank § 5511; see Consent Order, *supra* note 30.

¹²⁵ See Bar-Gill & Warren, *supra* note 103, at 4, 6, 84–90, 95, 97.

¹²⁶ See *id.* at 4, 84, 97. The federal and state laws that govern credit products have been described as a "tattered patchwork . . . that have failed to adapt to changing markets." *Id.* at 4.

¹²⁷ Truth in Lending Act (TILA), 15 U.S.C. §§ 1601–1693r (2012); Federal Trade Commission Act, 15 U.S.C. § 45 (2012); see CARD ACT REPORT, *supra* note 81, at 10.

¹²⁸ See CARD ACT REPORT, *supra* note 81, at 10; Bar-Gill & Warren, *supra* note 103, at 97.

¹²⁹ See CARD ACT REPORT, *supra* note 81, at 10, 95 (noting that prudential regulators, including the Federal Reserve Board, have the primary responsibility for monitoring the safety and soundness of financial institutions); Bar-Gill & Warren, *supra* note 103, at 90.

¹³⁰ Truth in Lending Act (TILA), Pub. L. No. 90-321, 82 Stat. 146 (1968); Dilworth, *supra* note 19.

Board implemented TILA through the promulgation of Regulation Z, which detailed banks' and other creditors' required disclosures.¹³¹

TILA disclosure rules were intended to reduce the information deficit that regulators believed was hindering consumers from making wise credit choices.¹³² Regulators hoped that by requiring that credit card providers give consumers more information with credit card offers, the providers would be motivated to compete for consumers' business by improving the terms of credit offers.¹³³ While TILA disclosure regulations arguably are successful in requiring credit card providers to disclose their terms, in the case of medical credit cards, consumers and patients often do not make use of the information to inform their choices.¹³⁴ Because patients are unlikely to compare credit offers in a rational manner at their time of need, medical credit card issuers are not prompted by competitive forces to offer terms more advantageous to patients.¹³⁵

Even if the disclosure of information had the desired effect of encouraging consumers to compare credit offers, the potential positive impact has been muffled by the fact that medical office staff members, not financial professionals, explain the terms of the medical credit cards to patients.¹³⁶ Although financial institutions are required to abide by TILA disclosure requirements, of-

¹³¹ 12 C.F.R. § 226 (2014). The Federal Reserve Board is the central bank of the United States. *See id.* Regulation Z requires lenders to present information about the terms and costs of credit in tabular form including annual percentage rates, penalty rates, and finance charges. *Id.* § 226.5.

¹³² *See* TILA 15 U.S.C. § 1601(a) (2012). The statute's Findings and Declaration of Purpose states:

The Congress finds that economic stabilization would be enhanced and the competition among the various financial institutions and other firms engaged in the extension of consumer credit would be strengthened by the informed use of credit. The informed use of credit results from an awareness of the cost thereof by consumers. It is the purpose of this title to assure a meaningful disclosure of credit terms so that the consumer will be able to compare more readily the various credit terms available to him and avoid the uninformed use of credit

Id.

¹³³ *See id.*

¹³⁴ *See* Barr-Gill & Warren, *supra* note 103, at 9, 12, 13, 35 (noting that “[c]onsumers do not seek to acquire more information because they are not aware that they need more information or that more information is available for them to acquire”); Hawkins, *supra* note 18, at 875–76 (stating that “[t]he vulnerable state of patients, combined with their trust in their doctors, means that many patients tend to follow physicians’ recommendations without critical thought”).

¹³⁵ *See* Hall & Schneider, *supra* note 101, at 652–53. “Doctors’ ‘monopoly’ power is intensified by patients’ almost irredeemable ignorance about almost all of almost every transaction.” *Id.*; *see also* Hawkins, *supra* note 18, at 844 (describing how patients take their doctors’ financing recommendations without doing their own outside research or “shop[ping] around”).

¹³⁶ Hawkins, *supra* note 18, at 877; Horwitz, *supra* note 18, at 813–14; Silver-Greenberg, *supra* note 17.

office staff are under no such compulsion.¹³⁷ Moreover, staff represent the health care provider, who has incentives to enroll patients in these cards, regardless of what may be the best option for that patient.¹³⁸

2. Section Five of the FTC Act Attempts to Protect Consumers

In addition to TILA, Section Five of the FTC Act also affects the credit card industry.¹³⁹ Section Five prohibits covered entities from engaging in “unfair or deceptive acts or practices.”¹⁴⁰ The FTC Act, however, does not consider depository institutions, including banks, to be a covered entity.¹⁴¹ If the Federal Trade Commission (FTC) determines that a bank engaged in unfair and deceptive practices with regard to its credit card products, its only remedy is to request that the Federal Reserve take action.¹⁴² Therefore, because banks that are not subject to direct FTC control issue the vast majority of medical credit cards, the FTC Act is an ineffective regulator of most medical credit card providers.¹⁴³

B. Financial Collapse Leads to Legal Reforms and the Birth of the CFPB

When the mortgage industry in the United States collapsed in 2008, Congress turned its attention to the consumer credit card market and its role in the financial crisis.¹⁴⁴ In 2009, Congress passed the CARD Act.¹⁴⁵ The stated purpose of the CARD Act was to “establish fair and transparent practices related to the extension of credit”¹⁴⁶ To do so it imposed a host of restrictions on credit card providers by amending TILA.¹⁴⁷ Under the CARD Act, credit card companies are no longer allowed to issue credit to consumers without considering the person’s ability to pay their minimum monthly payments.¹⁴⁸ Additionally, amounts and types of fees, including penalty fees, are severely re-

¹³⁷ See Truth in Lending Act (TILA), 15 U.S.C. §§ 1601–1693r (2012); Hawkins, *supra* note 18, at 843, 885–86.

¹³⁸ See *Overdose of Debt*, *supra* note 24, at 16.

¹³⁹ Federal Trade Commission Act (FTC Act), 15 U.S.C. § 45 (2012); see CARD ACT REPORT, *supra* note 81, at 10.

¹⁴⁰ FTC Act § 45.

¹⁴¹ *Id.* § 45(a)(2).

¹⁴² See Barr-Gill & Warren, *supra* note 103, at 88, 95.

¹⁴³ See *id.*

¹⁴⁴ See Susan Block-Lieb, *Accountability and the Bureau of Consumer Financial Protection*, 7 BROOK. J. CORP. FIN. & COM. L. 25, 34 (2012).

¹⁴⁵ Credit Card Accountability Responsibility and Disclosure Act of 2009 (CARD Act), Pub. L. 111-24, 123 Stat. 1734 (2009) (codified as amended in scattered sections of 15 U.S.C.).

¹⁴⁶ *Id.*

¹⁴⁷ 12 C.F.R. § 226 (2014); see CARD ACT REPORT, *supra* note 81, at 11.

¹⁴⁸ Credit Card Accountability Responsibility and Disclosure Act of 2009 (CARD Act), 15 U.S.C. § 1665e (2012); 12 C.F.R. § 226.51; see CARD ACT REPORT, *supra* note 81, at 11–12.

stricted and in some cases eliminated altogether.¹⁴⁹ The Act also tamps down on credit card providers' ability to increase interest rates on existing balances.¹⁵⁰

Initially, responsibility for the administration of the CARD Act was assigned to the Board of Governors of the Federal Reserve System.¹⁵¹ Yet after the creation of the CFPB through Title X of the Dodd-Frank Act, the administration of the CARD Act eventually became the responsibility of the CFPB.¹⁵² One of the CFPB's first actions was to amend TILA's Regulation Z, originally requiring disclosures by credit card companies, in order to comply with the new rules set out in the CARD Act.¹⁵³

The creation of the CFPB marked the first time that a single agency was granted the power to regulate the entire consumer financial products and services sector.¹⁵⁴ The stated purpose of the CFPB is to "seek to implement and, where applicable, enforce Federal consumer financial law consistently for the purpose of ensuring that all consumers have access to markets for consumer financial products and services and that markets for consumer financial products and services are fair, transparent, and competitive."¹⁵⁵ The CFPB's mission differs from that of the other regulatory agencies that are charged with bolstering the banking industry in that the CFPB is empowered to engage in rulemaking and issue orders and guidance to implement "Federal consumer financial law."¹⁵⁶ Additionally, the CFPB monitors the consumer financial

¹⁴⁹ CARD Act §§ 1637(k), 1637(n), 1665(d); CARD ACT REPORT, *supra* note 81, at 11–12.

