

6-1-2019

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Wonn, Jacob (2019) "Deferred-Interest Credit for What Ails You: A Proposal for Regulation of Healthcare Providers Under the Pennsylvania Credit Services Act," *Penn State Law Review*: Vol. 123 : Iss. 3 , Article 10.

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Deferred-Interest Credit for What Ails You: A Proposal for Regulation of Healthcare Providers Under the Pennsylvania Credit Services Act

Jacob Wonn*

ABSTRACT

In self-pay healthcare markets—such as dentistry, fertility care, and cosmetic surgery—patients commonly finance their treatment on credit. For this reason, many providers in these markets have partnered with third-party medical creditors to offer their patients financing options. These medical creditors appeal to patients through deferred-interest financing plans that allow borrowers to avoid owing interest if they pay off their full balance within a given time period; however, patients who fail to do so are charged exorbitant interest rates.

Unfortunately, patients frequently enter into these credit agreements without an accurate understanding of the terms and conditions, and providers are not currently required to make any efforts to assist patients in this respect. While the vast majority of these providers are likely acting in good faith, their promotion of medical credit products may nonetheless influence patients to make suboptimal borrowing decisions. In this way, providers may inadvertently contribute to patient financial distress and erode trust in provider-patient relationships.

Accordingly, this Comment proposes that healthcare providers engaged in such practices should be bound by the Pennsylvania Credit Services Act—a statute designed to regulate “credit services organizations” that assist consumers in obtaining credit. Whether providers can qualify as credit services organizations will depend upon a showing that they receive valuable consideration in return for assisting patients to obtain credit. This Comment will analyze the plausibility and

*J.D. Candidate, The Pennsylvania State University School of Law, 2019. Special thanks to Robin for sticking with me through three years of law school; to Professor Jim Hawkins for his tremendously helpful feedback; and to the Pennsylvania Attorney General’s Healthcare Section for exposing me to a variety of interesting legal issues during my externship, including the one addressed by this Comment.

likely effect of regulating healthcare providers as credit services organizations, and will ultimately conclude that the Credit Services Act offers an immediately practicable, albeit imperfect, safeguard against unrestrained promotion of medical credit.

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I. INTRODUCTION

In recent years, Americans have faced continually-increasing healthcare expenses,¹ and as a result, specialized medical creditors like CareCredit have carved out a profitable niche in the marketplace.² These medical credit products are routinely offered to patients around the country by dentists, veterinarians, optometrists, and other healthcare professionals in markets that consist primarily of uninsured or underinsured patients.³ Medical creditors offer patients attractive deferred-interest financing to pay for expensive treatment over time without accruing interest.⁴ There is always a catch, however, and for deferred-interest medical credit, this catch is the risk of a massive interest charge for patients who do not pay off their balance in time.⁵

Companies like CareCredit surely provide a valuable service to financially savvy patients who recognize this catch and plan for it. However, problems arise when patients think they are getting something like a regular credit card that simply does not charge interest.⁶ Given that most patients receive assistance from their healthcare providers in obtaining medical credit,⁷ one would naturally expect these trusted providers to ensure that their patients fully understand the obligations they are incurring. Unfortunately, many providers have failed to live up to this expectation.⁸ Financial incentives drive providers to vigorously promote these medical credit products,⁹ and in some cases, providers have even pressured or misled patients into utilizing medical credit.¹⁰

Such unrestrained healthcare provider promotion of medical credit can have adverse consequences on individual patients and on the economy at large.¹¹ A wealth of empirical evidence shows that consumer credit

1. See *infra* notes 63–64 and accompanying text.

2. See *infra* notes 69–72 and accompanying text.

3. See *infra* notes 73–77 and accompanying text.

4. See Nora Dowd Eisenhower & Beverly Yang, *What's the Deal with Health Care Credit Cards? Four Things You Should Know*, U.S. CONSUMER FIN. PROT. BUREAU BLOG (Feb. 5, 2014), <http://bit.ly/2S8hSf5>.

5. See *id.*

6. See Press Release, N.Y. Att'y Gen., A.G. Schneiderman Announces Agreement with GE Capital Retail Bank and CareCredit LLC (June 3, 2013), <http://on.ny.gov/2Du30Bp> [hereinafter N.Y. A.G. Press Release].

7. See *Patients Using Health Credit Cards? Settlement Requires New Protections*, 27 HEALTH CARE COLLECTOR 9, 9 (2013) (finding that 65% of CareCredit cardholders applied for the card while at their providers' offices).

8. See N.Y. A.G. Press Release, *supra* note 6.

9. See *infra* Sections III.A.2 (discussing how providers benefit by assisting patients to finance treatment the patients would not otherwise purchase), III.A.3 (discussing payments received by providers in exchange for facilitating medical credit transactions).

10. See N.Y. A.G. Press Release, *supra* note 6.

11. See *infra* Section II.A.2.

markets are already rife with behavioral biases that impair rational decision-making.¹² This impairment is likely exacerbated in clinical settings, such that patients faced with borrowing decisions are especially susceptible to provider recommendations.¹³ When providers influence patients to make unwise use of medical credit, the end result is an ever-expanding medical debt load that burdens patients across the country.¹⁴ Furthermore, to the extent that such conduct causes financial harm to patients, providers likely undermine the trust that is necessary for functional therapeutic relationships.¹⁵

With these concerns in mind, this Comment proposes that governmental action must be taken to ensure that healthcare providers behave in a responsible and ethical manner when promoting medical credit. Except in cases of outright fraud, no legal penalties exist to counteract the incentives that encourage providers to maximize patient utilization of medical credit.¹⁶ However, the Pennsylvania Attorney General recently attempted to solve this problem through enforcement of an existing statute—the Pennsylvania Credit Services Act¹⁷ (CSA)—against Allcare Dental for its unethical credit promotion practices.¹⁸ Unfortunately, this litigation settled in 2018, leaving unresolved its central issue of first impression: whether a healthcare provider that facilitates patient use of medical credit qualifies as a “credit services organization” (CSO) under the CSA.¹⁹

This Comment argues that the CSA should be enforced against healthcare providers as a means to prevent financial harm to patients caused by imprudent use of medical credit. In order to demonstrate the legal validity of this proposed enforcement scheme, Part III of this Comment will explain the ways in which healthcare providers like Allcare

12. For instance, consumers tend to be shortsighted about future costs and overly optimistic about their ability to pay off debt in a timely manner. *See infra* notes 31–33 and accompanying text.

13. More specifically, patients are likely influenced by the trust they place in their providers, the increased ease of borrowing with provider assistance, and the concurrent stress associated with decisions about personal health. *See infra* notes 41–54 and accompanying text.

14. *See infra* notes 65–72 and accompanying text.

15. *See infra* notes 80–85 and accompanying text.

16. *See* Jim Hawkins, *Doctors as Bankers: Evidence from Fertility Markets*, 84 TUL. L.R. 841, 882–91 (2010) [hereinafter Hawkins, *Doctors as Bankers*].

17. 73 PA. STAT. AND CONS. STAT. ANN. §§ 2181–92 (West 2018).

18. *See* Complaint in Equity and Petition for Permanent Injunction at 21–33, Commonwealth v. Allcare Dental Management, Inc., No. 150 M.D. 2011 (Pa. Commw. Ct. Mar. 29, 2011) [hereinafter Allcare Complaint].