¹⁵⁰ CARD Act §§ 1637(i)(1), 1666i-1, 1666i-2(a); CARD ACT REPORT, *supra* note 81, at 11.

¹⁵¹ Credit Card Accountability Responsibility and Disclosure Act of 2009 (CARD Act), Pub. L. 111-24, § 2, 123 Stat. 1734 (2009) (codified as amended in scattered sections of 15 U.S.C.).

¹⁵² Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank), 12 U.S.C. §§ 5491, 5581(b)(1) (2012); Warren, *supra* note 123, at 16. The Dodd-Frank Act was passed in July 2010; the newly created CFPB received the charge of administration of the CARD Act on July 21, 2011. Dodd-Frank § 5581(b)(1).

¹⁵³ 12 C.F.R. § 226 (2014); *see* CARD ACT REPORT, *supra* note 81, at 11.

¹⁵⁴ Dodd-Frank § 5491; *see* Block-Lieb, *supra* note 144, at 29, 31; Dee Pridgen, *Sea Changes in Consumer Financial Protection: Stronger Agency and Stronger Laws*, 13 WYO. L. REV. 405, 409–10 (2013); Mark Totten, *Credit Reform and the States: The Vital Role of Attorneys General After Dodd-Frank*, 99 IOWA L. REV. 115, 125–26 (2013). The CFPB's scope of oversight is evolving; its current covered entities include institutions holding more than ten billion dollars in assets and three types of nondepository financial institutions: providers of private student loans, payday loans, and mortgage-related services. Dodd-Frank §§ 5581–5587, 5514–5515. In addition to these three categories of nondepository institutions, the CFPB can also assert regulatory power over any nondepository institution it considers to be a "larger participant of a [consumer financial] market" as well as any entity it suspects is engaging in activity that poses risks to consumers. *Id.* § 5514. Depository institutions with ten billion dollars or less in assets are subject to certain CFPB rules but are not subject to CFPB supervision or enforcement. *Id.* § 5516.

¹⁵⁵ Dodd-Frank § 5511(a).

¹⁵⁶ *Id.* § 5511; *see* Bar-Gill & Warren, *supra* note 103, at 90.

product market and providers for compliance with the law.¹⁵⁷ It also conducts financial education programs and collects, investigates, and responds to consumer complaints.¹⁵⁸

The CFPB's oversight extends to at least nineteen federal laws, known as the "enumerated consumer laws," including TILA.¹⁵⁹ In addition to enforcing these federal laws, the CFPB also enforces the various implementing regulations of the federal laws.¹⁶⁰

Title X, in addition to creating the CFPB, prohibits acts relating to consumer financial products and services that are unfair, deceptive, or abusive; violations may result in civil monetary penalties and criminal prosecution.¹⁶¹ The CFPB is charged with enforcing these prohibitions.¹⁶² Under Title X an act or practice is unfair if it "(A) . . . causes or is likely to cause substantial injury to consumers which is not reasonably avoidable by consumers; and (B) such substantial injury is not outweighed by countervailing benefits to consumers or to competition."¹⁶³ An act or practice is abusive if it prevents a consumer from understanding the terms and conditions of a financial product or exploits the consumer's ignorance.¹⁶⁴ Finally, a representation, omission, act, or practice is deceptive if it: (1) misleads or is likely to mislead the consumer; (2) the consumer's interpretation of it is reasonable under the circumstances; and (3) is material.¹⁶⁵

The CFPB has a variety of tools at its disposal to enforce the law and protect consumers.¹⁶⁶ The CFPB may engage in rulemaking by promulgating

¹⁵⁷ Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank), 12 U.S.C. § 5511 (2012).

¹⁵⁸ *Id.*

¹⁵⁹ *Id.* § 5481(12).

¹⁶⁰ *Id.*; *Supervision and Examination Manual, Version 2*, CONSUMER FIN. PROT. BUREAU Overview 1 (Oct. 2012), http://files.consumerfinance.gov/f/201210_cfpb_supervision-and-examination-manual-v2.pdf.

¹⁶¹ Dodd-Frank §§ 5536, 5565, 5566.

¹⁶² Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank), 12 U.S.C. § 5531 (2012).

¹⁶³ *Id.* § 5531(c)(1).

¹⁶⁴ *Id.* § 5531(d). An abusive act or practice is defined as one that:

(1) materially interferes with the ability of a consumer to understand a term or condition of a consumer financial product or service; or (2) takes unreasonable advantage of—(A) a lack of understanding on the part of the consumer of the material risks, costs, or conditions of the product or service; (B) the inability of the consumer to protect the interests of the consumer in selecting or using a consumer financial product or service; or (C) the reasonable reliance by the consumer on a covered person to act in the interests of the consumer.

Id.

¹⁶⁵ *Supervision and Examination Manual, supra* note 160, at Procedures 9.

¹⁶⁶ Dodd-Frank §§ 5512, 5562.

rules, issuing orders, and providing guidance on federal consumer financial laws.¹⁶⁷ It conducts investigations of covered entities and has broad power to demand information from them, whether via direct testimony, written responses, or production of documents.¹⁶⁸ It also holds hearings and adjudication proceedings, including cease-and-desist proceedings.¹⁶⁹ The CFPB has the authority to initiate civil actions against covered entities and seek relief, including rescission or reformation of contracts, monetary refunds, or return of real property, restitution, disgorgement or compensation for unjust enrichment, and damages.¹⁷⁰ If the CFPB discovers that a covered entity has violated federal criminal law, it will forward the evidence to the U.S. Attorney General.¹⁷¹

In addition to the tools described above, the CFPB has devoted an unprecedented amount of resources to its outreach to and interaction with the public.¹⁷² The CFPB's enabling statute directs it to set up both a toll-free telephone number and a website for consumers to directly lodge complaints about consumer financial products or services.¹⁷³ Since the CFPB began accepting complaints regarding credit cards on July 21, 2011, through July 2014, it has received and responded to over fifty-three thousand credit card complaints.¹⁷⁴ Members of the public are able to view an updated spreadsheet of complaints and their resolution status on the CFPB website; the Bureau also prepares periodic public reports outlining the complaints it receives.¹⁷⁵

The CFPB, however, has progressed far beyond simply receiving complaints from the public.¹⁷⁶ It has reached out to consumers through social media, including Facebook and Twitter, to solicit complaints and narratives about consumer experiences with financial products and services and to encourage

¹⁶⁷ Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank), 12 U.S.C. § 5512 (2012).

¹⁶⁸ *Id.* § 5562.

¹⁶⁹ *Id.* § 5563.

¹⁷⁰ *Id.* § 5565.

¹⁷¹ *Id.* § 5566.

¹⁷² See Patricia A. McCoy, *Public Engagement in Rulemaking: The Consumer Financial Protection Bureau's New Approach*, 7 BROOK. J. CORP. FIN. & COM. L. 1, 2, 12–13 (2012).

¹⁷³ Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank), 12 U.S.C. § 5493 (2012). An agency's enabling act is the act that is passed by Congress that creates the agency. 32 CHARLES ALAN WRIGHT & CHARLES H. KOCH, *FEDERAL PRACTICE AND PROCEDURE* § 8133 (1982). See generally Katherine Porter, *The Complaint Conundrum: Thoughts on the CFPB's Complaint Mechanism*, 7 BROOK. J. CORP. FIN. & COM. L. 57 (2012) (describing and critiquing the CFPB's complaint system).