19. *See* Docket Sheet at 19–20, Commonwealth v. Allcare Dental Management, Inc., No. 150 M.D. 2011 (Pa. Commw. Ct. May 22, 2018), <http://bit.ly/2Gq0Jr8> [hereinafter Allcare Docket Sheet]; *see also infra* Section III.A.

can satisfy the statutory definition of CSO.²⁰ In order for these providers to be bound by the CSA, they must receive valuable consideration from patients in exchange for assistance with obtaining credit.²¹ Providers may satisfy this definitional requirement through two legal theories of consideration—*facilitated sales* and *indirect payment*—even without charging patients outright for such credit services.²² Ultimately, this Comment will conclude that the CSA provides a feasible scheme for regulating healthcare providers engaged in the promotion of medical credit.²³ Moreover, this scheme can provide a model for similar enforcement efforts by other states with CSA-cognate statutes.²⁴

II. BACKGROUND

This Part will examine the problems associated with healthcare provider promotion of medical credit, as well as a potential solution—namely, regulation under the Pennsylvania CSA. First, this Part discusses behavioral economics research indicating that provider involvement in patient borrowing decisions likely impairs rational consideration of medical credit products, potentially resulting in economic harm to those who choose to finance their treatment with such products.²⁵ Second, this Part argues that, insofar as providers influence these patients to incur financial obligations that they cannot afford, such practices likely contribute to the rising tide of medical debt in the United States and erode patient trust in healthcare providers.²⁶ Third, this Part discusses provisions of the Pennsylvania CSA that may serve as an effective vehicle for government regulation of such practices.²⁷ Finally, this Part will address the Pennsylvania Attorney General's recent effort to hold a dental provider accountable for its failure to follow the CSA's requirements in promoting medical credit products.²⁸

A. *The Need for Regulation of Healthcare Providers Engaged in Promoting Medical Credit Products*

One can hardly craft a sensible solution to any problem without first identifying exactly what the problem is. Thus, in order to understand how and why the Pennsylvania CSA should be applied to regulate healthcare

20. See *infra* Part III.

21. See 73 PA. STAT. AND CONS. STAT. ANN. § 2182.

22. See *infra* Sections III.A.2–.3.

23. See *infra* Section III.C.

24. See *infra* note 90 and accompanying text.

25. See *infra* Section II.A.1.

26. See *infra* Section II.A.2.

27. See *infra* Section II.B.1.

28. See *infra* Section II.B.2.

providers that solicit patient use of medical credit, we must first examine the consumer harms that regulation under the CSA would seek to remedy.

1. Behavioral Economic Patterns in Patient Utilization of Medical Credit²⁹

Consumer credit markets are rife with behavioral anomalies that drive suboptimal borrowing decisions.³⁰ Researchers theorize that excessive optimism and myopia commonly lead credit card users to underestimate their future costs.³¹ In this context, excessive optimism refers to the tendency of consumers to underestimate their future borrowing and overestimate their ability to avoid higher post-introductory interest rates.³² Similarly, myopia, or “hyperbolic discounting,” causes consumers to overvalue short-term benefits of credit use (such as low teaser introductory rates, rewards, and low monthly payments) relative to long-term risks (such as high post-introductory interest rates and various fees).³³

In medical credit markets, excessive optimism and myopia are reflected by patient decisions to borrow under deferred-interest financing.³⁴ These deferred-interest financing plans allow patients to pay zero interest for an introductory period, but if a borrowing patient fails to pay off the debt in full within this time, the creditor will retroactively charge interest on the patient’s entire starting balance from the date of

29. This subpart relies heavily on the work of law professor Jim Hawkins, Professor of Law at the University of Houston Law Center, one of only a few legal scholars that has devoted significant attention to the medical credit industry. *See generally* Jim Hawkins, *Toward Behaviorally Informed Policies for Consumer Credit Decisions in Self-Pay Medical Markets*, in *NUDGING HEALTH: HEALTH LAW AND BEHAVIORAL ECONOMICS* 172 (Glenn Cohen et al. eds., 2016) (discussing behavioral economic issues in medical credit markets and possible reform efforts) [hereinafter Hawkins, *Behaviorally Informed Policies*]; Hawkins, *Doctors as Bankers*, *supra* note 16 (discussing issues associated with doctor promotion of medical credit in the context of fertility care).

30. *See* Hawkins, *Behaviorally Informed Policies*, *supra* note 29, at 174.

31. *See id.*; Oren Bar-Gill & Ryan Bubb, *Credit Card Pricing: The Card Act and Beyond*, 97 *CORNELL L. REV.* 967, 976 (2012).

32. *See* Oren Bar-Gill, *Seduction by Plastic*, 98 *NW. U. L. REV.* 1373, 1375–76, 1405–07 (2004); Hawkins, *Behaviorally Informed Policies*, *supra* note 29, at 174. Credit card issuers commonly utilize low introductory interest rates, also known as “teaser” rates, to attract potential customers; during an initial teaser period, the cardholder’s balance accrues interest at a relatively low rate, if at all, but when the teaser period ends, the cardholder must pay a significantly higher post-introductory interest rate. *See* Bar-Gill, *supra*, at 1392.

33. *See* Hawkins, *Behaviorally Informed Policies*, *supra* note 29, at 174; Bar-Gill, *supra* note 32, at 1408; Jason Kilborn, *Behavioral Economics, Overindebtedness and Comparative Consumer Bankruptcy: Searching for Causes and Evaluating Solutions*, 22 *EMORY BANKR. DEV. J.* 13, 21–22, 37–38 (2005); Jonathan Slowik, *Credit Card Act II: Expanding Credit Card Reform by Targeting Behavioral Biases*, 59 *UCLA L. REV.* 1292, 1308–13 (2012).

34. *See* Hawkins, *Behaviorally Informed Policies*, *supra* note 29, at 174–75.

purchase.³⁵ In the medical credit market, these deferred interest rates are often astronomically high; for example, CareCredit, a prominent medical creditor, charges 26.99% APR interest on deferred-interest payment plans.³⁶

The New York Attorney General conducted an investigation of CareCredit, which found that 9 out of 10 consumers chose the deferred-interest option, and one-quarter of those consumers failed to pay off their balances before the 26.99% interest took effect—frequently because they did not understand the terms.³⁷ This troubling statistic suggests that patients are excessively optimistic about their ability to pay back medical debt before the high deferred-interest rate activates, and are likewise myopic in overvaluing the initial zero percent interest period relative to the long-term risk of incurring exorbitant finance charges.³⁸ Researchers contend that the effects of excessive optimism and myopia in medical credit markets produce a “behavioral market failure,” insofar as “consumers misjudge the cost relative to the value of the product.”³⁹

Moreover, healthcare provider-facilitated utilization of third-party medical credit is hypothesized to produce behavioral anomalies that, unlike excessive optimism and myopia, are unique to the context of patient borrowing decisions.⁴⁰ First, the relationship between healthcare providers and medical creditors likely produces a halo effect, whereby the trust that patients place in their healthcare providers translates to more favorable evaluations of the creditors that they promote.⁴¹ While no direct evidence of this halo effect in the medical credit context yet exists, ample evidence exists to show that patients trust their doctors’ recommendations and indeed prefer for doctors to make treatment decisions rather than deciding for themselves.⁴²

35. See Eisenhower & Yang, *supra* note 4.

36. *CareCredit Credit Card Account Agreement*, CARECREDIT 2, 4 (2017), <https://www.carecredit.com/YourTerms/June2017.pdf>. Compare CareCredit’s 26.99% APR to the national average APR for all consumer credit card accounts at the end of 2018: 14.73%. See *Consumer Credit—G.19*, BD. GOVERNORS FED. RESERVE SYS. (Mar. 7, 2019), <http://bit.ly/2ILMD1d>.

37. N.Y. A.G. Press Release, *supra* note 6.

38. See Hawkins, *Behaviorally Informed Policies*, *supra* note 29, at 174–75; Bar-Gill, *supra* note 32, at 1405; Bar-Gill & Bubb, *supra* note 31, at 975–77. Furthermore, the effects of myopia in patient borrowing decisions are likely compounded by medical creditors’ efforts to frame deferred-interest plans in a way that emphasize the short-term benefit of low monthly payments. See Hawkins, *Doctors as Bankers*, *supra* note 16, at 859.

39. Hawkins, *Behaviorally Informed Policies*, *supra* note 29, at 175.

40. See *id.*

41. See *id.*

42. See Russell Korobkin, *Comparative Effectiveness Research as Choice Architecture: The Behavioral Law and Economics Solution to the Health Care Cost Crisis*, 112 MICH. L. REV. 523, 540–41 (2014).

Professor Jim Hawkins, a medical credit scholar, posits that the confirmation bias⁴³ causes patients to interpret new information about their doctors in a way that will comport with their preexisting sense of trust.⁴⁴ As such, Professor Hawkins infers that patients interpret the information they receive from doctors regarding third-party financing options in a positive manner that comports with the trust they place in their doctors.⁴⁵ This proposed halo effect is likely exacerbated to the extent that the creditor and doctor display each other's logos and other intellectual property,⁴⁶ confusing patients as to the relationship between doctor and creditor.⁴⁷ Whatever the cause, healthcare providers undoubtedly have profound influence over patient utilization of medical credit; indeed, CareCredit reported that over half of its cardholders said they would have postponed or reduced the scope of their treatment had their providers not offered financing.⁴⁸

Second, patient decisions to accept medical credit under the guidance of healthcare providers are likely impacted by reduced salience due to automation and cognitive load.⁴⁹ Automation effects result from the ease and speed with which patients can be approved for medical credit, thereby

43. "Confirmation bias, as the term is typically used in the psychological literature, connotes the seeking or interpreting of evidence in ways that are partial to existing beliefs, expectations, or a hypothesis in hand." Raymond S. Nickerson, *Confirmation Bias: A Ubiquitous Phenomenon in Many Guises*, 2 REV. GEN. PSYCHOL. 175, 175 (1998).

44. See Hawkins, *Behaviorally Informed Policies*, *supra* note 29, at 175; see also Richard G. Frank, *Behavioral Economics and Health Economics*, in BEHAVIORAL ECONOMICS AND ITS APPLICATIONS 205, 205–06 (Peter Diamond & Hannu Vartianen eds., 2007) (showing that patients tend to avoid attributing adverse treatment outcome data to doctor performance).

45. See Hawkins, *Behaviorally Informed Policies*, *supra* note 29, at 175.

46. See *id.* at 175–76. For example, CareCredit receives a nonexclusive license to use the "name, trademarks, logos and other marks" from all participating healthcare professionals in connection with its "administration and operation." *Card Acceptance Agreement for Participating Professionals*, CARECREDIT § 16(k) (2016), available at <https://perma.cc/3EXH-LEBT> [hereinafter *CareCredit Agreement for Participating Professionals*] (CareCredit no longer publishes the current version of this agreement on its website; accordingly, this Comment relies on an archived prior version). Likewise, all participating healthcare professionals must agree to display CareCredit point-of-sale signage. *Id.* § 2(a).

47. See Hawkins, *Behaviorally Informed Policies*, *supra* note 29, at 175–76. Indeed, medical creditors like CareCredit appear to be fully aware of this potential for confusion, as its participation agreement with healthcare providers grants CareCredit a limited power of attorney to deposit patient checks mistakenly made out to providers, and likewise, requires providers to hold in trust any patient payments intended for CareCredit. See *CareCredit Agreement for Participating Professionals*, *supra* note 46, § 3(g). This concern is validated by the New York Attorney General's finding that a number of CareCredit customers mistakenly believed that they were signing up for in-house payment plans with their providers. See N.Y. A.G. Press Release, *supra* note 6.

48. Synchrony Financial, Annual Report (Form 10-K) at 15 (Feb. 22, 2018). Note that CareCredit is a subsidiary of Synchrony Financial. *Id.* at 7.

49. See Hawkins, *Behaviorally Informed Policies*, *supra* note 29, at 176.

reducing the salience of potentially risky credit terms that may otherwise deter patients.⁵⁰ While this automation effect has not been directly demonstrated in the context of provider-facilitated medical credit transactions, research in other contexts has found analogous effects.⁵¹

Furthermore, patients considering whether to accept medical credit products recommended by their healthcare providers likely suffer from high cognitive load, as these decisions often take place in providers' offices while patients are simultaneously making stressful decisions about whether to accept costly and potentially hazardous or life-changing health treatments.⁵² Researchers have found that "unfamiliar, tense, or distracting" situations tax an individual's cognitive faculties, diverting attention away from the decision-making process.⁵³ These findings suggest that when patients under cognitive load make medical credit decisions, potentially adverse credit terms have reduced salience and patients are left more susceptible to both internal biases and external influences like doctor recommendations.⁵⁴

In summary, a number of different behavioral anomalies influence patients to make suboptimal decisions in accepting deferred-interest medical credit products.⁵⁵ Patients faced with these credit decisions in clinical settings may defer to their healthcare providers' recommendations without rational consideration of the risks and benefits.⁵⁶ Patient deliberation is likely further impaired by expedited credit approval processes and concurrent stress associated with decisions about personal health.⁵⁷ Unlike excessive optimism and myopia, which are theorized to influence virtually all consumer credit decisions, these behavioral anomalies are specific to medical credit markets.⁵⁸ Accordingly, the

50. *See id.* In the part of its website directed toward providers, CareCredit emphasizes the ease and speed with which patients can gain access to credit. *See Frequently Asked Questions*, CARECREDIT, <https://gosyf.com/2yJGaAI> (last visited Aug. 2, 2019) (stating that patients receive decisions on their credit applications "within seconds," and that "office staff can then process charges to the cardholder account immediately").

51. *See* Hawkins, *Behaviorally Informed Policies*, *supra* note 29, at 176; *see also, e.g.*, Amy Finkelstein, *E-ZTax: Tax Salience and Tax Rates* 34–35 (Nat'l Bureau of Econ. Research, Working Paper No. 12924, 2007) (finding that the reduced salience of automated toll collection increases toll prices while decreasing elasticity of demand as compared to manual toll collection).

52. *See* Hawkins, *Behaviorally Informed Policies*, *supra* note 29, at 176.

53. Michael S. Barr et al., *Behaviorally Informed Regulations*, in *THE BEHAVIORAL FOUNDATIONS OF PUBLIC POLICY* 440, 442 (Eldar Shafir ed., 2013).

54. *See* Hawkins, *Behaviorally Informed Policies*, *supra* note 29, at 176–77.

55. *See id.* at 174–77.

56. *See id.* at 175.

57. *See id.* at 176–77.

58. *See id.* at 174–75.

involvement of healthcare professionals in patient borrowing arguably poses unique risks that justify government intervention.⁵⁹

2. Medical Credit's Contribution to Patient Debt and Distrust of Providers

Although medical credit may expand access to important health services that patients could not otherwise afford, it can also lead patients to incur unmanageable debt with long-lasting financial consequences.⁶⁰ Given the influence that healthcare providers can have over patient borrowing decisions,⁶¹ these providers have a responsibility to exercise their influence in an ethical manner. Otherwise, unrestrained provider promotion of medical credit may erode consumer trust in the health professions and contribute to increasing medical debt and bankruptcy in the United States.⁶² In light of these consumer welfare concerns, such practices should be regulated under the CSA.