¹⁷⁴ *Consumer Response: A Snapshot of Complaints Received*, CONSUMER FIN. PROT. BUREAU 20 (July 2014), http://files.consumerfinance.gov/f/201407_cfpb_report_consumer-complaint-snapshot.pdf.

¹⁷⁵ *Id.* at 5–7.

¹⁷⁶ See McCoy, *supra* note 172, at 2, 8, 12–13.

the public to participate in the formal rulemaking process.¹⁷⁷ The CFPB has even held public events to publicize its desire for comments.¹⁷⁸

C. The CFPB Cracks Down on GE CareCredit

In 2013, after receiving hundreds of complaints from consumers, the CFPB used its powers of enforcement to punish the largest provider of medical credit cards for deceptive practices.¹⁷⁹ On December 10, 2013, the CFPB announced that it was ordering GE Capital Retail Bank and its subsidiary, CareCredit, to refund just over thirty-four million dollars to more than one million customers who were victims of deceptive credit card enrollment tactics.¹⁸⁰ After investigation, the CFPB found that GE CareCredit customers were misled during the enrollment process into believing that the cards were interest-free.¹⁸¹ GE CareCredit was reprimanded for its failure to properly train and monitor the medical office staff that assisted patients with their GE CareCredit applications and the company was ordered to improve its practices.¹⁸²

Before the enforcement action, GE CareCredit offered both traditional fixed payment option plans and deferred interest, or promotional, plans to pa-

¹⁷⁷ See *id.* at 7–9, 10–14; *Participate*, CONSUMER FIN. PROT. BUREAU, <http://www.consumerfinance.gov> (last visited May 13, 2015). As required by the Administrative Procedure Act (APA), the CFPB must request public comment through an Advance Notice of Proposed Rulemaking (ANPR) that is published in the Federal Register. APA, 5 U.S.C. § 553 (2012). Members of the public are always free to submit comments through the Federal Register’s website at <http://www.regulations.gov>. *Id.* The CFPB utilized a “Know Before You Owe” outreach campaign on its website and through Facebook and Twitter to seek public feedback and comments about proposed drafts of new mortgage disclosure forms. McCoy, *supra* note 172, at 7. The CFPB received over 150,000 visits to the “Know Before You Owe” website and over 27,000 comments on the forms. *Id.* at 7–9. The CFPB used the “Know Before You Owe” website again in 2011, along with a blog post and media event, to solicit comments and feedback on drafts of proposed new student loan disclosure forms. *Id.* at 10–11. The draft forms were reviewed by over 20,000 readers online. *Id.* at 11. In May 2012, the CFPB simultaneously issued a formal ANPR regarding prepaid cards and advertised the ANPR through a public, live-streamed event on its website, and solicited comment through its blog, Facebook, and Twitter feeds. *Id.* at 13.

¹⁷⁸ See McCoy, *supra* note 172, at 13.

¹⁷⁹ See Consent Order, *supra* note 30; *CFPB Orders GE*, *supra* note 27 (explaining that the CFPB began its investigation of GE CareCredit after it received hundreds of complaints from consumers who reported that they were misled during the enrollment process into believing that the cards were interest-free); Ellis, *supra* note 27 (noting that GE CareCredit is the largest medical credit card provider, with four million cardholders who can use the card at 175,000 medical service providers). Sections 5563 and 5565 of the Dodd-Frank Wall Street Reform and Consumer Protection Act grant enforcement powers to the CFPB including the power to investigate regulated entities and bring civil actions against them for violations of consumer financial laws. 12 U.S.C. §§ 5563, 5565 (2012); Consent Order, *supra* note 30, at 1. The Consent Order was a “settlement of the administrative proceeding against [GE CareCredit] contemplated by the [CFPB]” Consent Order, *supra* note 30, at 27.

¹⁸⁰ *CFPB Orders GE*, *supra* note 27.

¹⁸¹ Consent Order, *supra* note 30, at 5–6; *CFPB Orders GE*, *supra* note 27.

¹⁸² Consent Order, *supra* note 30, at 4–13.

tients.¹⁸³ The fixed payment option charged a 14.9% annual percentage rate (APR) to customers who were required to make monthly payments until the balance was paid in full.¹⁸⁴ The deferred interest option, which was selected by 85% of patients, charged a 26.99% APR on the consumer's declining balance from the date of the consumer's original purchase if the consumer did not pay off the balance in full within a certain set period of time, ranging from six to twenty-four months.¹⁸⁵

Through its investigation of GE CareCredit, the CFPB discovered that the company failed to sufficiently train and monitor health care providers' staff members so that the information they provided to patients was accurate.¹⁸⁶ GE CareCredit therefore engaged in deceptive and unfair practices in violation of sections 5531 and 5536 of the Dodd-Frank Act.¹⁸⁷ As a result, patients received incorrect information from health care providers' staff members, which led them to incur interest charges they did not expect.¹⁸⁸ In some cases, the deferred interest option was explained to indicate that the credit would be "interest free for twelve months" rather than subject to deferred interest.¹⁸⁹ Staff also failed to provide written disclosures as required by Regulation Z of TILA and neglected to tell patients that they would be subject to 26.99% interest at the end of the promotional period.¹⁹⁰ Even if staff provided accurate written disclosures to patients, they often contradicted the written information orally so that patients did not understand the terms.¹⁹¹

The CFPB ordered GE CareCredit to comply with a variety of disciplinary measures through a Consent Order.¹⁹² GE CareCredit was directed to pay thirty-four million dollars to more than 1.2 million aggrieved consumers in addition to agreeing to cease and desist its unfair and deceptive practices.¹⁹³

¹⁸³ *Id.* at 3.

¹⁸⁴ *Id.* The APR is the actual cost of borrowing money, expressed in the form of an annualized interest rate. BLACK'S LAW DICTIONARY 888 (9th ed. 2009).

¹⁸⁵ Consent Order, *supra* note 30, at 3–4.

¹⁸⁶ *Id.* at 4–6.

¹⁸⁷ *Id.* at 6; Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank), 12 U.S.C. §§ 5531, 5536 (2012).

¹⁸⁸ Consent Order, *supra* note 30, at 6.

¹⁸⁹ *Id.* at 5.

¹⁹⁰ *Id.*; 12 C.F.R. § 226 (2014).

¹⁹¹ Consent Order, *supra* note 30, at 5. Some providers admitted to the CFPB during interviews that they did not understand how deferred interest credit cards worked. *CFPB Orders GE*, *supra* note 27.

¹⁹² Consent Order, *supra* note 30, at 7–26.

¹⁹³ *Id.* at 7, 20. GE CareCredit was ordered to put twenty-seven million dollars into a Reimbursement Fund to be distributed to consumers and an additional \$6.4 million into an Auxiliary Fund for the same purpose, subject to return if not fully distributed. *Id.* at 7. Patients who filed disputes with GE CareCredit and whose disputes were resolved against them were placed in the Appeal Group. *Id.* at 13. Members of the Appeal Group were members who

Additionally, the CFPB required GE CareCredit to create a Remedial Monitoring Plan to prevent further violations.¹⁹⁴ The Remedial Monitoring Plan compelled GE CareCredit to modify its contracts with health care providers in a way that requires providers to accurately describe the terms of the cards to patients.¹⁹⁵ To that end, the CFPB instructed GE CareCredit to improve the training and marketing materials it supplies to providers.¹⁹⁶

The Remedial Monitoring Plan also required GE CareCredit to change its contracts with health care providers to prohibit them from placing upfront charges for medical services not yet rendered on the cards unless the charges are for orthodontia, for custom products, or will be completed within thirty days.¹⁹⁷ Patients of dental and audiology practices who wish to charge more than one thousand dollars on the card must apply directly to GE CareCredit, rather than doing so in the provider's office.¹⁹⁸ GE CareCredit will inform those dental and audiology patients, through a written script approved by the CFPB, about the terms and conditions of the financing plan.¹⁹⁹ If a provider does not follow the terms of the Consent Order, a patient has the right to a refund of all dental or audiology charges made to his or her account, even if services were already rendered.²⁰⁰

Moreover, the Remedial Monitoring Plan requires GE CareCredit to make its best efforts to call patients within forty-eight hours of applying for credit

(i) did not receive some or all of the products or services for which [they were] charged, (ii) [were] promised a credit refund [that they did not receive], (iii) did not authorize the CareCredit application or charge, or (iv) [were] not adequately informed that they would owe interest if the balance was not paid in full upon expiration of the promotional period, the rate of interest, or that the applicable interest accrues on the outstanding balance during the promotional period from the purchase date.