In recent years, patients across the nation have faced increased out-of-pocket healthcare expenses and related debt.⁶³ Although the annual growth rate of healthcare costs has slowed in recent years, it continues to outpace both Gross Domestic Product and average family income.⁶⁴ As a consequence, consumer medical debt is exceedingly common in the United States.⁶⁵ In Pennsylvania alone, 21.8% of residents had past-due

59. *See id.* at 179. To be sure, without further empirical research of medical credit markets, one cannot conclude with certainty that the aforementioned behavioral anomalies exert significant influence on consumer decisions in this context; nonetheless, Professor Hawkins argues that policymakers should not “wait for perfect knowledge” to take action. *See id.* at 177–78. Furthermore, Professor Hawkins asserts that medical credit markets are especially compatible with the previously described behavioral economic model of consumer choice (though his reasoning is beyond the scope of this Comment). *See id.* at 178.

60. *See id.* at 174.

61. *See supra* notes 40–48 and accompanying text.

62. *See infra* notes 65–72, 80–85 and accompanying text.

63. *See generally* SARA L. COLLINS ET AL., THE COMMONWEALTH FUND, TOO HIGH A PRICE: OUT-OF-POCKET HEALTH CARE COSTS IN THE UNITED STATES (2014), <http://bit.ly/2DUPWUm> (discussing research findings on various types of out-of-pocket healthcare costs faced by U.S. consumers); LIZ HAMEL ET AL., THE KAISER FAMILY FOUNDATION, THE BURDEN OF MEDICAL DEBT: RESULTS FROM THE KAISER FAMILY FOUNDATION/NEW YORK TIMES MEDICAL BILLS SURVEY (2016), <http://bit.ly/2DSmVZ7> (discussing research findings on the prevalence of medical debt among U.S. consumers).

64. PWC HEALTH RES. INST., MEDICAL COST TREND: BEHIND THE NUMBERS 2018, at 3 (June 2017), <https://pwc.to/2GbZXTX>.

65. *See* U.S. CONSUMER FIN. PROT. BUREAU, CONSUMER CREDIT REPORTS: A STUDY OF MEDICAL AND NON-MEDICAL DEBT COLLECTIONS 18, 51 (2014), <http://bit.ly/2RGSJ78> (finding that medical collections tradelines—i.e., seriously delinquent accounts—accounted for over half of all collections tradelines and appeared on nearly one in five U.S. consumer credit reports, affecting around 42.9 million Americans); HAMEL ET AL., *supra* note 63, at 1 (finding that that over one-quarter of Americans struggled to pay a medical

medical debt during 2015.⁶⁶ Moreover, medical debt can have adverse consequences beyond run-of-the-mill financial strain; in severe cases, it can cause, or at least contribute to, personal bankruptcy.⁶⁷ A number of researchers have concluded that medical debt contributes to more than half of all personal bankruptcies, though the precise extent to which medical debt drives personal bankruptcy has been hotly debated.⁶⁸

Although no data is readily available to show the exact degree to which medical credit products contribute to medical debt and bankruptcy, existing evidence suggests that it is substantial. As of early 2019, the medical credit industry earns approximately \$24 billion in annual revenue.⁶⁹ CareCredit alone has a network of over 200,000 participating professionals and 11 million cardholders.⁷⁰ Moreover, CareCredit's parent corporation, Synchrony Financial, revealed in its most recent annual report to the Securities and Exchange Commission (SEC) that CareCredit was owed almost \$9 billion in loan receivables at the end of 2017 and booked over \$42 billion in revenue from loan interest and fees that year.⁷¹ This

bill in 2015, and more than half of these individuals owed over \$2,500, while 13% owed over \$10,000).

66. MICHAEL KARPMAN & KYLE J. CASWELL, URBAN INST., PAST-DUE MEDICAL DEBT AMONG NONELDERLY ADULTS, 2012–15, at 6–7 (2017), <https://urbn.is/2t4GOpF>.

67. See Donald D. Hackney et al., *What is the Actual Prevalence of Medical Bankruptcies?*, 43 INT'L J. SOC. ECON. 1284, 1284 (2015).

68. Compare David U. Himmelstein et al., *Illness and Injury as Contributors to Bankruptcy*, HEALTH AFF. (WEB EXCLUSIVE) W5-63, 66, 70 (2005), <http://bit.ly/2RC6ST2> (finding that 54.5% of all personal bankruptcy filings could be classified as medical bankruptcies, which primarily affected middle-class debtors), and Hackney et al., *supra* note 67, at 1295 (finding that, after accounting for misclassification, the actual prevalence of medical bankruptcy is approximately 50%), with David Dranove & Michael L. Millenson, *Medical Bankruptcy: Myth Versus Fact*, 25 HEALTH AFF. 74, 74 (2006) (finding that medical debt only causes 17% of personal bankruptcies, which primarily affected those with incomes near poverty level), and Tal Gross & Matthew J. Notowidigdo, *Health Insurance and the Consumer Bankruptcy Decision: Evidence from Expansions of Medicaid*, 95 J. PUB. ECON. 767, 776 (2011) (finding that prevalence of medical bankruptcy is closer to 26% and primarily affects lower-income households). *But see* Melissa B. Jacoby & Mirya Holman, *Managing Medical Bills on the Brink of Bankruptcy*, 10 YALE J. HEALTH POL'Y, LAW, & ETHICS 239, 240–43 (2010) (finding that medical bankruptcy research based on court records fails to account for the common scenario in which consumers pay off medical debt using credit cards and home equity loans prior to filing for bankruptcy, such that little to no medical debt appears in their records).

69. See *Medical Patient Financing: Market Research Report*, IBISWORLD (Jan. 2019), <http://bit.ly/2DOYrQt>. Furthermore, this amount has grown for the past five years. *Id.*

70. *About Us*, CARECREDIT, <https://gosity.com/2MWfJyp> (last visited on Aug. 2, 2019).

71. Synchrony Financial, Annual Report (Form 10-K) at 91 (Feb. 22, 2018). Furthermore, CareCredit's loan receivables and interest revenue both grew significantly between 2015 and 2017. *Id.*

data indicates that medical creditors are responsible for at least several billion dollars-worth of outstanding medical debt in the United States.⁷²

The medical credit industry's contribution to medical debt is likely concentrated in self-pay markets like dentistry, which are characterized by high numbers of uninsured patients and high out-of-pocket costs even with insurance.⁷³ Unsurprisingly, almost two-thirds of CareCredit's loan revenue comes from financing dental care,⁷⁴ and more than half of its participating professionals are dentists.⁷⁵ Indeed, CareCredit partners with "networks of healthcare practitioners that provide elective and other procedures that generally are not fully covered by insurance."⁷⁶ Given that provider promotion of medical credit appears to chiefly impact patients in self-pay markets like dentistry, consumer protection efforts should target these markets.⁷⁷

Beyond mere economic consequences, provider promotion of medical credit products may have adverse consequences for patient trust in healthcare professionals. To illustrate this concern, consider that CareCredit is endorsed by over 100 professional associations, such as the American Dental Association.⁷⁸ Over half of these endorsements are *paid* endorsements in which the association receives payment linked to the number of its members enrolled in the program and the volume of business that they refer.⁷⁹ Law professor Gina Calabrese has observed that these practices present a conflict of interest for healthcare professionals:

72. *See id.*

73. *See Marko Vujicic, Time to Rethink Dental "Insurance", 147 J. AM. DENTAL ASS'N 907, 907-09 (2016); see also Hawkins, Doctors as Bankers, supra note 16, at 856 n.65, 861 (discussing the prevalence of medical credit utilization for fertility treatments and other self-pay procedures). See also HAMEL ET AL., supra note 63, at 7 (finding that 41% of survey respondents struggled to pay a dental bill in 2015, and 12% reported that dental bills constituted the largest share of bills they struggled to pay); BD. GOVERNORS FED. RESERVE SYS., REPORT ON THE ECONOMIC WELL-BEING OF U.S. HOUSEHOLDS IN 2017, at 23 (May 2018), <http://bit.ly/2D9gFe1> (finding that 19% of survey respondents reported forgoing needed dental care due to the cost, a higher percentage than for any other type of medical service included in the survey).*

74. Synchrony Financial, Annual Report (Form 10-K) at 14 (Feb. 22, 2018). CareCredit's remaining revenue comes from other self-pay medical markets like vision, veterinary, and cosmetic care. *Id.*

75. *Compare Help Put Dental Care Within Reach of Your Patients*, CARECREDIT, <https://gosity.com/2GooOOY> (last visited on Feb. 2, 2019) (noting that over 100,000 dental providers are enrolled with CareCredit), with *Frequently Asked Questions*, supra note 50 (noting that over 200,000 total providers are enrolled with CareCredit).

76. Synchrony Financial, Annual Report (Form 10-K) at 14 (Feb. 22, 2018).

77. The Pennsylvania Attorney General's claims against Allcare Dental for violations of the CSA lend credence to this view. *See infra* Section II.B.2.

78. Synchrony Financial, Annual Report (Form 10-K) at 14 (Feb. 22, 2018).

79. *Id.* As a result of the New York Attorney General's settlement with CareCredit in 2013, CareCredit can no longer use these paid endorsements in marketing its credit products to New York consumers. *See* N.Y. A.G. Press Release, supra note 6.

“[w]hen you have doctors promoting cards and loans with unconscionable finance terms as if they were sales agents for the lenders, it raises serious ethical issues, given the trust patients place in physicians, whose first obligation should be to their patients.”⁸⁰ Pennsylvania courts have gone so far as to state that medical professionals owe a fiduciary duty to their patients, though no case has yet addressed the scope of this duty with regard to financial matters.⁸¹

In any event, a 2014 study found that patients’ trust in their healthcare providers is significantly influenced by financial factors; a majority of Americans believe that high costs are the biggest problem facing the healthcare system, and lower-income patients are less trusting of their doctors.⁸² These findings led the authors to conclude that medical professionals must make a stronger effort to care for the financial health of patients.⁸³ Moreover, evidence suggests that patient trust in their medical providers may have significant health consequences.⁸⁴ Thus, regulation of healthcare providers under the Pennsylvania CSA can serve the valuable social purpose of preserving trust in patient-provider relationships that may otherwise suffer from unrestrained promotion of potentially harmful medical credit products.⁸⁵

80. *Credit cards and finance lines for medical care*, CONSUMER REPORTS, <http://bit.ly/2RETT2N> (last updated July 2008).

81. See *Weiley v. Albert Einstein Med. Ctr.*, 51 A.3d 202, 217–18 (Pa. Super. Ct. 2012); see also *Toney v. Chester Cty. Hosp.*, 961 A.2d 192, 199–200 (Pa. Super. Ct. 2008), *aff’d*, 614 Pa. 98 (2011). But see *Moore v. Regents of Univ. of Cal.*, 793 P.2d 479, 485 n.10 (Cal. 1990) (concluding that a doctor’s fiduciary duty to his patient did not extend to financial matters, only health-related matters). Given modern research on the impact of financial distress on physical and psychological health, one may plausibly argue that financial matters *are* health-related matters within a doctor’s fiduciary duty. See John A. Sturgeon et al., *The Psychosocial Context of Financial Stress: Implications for Inflammation and Psychological Health*, 78 J. PSYCHOSOMATIC MED. 134, 141 (2016).

82. Robert J. Blendon et al., *Public Trust in Physicians—U.S. Medicine in International Perspective*, 371 NEW ENG. J. MED. 1570, 1571–72 (2014).

83. *Id.* at 1572.

84. See Kathryn Whetten et al., *Exploring Lack of Trust in Care Providers and the Governments as Barrier to Health Service Use*, 96 AM. J. PUB. HEALTH 716, 719–20 (2006) (finding that HIV patients’ trust in healthcare providers was positively associated with treatment plan compliance and favorable health outcomes); Donald Musa et al., *Trust in the Healthcare System and Use of Preventive Health Services by Older Black and White Adults*, 99 AM. J. PUB. HEALTH 1293, 1297 (2009) (finding that patients’ trust in their physicians “played a significant role” in increasing utilization of preventive health services).

85. See Roy Spece et al., *An Empirical Method for Materiality: Would Conflict of Interest Disclosures Change Patient Decisions?*, 40 AM. J. L. & MED. 253, 261–62, 268–69 (2014) (finding that disclosure of physicians’ financial conflicts of interest reduced patient trust and increased likelihood that patients would reject physicians’ treatment recommendations).

B. *Regulation of Healthcare Providers Under the Pennsylvania Credit Services Act*

Thus far, government regulation of healthcare providers engaged in promoting medical credit has been virtually nonexistent.⁸⁶ Instead, regulators have sought to advance consumer protection in medical credit markets through creditor-side enforcement actions, as demonstrated by the U.S. Consumer Financial Protection Bureau's \$34.1 million restitution order against CareCredit for deceptive credit card enrollment practices.⁸⁷ However, this piecemeal creditor-side enforcement fails to regulate the medical credit industry as a whole, and likewise fails to impose any legal duty on healthcare providers to act in their patients' best interests when promoting risky deferred-interest medical credit products.⁸⁸

Although specialized legislation might provide the best long-term solution to this issue,⁸⁹ the legislative process is notoriously slow, and Pennsylvania already has a law on the books—the CSA—that can serve to regulate healthcare providers engaged in medical credit promotion. Furthermore, a number of other states have laws that are closely analogous to the Pennsylvania CSA,⁹⁰ which may allow the enforcement scheme proposed by this Comment to serve as a model for consumer protection efforts across the nation.

1. Relevant Provisions of the Pennsylvania Credit Services Act and Proposed Application to Healthcare Providers

The CSA applies to “credit services organizations” (CSOs), which it defines as:

[a] person who, with respect to the extension of credit by others, sells, provides or performs . . . any of the following services in return for the payment of money or other valuable consideration: . . . (iii) Obtaining an extension of credit for a buyer.⁹¹

86. See Hawkins, *Doctors as Bankers*, *supra* note 16, at 882–91.

87. See CFPB Orders *GE CareCredit to Refund \$34.1 Million for Deceptive Health-Care Credit Card Enrollment*, U.S. CONSUMER FIN. PROT. BUREAU (Dec. 10, 2013), <http://bit.ly/2GhH2Sk>; see also N.Y. A.G. Press Release, *supra* note 6.

88. See Hawkins, *Doctors as Bankers*, *supra* note 16, at 884–86.

89. See *id.* at 891–96 (discussing proposed legislative solutions to address healthcare providers engaged in promoting medical credit products).

90. See, e.g., California Credit Services Act, CAL. CIV. CODE § 1789.12(a) (West 2018); Maryland Credit Services Business Act, MD. CODE ANN., COM. LAW § 14-1901(e) (West 2018); Illinois Credit Services Act, 815 ILL. COMP. STAT. ANN. § 605/3(d) (West 2018); Wisconsin Credit Services Organizations Act, WIS. STAT. ANN. § 422.501(2) (West 2018).