Id. at 13–14. Patients who “(i) enrolled through the Provider Channel, (ii) completed a deferred-interest transaction for dental or audiology services . . . and (iii) were assessed interest on such promotion . . .” were placed in the Deferred Interest Group. *Id.* at 14. Both groups were eligible for reimbursement. *Id.* at 13–14; *CFPB Orders GE*, *supra* note 27.

¹⁹⁴ Consent Order, *supra* note 30, at 7.

¹⁹⁵ *Id.* at 7–8. The Consent Order mandated that GE CareCredit include “Transparency Principles” in their contracts with medical providers. *Id.* The Transparency Principles require that medical providers accurately describe the terms of the GE CareCredit card to patients. *Id.* For three years GE CareCredit must submit an annual report to the CFPB describing its compliance with the Consent Order, including information about the termination and suspension of medical providers. *Id.* at 23. The CFPB enforces the Consent Order and violations may be punished through the imposition of civil penalties. *Id.* at 28.

¹⁹⁶ *Id.* at 10–11.

¹⁹⁷ *Id.* at 8.

¹⁹⁸ *Id.* at 8–9.

¹⁹⁹ *Id.*

²⁰⁰ *Id.* at 9.

through a health care provider's office.²⁰¹ Through this "Welcome Call," GE CareCredit employees will, again through a written script approved by the CFPB, inform patients about the amount of the initial charges made to the account, notify them that the health care must be completed within thirty days, and explain the deferred interest option.²⁰² Two months before the end of an individual's promotional period, GE CareCredit must notify individuals through paper bills or emails that their promotional period is due to end.²⁰³

Finally, as part of the Consent Order, GE CareCredit is prohibited from giving kickbacks, rebates, compensation, or in-kind services to any health care provider in exchange for that provider's loan volume.²⁰⁴ GE CareCredit also assumes the responsibility of closely monitoring health care providers who fail to properly administer the program and may ultimately terminate the providers from offering the cards to their patients.²⁰⁵ GE CareCredit must also improve its consumer complaint and dispute system.²⁰⁶

The Consent Order, though wide-ranging, did not require GE CareCredit to stop offering deferred interest credit cards to patients.²⁰⁷ As a result, GE CareCredit and other medical credit card providers may continue to advance deferred interest credit cards to patients as a way to finance health care costs.²⁰⁸

III. MEDICAL CREDIT CARDS: A PRESCRIPTION FOR REFORM

To advance its mission of protecting vulnerable consumers, the CFPB must take action to further regulate the medical credit card industry.²⁰⁹ The CFPB should expand upon its 2013 enforcement action against GE CareCredit

²⁰¹ *Id.* at 9–10.

²⁰² *Id.*

²⁰³ *Id.* at 10.

²⁰⁴ *Id.* at 11.

²⁰⁵ *Id.* at 11–12.

²⁰⁶ *Id.* at 12–13.

²⁰⁷ *See id.* at 1–29.

²⁰⁸ *See Overdose of Debt*, *supra* note 24, at 15–16; Silver-Greenberg, *supra* note 17; Grow & Berner, *supra* note 1.

²⁰⁹ *See* Letter from Christine Tetreault, Staff Attorney, Consumers Union, to Monica Jackson, Consumer Fin. Prot. Bureau (Feb. 19, 2013), *available at* http://consumersunion.org/wp-content/uploads/2013/02/CU_CARD_Act_Comment_2_13.pdf (submitting comments to the CFPB and stating that deferred interest credit cards should be banned because they are confusing and deceptive); Nick Bourke & Ardie Hollifield, *Two Steps Forward: After the Credit CARD Act, Credit Cards are Safer and More Transparent—But Challenges Remain*, PEW CHARITABLE TRUSTS 9 (July 2010), <http://www.pewtrusts.org/~media/Assets/2010/07/22/PEWCreditCard-FINAL.pdf> (noting that Pew's Safe Credit Card Standards would prohibit deferred interest offers); Lauren K. Saunders, *Beyond the Credit CARD Act: Features of a Safer Credit Card*, NAT'L CONSUMER L. CTR. 7 (Nov. 2010), https://www.nclc.org/images/pdf/credit_cards/features-safer-credit-card.pdf (advocating for a ban on deferred interest cards because of their burdensome terms).

and engage in rulemaking to ban deferred interest medical credit cards.²¹⁰ Short of an outright ban, the CFPB should impose the reforms contained in its GE CareCredit Consent Order on the entire medical credit card industry through rulemaking.²¹¹ Similarly, the CFPB should use rulemaking to revise the Credit Card Accountability and Disclosure Act (CARD Act) regulations to help consumers understand how to avoid paying deferred interest.²¹² Lastly, the CFPB should also build upon its congressional mandate to educate the public about consumer financial issues by educating the health care providers who offer medical credit cards about their terms and conditions.²¹³

A. Banning Deferred Interest Medical Credit Cards

The CARD Act directed the CFPB to prepare a report every two years about the consumer credit market.²¹⁴ In its first report, issued in October 2013, the CFPB identified deferred interest credit cards as requiring further study and assessment.²¹⁵ According to the CFPB, forty-three percent of consumers with low credit scores end up paying a lump sum of retroactive interest on deferred interest cards.²¹⁶ Even though the majority of borrowers with low credit scores escape paying retroactive interest, the CFPB reported that deferred interest products pose risks to potentially vulnerable consumers, which led the Bureau to identify deferred interest cards as an area of continuing concern and monitoring.²¹⁷

Deferred interest medical credit cards confuse patients, impose large financial burdens, and can be used deceptively.²¹⁸ The best way to prevent these

²¹⁰ See Tetreault, *supra* note 209, at 4; Bourke & Hollifield, *supra* note 209, at 9; Saunders, *supra* note 209, at 7.

²¹¹ See Tetreault, *supra* note 209, at 6–7; Bourke & Hollifield, *supra* note 209, at 9; Saunders, *supra* note 209, at 10.

²¹² Credit Card Accountability Responsibility and Disclosure Act of 2009 (CARD Act), Pub. L. 111-24, 123 Stat. 1734 (2009) (codified as amended in scattered sections of 15 U.S.C.); see CARD ACT REPORT, *supra* note 81, at 78–79; Tetreault, *supra* note 209, at 6.

²¹³ Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank), 12 U.S.C. § 5511(c)(1) (2012); see Horwitz, *supra* note 18, at 828.

²¹⁴ Credit Card Accountability Responsibility and Disclosure Act of 2009 (CARD Act), 15 U.S.C. § 1616 (2012); CARD ACT REPORT, *supra* note 81, at 4.

²¹⁵ CARD ACT REPORT, *supra* note 81, at 81.

²¹⁶ *Id.* at 7. Low credit scores, known as subprime, are defined by the CFPB as scores of 659 or less. *Id.* at 15.

²¹⁷ See *id.* at 81.

²¹⁸ See Hall & Schneider, *supra* note 101, at 650–53 (describing the impact illness has on patients' ability to evaluate choices); Hawkins, *supra* note 18, at 875–78 (describing how patients' trust in their doctors prevents them from shopping for better financing options); *Overdose of Debt*, *supra* note 24, at 16 (describing the terms and conditions of deferred interest medical credit cards and the questionable marketing tactics used by credit card providers); Silver-Greenberg, *supra* note 17 (discussing the confusion patients experience when applying for these cards in providers' offices, the

problems is for the CFPB to ban deferred interest medical credit cards.²¹⁹ Instead of offering financing with deferred interest, medical credit cards should offer financing with terms equivalent to those attached to general-purpose credit cards.²²⁰ General-purpose credit cards are better for patients because many are able to offer truly interest-free financing for set periods of time.²²¹

The terms of deferred interest medical credit cards are dangerous for patients.²²² The cards carry with them extremely high interest rates, and if the patient does not pay off the balance during the promotional period, those rates are applied retroactively to the patient's entire balance.²²³ If a patient pays off the balance just one month after the promotional period ends, the balance can increase to twenty-seven times more than the original cost.²²⁴ Borrowers with low credit scores are harmed disproportionately by deferred interest medical credit cards.²²⁵ In 2010, less than sixty percent of borrowers with low credit scores avoided paying deferred interest by paying off their balance before the end of the promotional period.²²⁶ In contrast, eighty-eight percent of borrowers with high credit scores paid off their balances in time.²²⁷

General-purpose credit cards are a safer alternative for patients.²²⁸ General-purpose credit cards may offer teaser or introductory rates as low as zero

deceptive practices some providers engage in when marketing the cards to patients, and the financial burden on patients when they incur deferred interest); Dilworth, *supra* note 19 (describing the financial burden faced by patients unable to pay off balances on deferred interest medical credit cards before the end of the promotional period); Grow & Berner, *supra* note 1 (providing examples of patients who misunderstood the terms of these credit cards and their resulting financial burden, along with deceptive marketing practices some providers engage in).

²¹⁹ See Tetreault, *supra* note 209, at 4; Bourke & Hollifield, *supra* note 209, at 9; Saunders, *supra* note 209, at 7.

²²⁰ See CARD ACT REPORT, *supra* note 81, at 81; Saunders, *supra* note 209, at 7.

²²¹ See CARD ACT REPORT, *supra* note 81, at 81; Saunders, *supra* note 209, at 7.

²²² See CARD ACT REPORT, *supra* note 81, at 81; Tetreault, *supra* note 209, at 4; *Overdose of Debt*, *supra* note 24, at 15–16; Silver-Greenberg, *supra* note 17; Bourke & Hollifield, *supra* note 209, at 9; Dilworth, *supra* note 19; Grow & Berner, *supra* note 1; Saunders, *supra* note 209, at 7.

²²³ See Consent Order, *supra* note 30, at 3; *Overdose of Debt*, *supra* note 24, at 14, 16; Silver-Greenberg, *supra* note 17; Dilworth, *supra* note 19; Olen, *supra* note 22.

²²⁴ See John Kiernan, *Card Hub Credit Card Deferred Interest Study 2013*, CARDHUB, <http://www.cardhub.com/edu/deferred-interest-study/> (updated Jan. 24, 2014).

²²⁵ See CARD ACT REPORT, *supra* note 81, at 80–81.

²²⁶ *Id.* at 80.

²²⁷ See *id.* High credit scores, known as superprime scores, are defined by the CFPB as credit scores of 720 or greater. *Id.* at 15.

²²⁸ See CARD ACT REPORT, *supra* note 81, at 81. The CFPB noted that, “[i]n contrast to the promotional rates found in the general-purpose credit card market—which often provide an interest-free period with no potential retroactive assessment of interest—deferred interest products can end up costing a significant segment of vulnerable consumers a sizable amount of money.” *Id.* A National Consumer Law Center report warned that “[d]eferred interest plans are much more dangerous than [general-purpose cards’] teaser rates, which can expire or be lost but do not revive dormant interest from previous months.” Saunders, *supra* note 209, at 7.

percent.²²⁹ If the borrower does not pay off the balance by the end of the promotional period, interest is charged only on the remaining balance from the end of the promotional period going forward, not applied retroactively.²³⁰ Interest rates on general-purpose credit cards are more modest than the rates charged by deferred interest credit cards and therefore place a smaller financial burden on patients.²³¹

A counterargument to banning deferred interest medical credit cards—thereby potentially reducing credit card providers' profit—is that a ban will lessen the amount of credit available to high-risk borrowers who would otherwise be unable to obtain financing for necessary medical treatment.²³² Similar arguments were made in the wake of the CARD Act's passage, but critics' fears did not come to pass.²³³ The CARD Act's provisions, which went into effect in 2010, limited the extension of credit to only those who could show an ability to repay their debts.²³⁴ After new account approval rates dropped sharply between 2007 and 2009 due to the financial crisis, by 2012 new account approval rates were back up to seventy-four percent of the rate of approvals in 2007 for borrowers with low credit scores.²³⁵ Despite fears that credit market reforms would squeeze out high-risk borrowers, the consumer credit market has continued to provide opportunities for those borrowers to obtain credit.²³⁶

²²⁹ See Bar-Gill, *supra* note 45, at 1392.

²³⁰ See CARD ACT REPORT, *supra* note 81, at 78; Bar-Gill, *supra* note 45, at 1392; Bourke & Hollifield, *supra* note 209, at 9; Saunders, *supra* note 209, at 7.

²³¹ See CARD ACT REPORT, *supra* note 81, at 32, 78; Tetreault, *supra* note 209, at 4.

²³² See Pridgen, *supra* note 154, at 434; Todd Zywicki, *The Consumer Financial Protection Bureau: Savior or Menace?*, 81 GEO. WASH. L. REV. 856, 902 (2013) (arguing that risk-based pricing “enable[s] extensions of credit cards to a more heterogeneous group of consumers”); Silver-Greenberg, *supra* note 17 (reporting that some deferred interest medical credit card providers do not require credit checks and thus extend credit to borrowers who are not well positioned to take on additional debt); Dilworth, *supra* note 19 (stating that medical credit cards have higher approval rates than general purpose credit cards therefore allowing patients with poor credit to qualify).

²³³ See CARD ACT REPORT, *supra* note 81, at 61 (stating that “nothing in the evidence reviewed suggests that the CARD Act was responsible for the reduction in credit access—which largely preceded the Act’s enactment—or that the CARD Act has retarded the pace of recovery”); Pridgen, *supra* note 154, at 434 (noting that some critics feared that consumer protection rules contained in the CARD Act would restrict access to credit and increase the cost of credit); Zywicki, *supra* note 232, at 927 (arguing that the CARD Act and the CFPB deprive “[t]he most vulnerable consumers . . . of credit choices”); Joshua M. Frank, *Credit Card Clarity: CARD Act Reform Works*, CTR. FOR RESPONSIBLE LENDING 14 (Feb. 16, 2011), <http://www.responsiblelending.org/credit-cards/research-analysis/Final-CRL-CARD-Clarity-Report2-16-11.pdf> (reporting that “[i]n fact, there is no evidence that the CARD Act or the prior FRB credit card rules burdened consumers either with higher costs or reduced access”).

²³⁴ Credit Card Accountability Responsibility and Disclosure Act of 2009 (CARD Act), 15 U.S.C. § 1665e (2012); see also 12 C.F.R. § 226.51(a) (2014).

²³⁵ See CARD ACT REPORT, *supra* note 81, at 47–48.