91. 73 PA. STAT. AND CONS. STAT. ANN. § 2182 (West 2018).

Assuming that healthcare providers can satisfy this definition,⁹² the CSA provides a number of safeguards and remedies that can be enforced to ensure that healthcare providers adequately guard their patient's interests when promoting third-party medical credit products. The following paragraphs will discuss provisions of the CSA that can be enforced against healthcare providers in order to prevent patient financial distress and maintain trust in patient-provider relationships.⁹³

First, Section 2186(a)⁹⁴ of the CSA requires that CSOs execute a signed, written contract with each buyer that must contain “[t]he terms of payment to be made by the buyer, including the total of all payments to be made by the buyer, whether to the credit services organization or to some other person.”⁹⁵ Likewise, the contract must contain “[a] full and detailed description of the services to be performed by the credit services organization for the buyer, including all guarantees.”⁹⁶ If the provider's credit services will be indirectly compensated by the patient through funds tendered to the third-party creditor,⁹⁷ then presumably Section 2186(a) would require the credit services contract to disclose any such indirect payment.⁹⁸ This disclosure could serve to elucidate the provider's pecuniary relationship with a third-party creditor, which may thereby dispel the influence of any halo effect on the patient's borrowing decision.⁹⁹

Second, Section 2186(c) provides that credit service contracts must be accompanied by a standard notice of cancellation that informs buyers of their right to cancel the contract within five days of its execution.¹⁰⁰ The notice of cancellation provision effectively provides a five-day “cooling off period” for patients to reconsider their decision to use medical credit.¹⁰¹ Thus, patients enrolling in a medical credit program with the assistance of a healthcare provider would likely be required to wait five days before using the credit to pay for treatment.¹⁰² This “cooling off” period would

92. See *infra* at Section III.A.

93. See *supra* at Section II.A.2.

94. 73 PA. STAT. AND CONS. STAT. ANN. § 2186(a) (West 2018).

95. *Id.*

96. *Id.*

97. See *infra* Section III.A.3 (discussing indirect payment as consideration for credit services).

98. This provision requires credit service contracts to contain all terms of payment to be made by the buyer, “whether to the credit services organization or to some other person.” See 73 PA. STAT. AND CONS. STAT. ANN. § 2186(a) (emphasis added).

99. See *supra* Section II.A.1.

100. See 73 PA. STAT. AND CONS. STAT. ANN. § 2186(c).

101. See *id.*; Hawkins, *Behaviorally Informed Policies*, *supra* note 29, at 176.

102. See *infra* Section III.B. Medical credit products generally cannot be used to purchase any emergency services anyway, so this waiting period is unlikely to present any undue burden on healthcare access. See, e.g., CareCredit, *Agreement for Participating*

serve to counteract the reduced salience of credit terms that results from making rushed credit decisions in clinical settings.¹⁰³

Third, Sections 2184¹⁰⁴ and 2185¹⁰⁵ of the CSA require that a CSO provide an information sheet to each buyer, which must be signed by the buyer prior to execution of a written credit services contract.¹⁰⁶ The information sheet must contain specified information regarding the services that the CSO will undertake to perform on behalf of the buyer, the buyer's obligations to the CSO, and the buyer's rights with respect to consumer credit reporting agencies.¹⁰⁷ Again, the information sheet requirement may enable patients to make more informed decisions about whether to accept third-party credit.¹⁰⁸

Fourth, Section 2183(4)¹⁰⁹ prohibits CSOs from making any "untrue or misleading representations," or engaging in any "act, practice, or course of business," that potentially operates as a "deception or fraud" upon any person in connection with the offer or sale of its services.¹¹⁰ If enforced, this broad prohibition on "untrue or misleading" conduct would likely cause providers to err on the side of greater disclosure and transparency when obtaining credit for patients.¹¹¹ For instance, this provision would hopefully encourage providers to ensure that patients understand how

Professionals, *supra* note 46, § 6(a)(xiii). If a patient is determined to make an immediate non-emergency purchase using a medical credit product, they can simply apply independently to avoid the five-day waiting period. *See* 73 PA. STAT. AND CONS. STAT. ANN. §§ 2182, 2186 (West 2018) (limiting applicability of the CSA's contract requirements to transactions between "buyers" and "credit services organizations" as defined in the statute; lending institutions like CareCredit are expressly excluded from the definition of "credit services organization," so a direct transaction between a patient and CareCredit will not be subject to the CSA's notice of cancellation or other provisions). Requiring such patients to apply for credit directly with a lender would still serve to eliminate or at least mitigate the influence of halo or automation effects caused by a provider's facilitation of the lending process. *See supra* Section II.A.1.

103. *See supra* Section II.A.1. The wisdom of requiring such a "cooling off" period is affirmed by the New York Attorney General's settlement with CareCredit, which prohibited charging a patient any amount over \$1000 within three days of the patient's initial application. *See* N.Y. A.G. Press Release, *supra* note 6.

104. 73 PA. STAT. AND CONS. STAT. ANN. § 2184 (West 2018).

105. 73 PA. STAT. AND CONS. STAT. ANN. § 2185 (West 2018).

106. *See* 73 PA. STAT. AND CONS. STAT. ANN. §§ 2184–85.

107. *See id.*

108. *See* Hawkins, *Behaviorally Informed Policies*, *supra* note 29, at 180.

109. 73 PA. STAT. AND CONS. STAT. ANN. § 2183(4) (West 2018).

110. *See id.*

111. *See* Hawkins, *Behaviorally Informed Policies*, *supra* note 29, at 180 (noting that healthcare providers are especially unlikely to attempt to "evade or thwart legal intervention").

deferred-interest credit works, as many patients are likely unfamiliar with such arrangements.¹¹²

Fifth, Section 2183(1) prohibits a CSO from accepting any payment or other valuable consideration until it has performed agreed-upon services in full.¹¹³ Thus, when a provider assists a patient with obtaining credit to finance the purchase of treatment, Section 2183(1) ostensibly prohibits the provider from charging the patient until the treatment is performed in full.¹¹⁴ For this to be true, such treatment would need to be part of the provider's agreed-upon performance under the credit service contract.¹¹⁵

Finally, consumers harmed by violations of the CSA are permitted to recover actual damages, reasonable attorney fees, costs, and even punitive damages if the trial court "deems it proper."¹¹⁶ More importantly, Section 2190(a)¹¹⁷ provides that violating any of the CSA's provisions constitutes an "unfair trade practice" in violation of the Pennsylvania Unfair Trade Practices and Consumer Protection Law (UTPCPL).¹¹⁸ In addition to creating a private right of action,¹¹⁹ the UTPCPL permits public enforcement actions for injunctive relief,¹²⁰ restitution and costs,¹²¹ as well as civil penalties.¹²² As remedial legislation, the UTPCPL is to be construed liberally in order to achieve its purpose of preventing unfair or deceptive practices.¹²³ Moreover, the Pennsylvania courts have interpreted the UTPCPL's prohibition against unfair trade practices more broadly in public enforcement actions than in private ones.¹²⁴ The fact that any violation of the CSA constitutes a *per se* violation of the UTPCPL indicates the legislature's recognition that both statutes serve an overarching purpose of consumer protection,¹²⁵ and for this reason, the

112. Indeed, the New York Attorney General's investigation of CareCredit revealed that many patients were misled by providers into thinking that CareCredit was interest-free. See N.Y. A.G. Press Release, *supra* note 6.

113. See 73 PA. STAT. AND CONS. STAT. ANN. § 2183(1).

114. 73 PA. STAT. AND CONS. STAT. ANN. § 2183(1). The New York Attorney General's investigation of CareCredit revealed that prepayment of providers was a common problem. See N.Y. A.G. Press Release, *supra* note 6.

115. See *infra* Section III.B.

116. 73 PA. STAT. AND CONS. STAT. ANN. § 2191 (West 2018).

117. 73 PA. STAT. AND CONS. STAT. ANN. § 2190(a) (West 2018).

118. See *id.*; 73 PA. STAT. AND CONS. STAT. ANN. §§ 201-1 to -9.3 (West 2018).

119. See 73 PA. STAT. AND CONS. STAT. ANN. § 201-9.2.

120. See 73 PA. STAT. AND CONS. STAT. ANN. § 201-4.

121. See 73 PA. STAT. AND CONS. STAT. ANN. § 201-4.1.

122. See 73 PA. STAT. AND CONS. STAT. ANN. § 201-8.

123. See Commonwealth *ex rel.* Creamer v. Monumental Properties, Inc., 329 A.2d 812, 815-17 (Pa. 1974).

124. See Commonwealth v. Percudani, 844 A.2d 35, 48 (Pa. Commw. Ct. 2004).

125. 73 PA. STAT. AND CONS. STAT. ANN. § 2190 (West 2018).

CSA should also be liberally construed in public enforcement actions to achieve this purpose.¹²⁶

2. Pennsylvania's Recent Litigation of Claims Under the CSA Against Allcare Dental

In 2011, the Pennsylvania Attorney General filed suit against the Allcare Dental corporate family for violations of the CSA.¹²⁷ At the time of this filing, the Office of Attorney General had received over 800 consumer complaints against Allcare.¹²⁸ The Attorney General alleged that Allcare Dental qualified as a CSO because it assisted patients with applying for third-party credit in order to finance the purchase of its dental products and services.¹²⁹ According to the Attorney General's theory, by obtaining extensions of credit on behalf of patients that would not have otherwise purchased Allcare's products or services, Allcare received valuable consideration in the form of a prepaid customer.¹³⁰

Based on the premise that Allcare Dental acted as a CSO, the Attorney General's Complaint alleged that Allcare violated the CSA in two ways.¹³¹ First, the Attorney General alleged that Allcare failed to provide patients with the CSA's required written notice of cancellation.¹³² Second, the Attorney General alleged that Allcare violated the CSA by requiring consideration from patients prior to rendering full performance of its obligations under the credit service agreement (as in, before Allcare provided dental work to the patient).¹³³ In its Prayer for Relief, the Attorney General requested that Allcare be permanently enjoined from engaging in any practices found to violate the CSA, in addition to paying civil penalties and restitution to its patients for any such violations.¹³⁴ Although the *Allcare* litigation ultimately settled,¹³⁵ it still laid a foundation for future efforts to regulate healthcare providers under the CSA—a foundation that can be analyzed and improved upon.

To summarize, unrestrained provider promotion of medical credit risks serious economic harm to patients, as well as social harm to the trust placed in healthcare professionals. Fortunately, the Pennsylvania CSA exists to regulate businesses that assist consumers in obtaining credit, and

126. See *Monumental Properties*, 329 A.2d at 815–17; *Percudani*, 844 A.2d at 48.

127. See Allcare Complaint, *supra* note 18, at 21–33.

128. See *id.* at 5.

129. See *id.* at 9.

130. See *id.* at 10.

131. See *id.* at 21–33.

132. See *id.* at 28–33; 73 PA. STAT. AND CONS. STAT. ANN. § 2186 (West 2018).

133. See Allcare Complaint, *supra* note 18, at 21–28; 73 PA. STAT. AND CONS. STAT. ANN. § 2183 (West 2018).

134. See Allcare Complaint, *supra* note 18, at 23–24, 27, 29–30, 33.

135. Allcare Docket Sheet, *supra* note 19, at 19–20.

the *Allcare* litigation offers hope that the CSA can be enforced against healthcare providers to ensure that patient borrowing decisions are not made on the basis of incomplete information or improper influence.

III. ANALYSIS

In order to enforce the CSA against healthcare providers that facilitate patient use of medical credit, these providers must qualify as CSOs.¹³⁶ Specifically, these providers must perform credit services in return for “payment of money or other valuable consideration.”¹³⁷ Whether healthcare providers can satisfy this definition is an issue of first impression in Pennsylvania. This Part will consider whether *any* provider could qualify as a CSO, and whether Allcare Dental in particular satisfied this definition.¹³⁸ Assuming that Allcare did qualify as a CSO, this Part will further consider whether the Pennsylvania Attorney General’s specific claims against Allcare should have succeeded.¹³⁹ Finally, this Part will recommend that several specific provisions of the CSA should be used in future enforcement efforts against healthcare providers.¹⁴⁰

A. *Healthcare Providers that Promote Medical Credit Should Qualify as “Credit Services Organizations” Under the Credit Services Act*

As previously discussed,¹⁴¹ CSOs are defined as entities that perform credit services, such as “obtaining an extension of credit for the buyer,” in exchange for “payment of money or other valuable consideration.”¹⁴² For reasons that will be explained below,¹⁴³ the Pennsylvania common law definition of contract “consideration” must govern the definition of this term within the CSA.

Two primary theories of consideration exist to bring healthcare providers within the scope of the CSA. First, the facilitated sales theory proposes that a provider may receive consideration for its credit services in the form of increased sales revenue from patients who would not otherwise purchase treatment from the provider.¹⁴⁴ The Pennsylvania Attorney General relied on this theory in its lawsuit against Allcare

136. See 73 PA. STAT. AND CONS. STAT. ANN. § 2182 (West 2018).

137. See *id.*

138. See *infra* Section III.A.

139. See *infra* Section III.B.

140. See *infra* Section III.C.

141. See *supra* Section II.B.1.

142. 73 PA. STAT. AND CONS. STAT. ANN. § 2182 (West 2018).

143. See *infra* Section III.A.1.

144. See *infra* Section III.A.2.

Dental.¹⁴⁵ Second, the indirect payment theory proposes that a provider may receive consideration for its credit services through payments that it receives from third-party creditors in exchange for facilitating patient credit use.¹⁴⁶ Other states' courts have relied on this theory in enforcing their CSA-analog statutes against tax preparers.¹⁴⁷

1. The CSA's Definition of "Credit Services Organization" Incorporates the Pennsylvania Common Law of Contract Consideration

When a Pennsylvania statute uses a legal term of art, such as "consideration," this term is defined by the common law unless the statute evinces a legislative intent to the contrary.¹⁴⁸ Nothing in the statutory text of the CSA implies any intent to alter the common law meaning of "consideration" as the term is used in defining "credit services organization."¹⁴⁹ Thus, to determine whether a healthcare provider qualifies as a CSO by obtaining credit for patients in exchange for the "payment of money or other valuable consideration,"¹⁵⁰ we must first define "consideration" according to Pennsylvania common law.

"Consideration" is an essential element of any enforceable contract; in simple terms, consideration is the "'price' of a promise."¹⁵¹ Consideration consists of a detriment to the promisee with some corresponding benefit to the promisor that both induces and is induced by the promise.¹⁵² Whether this process of reciprocal inducement actually occurred in a given case depends on "the motives manifested by the parties."¹⁵³ A helpful, but not dispositive, test for determining the intent of the parties is to ask whether the alleged consideration conferred any benefit on the promisor; if so, it is a "fair inference" that this benefit induced the promise.¹⁵⁴ However, courts typically do not weigh the value

145. See Allcare Complaint, *supra* note 18, at 10.

146. See *infra* Section III.A.3.

147. See *CashCall, Inc. v. Maryland Com'r of Fin. Regulation*, 139 A.3d 990, 1004–05 (Md. 2016); *Fugate v. Jackson Hewitt, Inc.*, 347 S.W.3d 81, 85–86 (Mo. Ct. App. 2011); *Harper v. Jackson Hewitt, Inc.*, 706 S.E.2d 63, 71 (W. Va. 2010).