²³⁶ See *id.*

Similarly, a ban on deferred interest medical credit cards would likely not prevent patients from accessing credit through general-purpose credit cards.²³⁷

B. The CFPB Should Utilize Rulemaking to Ban or Restrict Deferred Interest Medical Credit Cards

Unless specified by statute, administrative agencies may act through rulemaking, adjudication, or by issuing advisory guidance to the entities they regulate.²³⁸ To date, the CFPB has favored the use of adjudication rather than rulemaking in relation to deferred interest medical credit cards.²³⁹ After amending Regulation Z's disclosure rules through rulemaking to conform to the CARD Act, the CFPB refrained from engaging in further rulemaking that directly targeted deferred interest medical credit cards.²⁴⁰ Instead, the Agency chose to use its power of adjudication in an enforcement action against GE CareCredit.²⁴¹ The resulting Consent Order was wide-ranging and made a significant financial impact on GE CareCredit, requiring the company to change many of its deceptive practices and to pay a hefty sum in restitution.²⁴²

Rather than focusing on restraining one medical credit card provider at a time through adjudication, the CFPB should use rulemaking to ban deferred

²³⁷ See *id.*

²³⁸ See Administrative Procedure Act (APA), 5 U.S.C. §§ 500–596 (2012); *SEC v. Cheney Corp.*, 332 U.S. 194, 203 (1947) (holding that an agency is free to choose its policymaking form); Magill, *supra* note 32, at 1386, 1405.

²³⁹ See Consent Order, *supra* note 30; Laureen Galeoto et al., *Are CFPB Joint Enforcement Actions Here to Stay?*, LAW360 (Nov. 20, 2012), www.advance.lexis.com. An agency's choice of methods is often determined by both procedural and strategic concerns. See Magill, *supra* note 32, at 1390, 1444–45 (discussing various factors agencies consider when choosing rulemaking or adjudication including cost, time, enforcement challenges, and scope). When an agency engages in rulemaking, it implements a rule that applies broadly to the agency's constituents. See *id.* at 1394, 1444; David L. Shapiro, *The Choice of Rulemaking or Adjudication in the Development of Administrative Policy*, 78 HARV. L. REV. 921, 924 (1965). Rulemaking requires the issuance of a notice to the public that the agency intends to engage in rulemaking and requires the agency to solicit and consider public comments. See APA § 553; Magill, *supra* note 32, at 1390. In contrast, when an agency engages in adjudication, only the parties to the proceeding are involved. See APA § 554; Magill, *supra* note 32, at 1391; Shapiro, *supra*. Unlike rulemaking, where the rule produced is equivalent to a statute, the product of adjudication is binding only on the parties to the proceeding. See Magill, *supra* note 32, at 1394. Nevertheless, adjudication may be influential for its precedential value. See *id.* Parties similarly situated to the adjudicated parties may choose to comply with the adjudication results rather than face future enforcement action from the agency. See *id.*; Galeoto, et al., *supra* (noting that CFPB consent orders are “intended to educate the covered industry”).

²⁴⁰ See 12 C.F.R. § 226 (2014); CARD ACT REPORT, *supra* note 81, at 11; Steven Forry, *2012: The CFPB Sets Its Sights on Credit Card Companies*, BUS. L. TODAY 1–4 (Mar. 2013), http://www.americanbar.org/publications/blt/2013/03/02_forry.html; Eric J. Mogilnicki & Melissa S. Malpass, *The First Year of the Consumer Financial Protection Bureau*, 68 BUS. L. 557, 560–62 (2013).

²⁴¹ See Consent Order, *supra* note 30; CFPB Orders *GE*, *supra* note 27; Ellis, *supra* note 27.

²⁴² See generally Consent Order, *supra* note 30.

interest medical credit cards.²⁴³ If the CFPB decides instead to allow the use of deferred interest medical credit cards, it should use rulemaking to expand to the entire medical credit card industry the restrictions imposed on GE CareCredit through the Consent Order.²⁴⁴

1. Reasons Why the CFPB May Favor Adjudication over Rulemaking

Adjudication is considered to be the best choice when an agency needs to act quickly to deal with a threat to the public because adjudication does not require a lengthy notice and comment period.²⁴⁵ The desire for such swift action may have prompted the CFPB to choose to adjudicate against GE CareCredit rather than engage in the more lengthy and involved rulemaking process.²⁴⁶ Sometimes agencies choose adjudication when there is a lack of agreement in the industry or public at large about what the correct approach should be to a problem, or if the area seems to be in flux.²⁴⁷ In the case of deferred interest medical credit cards, the CFPB may be reluctant to use its rulemaking powers to ban or severely limit the cards because deferred interest credit cards are so prevalent throughout the retail sector.²⁴⁸ Agencies also must be stewards of their scarce resources; adjudication is seen as less costly than rulemaking and the CFPB could be marshaling its resources for other initiatives.²⁴⁹

Moreover, the CFPB's rulemaking power is subject to several constraints that may push it towards adjudication over rulemaking.²⁵⁰ The Regulatory Flexibility Act (RFA) requires agencies, including the CFPB, to follow certain

²⁴³ See Tetreault, *supra* note 209, at 4; Magill, *supra* note 32, at 1386; Saunders, *supra* note 209, at 7.

²⁴⁴ See Tetreault, *supra* note 209, at 6–7; Saunders, *supra* note 209, at 10.

²⁴⁵ See Magill, *supra* note 32, at 1396. Magill explains that “[t]hose who believe the agency should act quickly to respond . . . may view a legislative rule as too cumbersome.” *Id.*

²⁴⁶ See *id.*

²⁴⁷ See *id.* at 1396–97. Magill states that “[s]ome might also argue that an incremental, adjudication-based approach is more appropriate because of the absence of consensus on an appropriate general policy” *Id.*

²⁴⁸ See Kiernan, *supra* note 224. Almost half of the major retailers who provide financing to their customers offer a deferred interest plan. *Id.*

²⁴⁹ See Magill, *supra* note 32, at 1397. Magill notes that “[s]till others might be skeptical of the seriousness of the threat posed by the particular transactions and will view a legislative rule as especially unwise because the agency will devote too many resources to prohibiting an unthreatening transaction.” *Id.*

²⁵⁰ See Adam J. Levitin, *The Consumer Financial Protection Bureau: An Introduction*, 32 REV. BANKING & FIN. L. 321, 351–54 (2013); Arthur E. Wilmarth, Jr., *The Financial Services Industry's Misguided Quest to Undermine the Consumer Financial Protection Bureau*, 31 REV. BANKING & FIN. L. 881, 923–24 (2011–2012).

procedures to limit the cost of their rules to small business entities.²⁵¹ Agencies must perform both an initial and final regulatory flexibility analysis of any rulemaking that describes the impact the rule will have on small entities.²⁵² If the rule will have a significant impact on small entities, they must be allowed to participate in the rulemaking process.²⁵³

The Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA) amended the RFA and imposes additional rulemaking requirements on certain agencies including the CFPB.²⁵⁴ Before the CFPB publishes a proposed rule, it must detail the rule's potential impact on small entities to the Small Business Administration (SBA).²⁵⁵ The SBA then convenes a review panel and may take up to sixty days to report its concerns to the CFPB.²⁵⁶ The CFPB must then modify its proposed rule if necessary.²⁵⁷ Following the SBREFA panel process, the CFPB may publish its proposed rule.²⁵⁸

The panel process creates rulemaking transaction costs and delays rulemaking.²⁵⁹ In general, rulemaking for a federal agency takes an average of eighteen months.²⁶⁰ The SBREFA process may add an additional two months to CFPB's rulemaking timeline.²⁶¹ As a result, the CFPB may choose to avoid rulemaking when it can and instead pursue its aims through adjudication, which is not subject to this burdensome process.²⁶² In the alternative, the CFPB may choose to propose incremental, rather than broad, rules to avoid fending off challenges from small entities.²⁶³

²⁵¹ Regulatory Flexibility Act (RFA), 5 U.S.C. §§ 601–612 (2012); *see Levitin, supra* note 250, at 348–49.

²⁵² RFA §§ 603–604; *see Levitin, supra* note 250, at 349.

²⁵³ RFA § 609(a); *see Levitin, supra* note 250, at 349.

²⁵⁴ Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA), 5 U.S.C. §§ 801–808 (2012); Credit Card Accountability Responsibility and Disclosure Act of 2009 (CARD Act), 15 U.S.C. § 657 (2012); *see Levitin, supra* note 250, at 348–49.

²⁵⁵ RFA § 609(b)(1); *see Levitin, supra* note 250, at 349; Wilmarth, *supra* note 250 at 923–24.

²⁵⁶ Regulatory Flexibility Act (RFA), 5 U.S.C. §§ 609(b)(3), 609(b)(5) (2012); *see Levitin, supra* note 250, at 349–50.

²⁵⁷ RFA § 609(b)(6); *see Levitin, supra* note 250, at 350.

²⁵⁸ RFA § 609(b); *see Levitin, supra* note 250, at 350. The publication must include: an initial regulatory flexibility analysis describing the impact the rule will have on small entities, a description of any projected increase in the cost of credit for small entities, any significant alternatives to the proposed rule that would minimize the cost of credit for small entities, the steps the CFPB has taken to reduce the cost of the rule to small entities, and any input the CFPB received from small business representatives. RFA §§ 609(a)–(b), 603(d)(1); *see Levitin, supra* note 250, at 350–51.

²⁵⁹ *See Levitin, supra* note 250, at 350.

²⁶⁰ *See id.* at 350–51.

²⁶¹ *See id.* at 351.

²⁶² *See id.*

²⁶³ *See Wilmarth, supra* note 250, at 909.

In addition to the requirements of the SBREFA, the CFPB must also perform a cost-benefit analysis whenever it undertakes rulemaking.²⁶⁴ The CFPB is required by its own statute to consider whether the rule would reduce access to consumer financial products or services, or have a negative impact on small depositaries and rural consumers.²⁶⁵ The CFPB is not required to perform this cost-benefit analysis on its adjudications, enforcement decisions, or settlements, thereby potentially encouraging the CFPB to shy away from rulemaking towards adjudication.²⁶⁶

The CFPB's rulemaking power is also constrained by its statutory requirement to consult with prudential regulators and other federal agencies before proposing rules.²⁶⁷ This consultation requirement, coupled with the ability of the Financial Stability Oversight Council to veto the CFPB's rulemaking, may result in the CFPB favoring adjudication over rulemaking.²⁶⁸

2. CFPB Adjudication Is Insufficient to Remedy Issues Within the Medical Credit Card Industry

The CFPB's choice to adjudicate against GE CareCredit rather than use rulemaking to either ban deferred interest medical credit cards or reform the entire medical credit card industry is an incomplete response to a continuing problem.²⁶⁹ Adjudication has a limited reach; for example, GE CareCredit is the only deferred interest medical credit card provider that is bound by the terms of its Consent Order.²⁷⁰ As a result, the GE CareCredit Consent Order did not create clear guidelines to direct the other deferred interest medical

²⁶⁴ Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank), 12 U.S.C. § 5512(b)(2) (2012); *see* Levitin, *supra* note 250, at 352–53.

²⁶⁵ Dodd-Frank § 5512(b)(2); *see* Levitin, *supra* note 250, at 352–53; Wilmarth, *supra* note 250, at 923–24.

²⁶⁶ Dodd-Frank § 5512(b)(2); *see* Levitin, *supra* note 250, at 352–53.

²⁶⁷ Dodd-Frank §§ 5512(B), 5481(24) (defining prudential regulator as “the appropriate Federal banking agency, as that term is defined in section 1813 of this title”); *see* Wilmarth, *supra* note 250, at 923. In particular, the CFPB must check with the regulators and agencies “regarding consistency with prudential, market, or systemic objectives administered by such agencies” Dodd-Frank § 5512(b)(2)(B). If a prudential regulator provides the CFPB with a written objection to a proposed rule, the CFPB must include a description of the objection in the release of the rule and the reason for the CFPB's adoption or rejection of the objection. *Id.* § 5512(b)(2)(C).

²⁶⁸ Dodd-Frank § 5513; *see* Levitin, *supra* note 250, at 353; Wilmarth, *supra* note 250, at 910–11. The Financial Stability Oversight Council (FSOC) was created by Dodd-Frank to identify risks to the financial stability of the United States that could arise from financial institutions. Dodd-Frank §§ 5321, 5322.

²⁶⁹ *See* Tetreault, *supra* note 209; Magill, *supra* note 32, at 1396; Saunders, *supra* note 209, at 7.

²⁷⁰ *See* Consent Order, *supra* note 30; Magill, *supra* note 32, at 1396.

credit card providers.²⁷¹ In the absence of rules incorporating the terms of the Consent Order that would apply to all providers, the CFPB can only bring about change by monitoring the other providers and initiate enforcement actions against them.²⁷²

It would be more efficient and effective for the CFPB to promulgate rules that would either ban deferred interest medical credit cards or reform the entire medical credit card industry.²⁷³ In addition to rulemaking being more efficient and effective because it impacts all similarly situated entities equally, there are other reasons rulemaking is the right next step for the CFPB.²⁷⁴ The APA requirement that the agency give notice of its intention to engage in rulemaking and solicit comments from the public would ensure that the agency considers information from multiple relevant sources.²⁷⁵ In addition, the process of receiving and vetting comments from many different informed sources and industry participants is more conducive to policymaking than the trial-like proceedings connected to adjudication.²⁷⁶

The CFPB's use of rulemaking would also be fairer to the medical credit card industry.²⁷⁷ First, as previously described, only GE CareCredit is bound by the terms of the Consent Order, potentially rendering it at a disadvantage to competitors.²⁷⁸ Second, clear rules would allow regulated entities to engage in advanced planning to ensure ongoing compliance.²⁷⁹ In contrast, continued

²⁷¹ See Shapiro, *supra* note 239, at 926. Shapiro noted that “[i]mplicit in some criticism of the failure to utilize the rulemaking process is the view that the lack of regulations is equivalent to a lack of clearly articulated standards to guide those subject to the agency’s jurisdiction.” *Id.*

²⁷² See *id.*

²⁷³ See *id.* (stating that “in the absence of regulations, the agency must ordinarily start from scratch in establishing its case in each adjudicatory proceeding even though similar issues have been resolved in prior adjudications”).

²⁷⁴ See *id.* at 935.

²⁷⁵ See Administrative Procedure Act (APA), 5 U.S.C. § 553 (2012); Shapiro, *supra* note 239, at 936 (“In rulemaking proceedings . . . agencies are relatively free to consult with their staffs, to receive far-ranging submissions of data . . .”).

²⁷⁶ See Shapiro, *supra* note 239, at 936.

²⁷⁷ See *id.* at 935 (noting that “when a practice is widespread in an industry, a rulemaking proceeding operates evenhandedly to bar that practice on the part of all, while an order directed to only one permits his competitors to gain an unfair advantage”).

²⁷⁸ See *id.*; Rick Fisher, et. al., *Client Alert: CFPB Brings First Enforcement Action Involving Deferred Interest Products, Imposes Novel and Burdensome Application Requirements as Remediation*, MORRISON FOERSTER 3 (Dec. 11, 2013), <http://media.mofo.com/files/Uploads/Images/131211-CFPB-Brings-First-Enforcement.pdf> (warning that “deferred interest programs could be significantly burdened if the CFPB applied the terms of the CareCredit consent order to other industry participants”).

²⁷⁹ See Shapiro, *supra* note 239, at 926, 941 (“The issuance of regulations . . . can serve the function of readily accessible codification . . .”); see also *id.* at 940 (“[T]he enunciation of rules in adjudicatory proceedings frequently has the effect of ‘hiding the ball’ from those who are not initiated into the mysteries of a particular agency and its works.”).

CFPB adjudication may result in the promulgation of ad hoc, disjointed directives.²⁸⁰ For reasons of efficiency, competitive fairness, and effectiveness, the CFPB should use its rulemaking powers to either ban or strictly regulate deferred interest medical credit cards.²⁸¹

3. Imposing GE CareCredit's Consent Order on the Entire Industry and Improving the CARD Act

Short of an outright ban on deferred interest medical credit cards, the CFPB should impose the terms of the GE CareCredit Consent Order on the entire medical credit card industry.²⁸² In addition, it should engage in rulemaking to expand its current CARD Act regulations to protect patients.²⁸³ The CARD Act currently requires that payments made in the last two months of a deferred interest promotional period be allocated to the promotional balance.²⁸⁴ In addition, the CARD Act sets the minimum promotional period for deferred interest rates at six months.²⁸⁵ CFPB rules call for credit card providers to disclose the length of the promotional period clearly and conspicuously.²⁸⁶ Creditors may only use the term “no interest” to describe a deferred interest product if they also include a “if paid in full” caveat in a clear and conspicuous manner.²⁸⁷ Additionally, on the front of each statement to patients, creditors must put the date by which the borrower must pay off the balance in full to avoid paying interest.²⁸⁸

The CFPB should make further improvements to the CARD Act regulations to reduce the chances that borrowers pay unexpected amounts of interest.²⁸⁹ The current language that must be included on deferred interest credit card statements should be expanded to more clearly explain to borrowers how to avoid paying interest.²⁹⁰ In addition, current CARD Act regulations that re-

²⁸⁰ *See id.* at 926, 940, 941.

²⁸¹ *See* Tetreault, *supra* note 209, at 4; Saunders, *supra* note 209, at 7–10.

²⁸² *See* Tetreault, *supra* note 209, at 6; Saunders, *supra* note 209, at 10.

²⁸³ Credit Card Accountability Responsibility and Disclosure Act of 2009 (CARD Act), Pub. L. 111-24, 123 Stat. 1734 (2009) (codified as amended in scattered sections of 15 U.S.C.); *see* CARD ACT REPORT, *supra* note 81, at 78–79; Tetreault, *supra* note 209, at 4.

²⁸⁴ Credit Card Accountability Responsibility and Disclosure Act of 2009 (CARD Act), 15 U.S.C. § 1666c(b)(2).

²⁸⁵ *Id.* § 1666i-2(b).

²⁸⁶ 12 C.F.R. § 226.55(b)(1)(i) (2014).

²⁸⁷ *Id.* § 226.16(h)(3).

²⁸⁸ *Id.* § 226.7(b)(14).

²⁸⁹ *See* Tetreault, *supra* note 209, at 6–7.

²⁹⁰ *See* 12 C.F.R. § 226.16(h)(4); Tetreault, *supra* note 209, at 6. 12 C.F.R. § 226 Appendix G, Sample G-18(h) reads: “You must pay your promotional balance in full by [date] to avoid paying accrued interest charges.” 12 C.F.R. § 226 Appendix G, Sample G-18(h). The Consumers Union proposed to add the following language:

quire creditors to evaluate only the ability of the borrower to make minimum payments at the time the credit is issued are inadequate.²⁹¹ Creditors should be required to assess not just the borrower's ability to make minimum payments but also the borrower's ability to pay off the entire balance during the deferred interest period.²⁹²

C. The CFPB Should Educate Health Care Providers About the Potential Perils of Deferred Interest Medical Credit Cards

When physicians take the Hippocratic Oath, they agree to “keep [patients] from harm and injustice.”²⁹³ To that end, physicians and other medical providers must learn about the financial products that they offer to their patients and refrain from offering harmful products.²⁹⁴ Part of the CFPB's mission is to conduct consumer education programs.²⁹⁵ Given that physicians and medical providers are the initial consumers of deferred interest medical credit cards, the CFPB should reach out to medical and other professional associations and partner with them to educate physicians about the terms and conditions of the products they are offering to patients.²⁹⁶ Ideally, if physicians and medical providers learn about the deleterious impact that these medical credit cards can have on patients, they will cease to offer the cards to their patients, or they will press credit companies to provide general-purpose credit cards with fair terms to patients instead.²⁹⁷ If physicians and medical providers continue to offer the

You will be charged interest on your purchase starting back to the original purchase date if you do not pay off the entire balance by [deferred interest period/date], you make a late payment, go over your limit, or otherwise violate your account terms. Making only the minimum payment on your account will not pay off the purchase in time to avoid interest.

Tetreault, *supra* note 209, at 6.

²⁹¹ See Tetreault, *supra* note 209 at 6–7. 12 C.F.R. § 226.51(a) (2014) requires card issuers to consider “the consumer’s independent ability to make the required minimum periodic payments under the terms of the account based on the consumer’s income or assets and current obligations.” 12 C.F.R. § 226.51(a).

²⁹² See Tetreault, *supra* note 209, at 6–7. The Consumers Union proposed to add the following to 12 C.F.R. § 226.51(a)(2)(ii)(B): “If the account carries deferred interest, the minimum payment formula applied when considering the consumer’s ability to pay must result in monthly payment sufficient to pay off the balance before the end of the deferred interest period.” *Id.*

²⁹³ LUDWIG EDELSTEIN, HIPPOCRATES: THE OATH 3 (1943); Lisa R. Hasday, *The Hippocratic Oath as Literary Text: A Dialogue Between Law and Medicine*, 2 YALE J. HEALTH POL’Y L. & ETHICS 299, 299 (2001–2002).

²⁹⁴ See Horwitz, *supra* note 18, at 828.

²⁹⁵ Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank), 12 U.S.C. § 5511(c)(1) (2012).

²⁹⁶ See *id.*

²⁹⁷ See Truth in Lending Act (TILA), 15 U.S.C. § 1601 (2012).

deferred interest cards, at least they will be able to speak knowledgeably to their patients about how they function.²⁹⁸

CONCLUSION

Deferred interest medical credit cards are deceptive and dangerous, and should be banned. When sick and vulnerable patients seek relief from medical providers, credit card companies seeking to profit at their expense should not, in turn, prey on them. Deferred interest medical credit cards lead all too often to patients being responsible for retroactive interest at extremely high rates. Absent a blanket ban, medical credit cards should have terms and conditions equivalent to general-purpose credit cards where any interest charged is based on the balance that remains at the end of a promotional period, rather than on the entire amount originally charged to the card. If medical credit cards were structured like general-purpose credit cards, they could offer the benefit of a promotional period that is truly interest-free and would not needlessly confuse fragile patients.

The Consumer Financial Protection Bureau (CFPB) should build on its 2013 enforcement action against GE CareCredit and engage in rulemaking to completely ban deferred interest medical credit cards. Short of an outright ban, the CFPB ought to use rulemaking to impose the reforms in its GE CareCredit Consent Order on the entire medical credit card industry. In addition, the CFPB should use rulemaking to revise Credit Card Accountability and Disclosure Act (CARD Act) regulations to require that creditors ensure that patients understand the terms of the deferred interest cards and how to avoid paying interest. This would advance the CFPB's mandate of consumer protection. Lastly, the CFPB should fulfill its mission by offering education for medical providers so that providers understand how the financial products they offer to their patients may ultimately harm the very patients they are trying to help. Medical providers must also take responsibility for the way that financing is presented to patients by their office staff and make sure that no high-pressure and deceptive tactics are used.

When Alice Diltz was confronted with an expensive but necessary dental procedure, she trusted the medical staff that cared for her to provide her with a reasonable way to finance the procedure. Her struggle to repay thousands of dollars for a procedure that was not even completed could have been avoided by the CFPB's implementation of consumer-focused reforms to the medical credit card industry. It is imperative that these changes occur, so that patients who need care do not sacrifice their financial well-being while pursuing their physical well-being.

²⁹⁸ See *CFPB Orders GE*, *supra* note 27.