148. See *Bridgeford v. Groh*, 160 A. 451, 453 (Pa. 1932) ("[A] statute should be so interpreted that it will accord, as nearly as may be, with the theretofore existing course of the common law."); *Commonwealth v. Hartung*, 39 A.2d 734, 737 (Pa. Super. Ct. 1944) ("A statute does not work a change in the common law unless the intent to alter it clearly appears.").

149. See 73 PA. STAT. AND CONS. STAT. ANN. §§ 2181–92 (West 2018).

150. See 73 PA. STAT. AND CONS. STAT. ANN. § 2182.

151. See *Pensy Supply, Inc. v. Am. Ash Recycling Corp. of Pa.*, 895 A.2d 595, 600 (Pa. Super. Ct. 2006).

152. See *id.* at 600–01.

153. See *id.* at 601.

154. See *id.*

of consideration relative to the promise for which it was exchanged.¹⁵⁵ Similarly, the consideration need not take any particular form; in the timeless words of Sir Edward Coke, a “horse, hawk, or robe” will suffice.¹⁵⁶

Furthermore, “consideration” is distinguished from a mere “condition” that is inherently required for the promisee to receive the benefit of a gratuitous promise.¹⁵⁷ If the promisor’s promise is not induced by the promisee’s detriment, then the promised benefit is classified as a “conditional gift” and does not give rise to contractual rights or duties.¹⁵⁸ This distinction is best illustrated by the classic example in which a downtrodden man is promised a free coat if he simply walks to the store to retrieve it; walking to the store is merely a condition to receive the coat, not consideration for the gratuitous promise.¹⁵⁹

Thus, for a healthcare provider to qualify as a CSO, its patients must have paid money or other “valuable consideration” for the provider’s assistance with obtaining credit.¹⁶⁰ Under the Pennsylvania common law, this requirement should be satisfied if the provider’s credit services induced patients to incur some detriment that, in turn, motivated the provider to offer these services.¹⁶¹ Two alternative theories of consideration may suffice to bring healthcare providers within the scope of the CSA: *facilitated sales* and *indirect payment*.

2. Facilitated Sales as Consideration for Healthcare Provider Credit Services

In the absence of outright payment for credit services, healthcare providers might satisfy the CSA’s consideration requirement¹⁶² in the form of increased sales revenue from patients using third-party credit that the provider helped them obtain. According to the Pennsylvania Attorney General’s complaint in the *Allcare* lawsuit, by obtaining extensions of credit on behalf of patients that would not have otherwise purchased Allcare’s products or services, Allcare received valuable consideration in the form of a “prepaid customer.”¹⁶³ Indeed, patients who used Allcare’s credit services were required to sign a “Third-Party Financing Disclosure”

155. See *Mikos v. Kida*, 172 A. 101, 102 (Pa. 1934).

156. *Pinnell’s Case* (1602) 77 Eng. Rep. 237; 5 Co. Rep. 117 a.

157. See *Pennsy*, 895 A.2d at 600.

158. See *id.*

159. See *id.* at 600–01.

160. See 73 PA. STAT. AND CONS. STAT. ANN. § 2182 (West 2018).

161. See *Pennsy*, 895 A.2d at 600–02.

162. See 73 PA. STAT. AND CONS. STAT. ANN. § 2182.

163. See Allcare Complaint, *supra* note 18, at 10.

form, which stated that:

I [the buyer] acknowledge that the personal information being provided to Allcare Dental & Dentures (“Allcare”) is for the purpose of obtaining a loan or a line of credit from a third-party lender with no affiliation to Allcare, to finance the cost of dental work. Allcare will assist me [the buyer] in applying for credit¹⁶⁴

This excerpt states that Allcare’s credit services were provided for the purpose of financing dental work.¹⁶⁵ This exchange satisfies the aforementioned reciprocal inducement model of consideration.¹⁶⁶ To wit, Allcare’s promise to assist patients in obtaining credit induced them to debt-finance dental work that they would not purchase otherwise.¹⁶⁷ Likewise, by agreeing to purchase dental work, these patients induced Allcare to promise assistance with obtaining credit.¹⁶⁸

While the facilitated sales theory appears to satisfy the CSA’s consideration requirement, at least as “consideration” is defined under the common law, this theory has not been addressed by Pennsylvania courts. A few courts in other states with CSA-analog statutes¹⁶⁹ have confronted the facilitated sales theory, though only one has accepted it.¹⁷⁰ While these out-of-state cases are obviously not binding on Pennsylvania courts, they are nonetheless helpful for assessing the plausibility of the facilitated sales theory as it relates to enforcement of the CSA against healthcare providers.

First, in *Snook v. Ford Motor Co.*,¹⁷¹ a customer filed suit under the Ohio Credit Services Organization Act¹⁷² (Ohio CSA) against an auto dealership that helped her obtain credit to purchase one of its vehicles.¹⁷³ The Ohio Court of Appeals concluded that, in order to qualify as a “buyer” of credit services, the customer would have to show that she exchanged valuable consideration of “money or its equivalent” specifically for the dealership’s assistance in obtaining credit.¹⁷⁴ Otherwise, the court

164. *Id.* at 9–10 (emphasis removed).

165. *See id.* at 10.

166. *See supra* Section III.A.1.

167. *See* Allcare Complaint, *supra* note 18, at 10.

168. *See id.*

169. *Compare* 73 PA. STAT. AND CONS. STAT. ANN. § 2182 (West 2018), *with* OHIO REV. CODE ANN., § 4712.01(C) (West 2018), *and* 815 ILL. COMP. STAT. ANN. 605/3(d) (West 2018), *and* WIS. STAT. ANN. § 422.501(2) (West 2018).

170. *Compare* Premium Air, Inc. v. Luchinski, No. 2006AP2976, 2007 WL 1345839, at *2 (Wis. Ct. App. May 9, 2007) (adopting facilitated sales theory), *with* *Snook v. Ford Motor Co.*, 755 N.E.2d 380, 382–83 (Ohio Ct. App. 2001) (rejecting said theory), *and* *Midstate Siding & Window Co. v. Rogers*, 789 N.E.2d 1248, 1253–54 (Ill. 2003) (same).

171. *Snook v. Ford Motor Co.*, 755 N.E.2d 380, 382–83 (Ohio Ct. App. 2001).

172. OHIO REV. CODE ANN. §§ 4712.01–.99 (West 2018).

173. *Snook*, 755 N.E.2d at 381.

174. *See id.* at 381–83. The trial court ruled in favor of the customer, reasoning that she purchased the dealer’s credit services as part of an inseparable “bundle” of goods and

reasoned, the dealership's credit service was a mere gratuity.¹⁷⁵ Notably, the court reserved judgment as to whether the dealership qualified as a CSO.¹⁷⁶

In contrast, the dissenting opinion implicitly endorsed the facilitated sales theory of consideration in concluding that the plaintiff qualified as a "buyer" under the Ohio CSA.¹⁷⁷ The dissent reached this conclusion on the basis of the plaintiff's un rebutted affidavit,¹⁷⁸ which stated that she would not have purchased a vehicle from the dealership if it had not helped her obtain an extension of credit.¹⁷⁹ The dissent reasoned that separate consideration for the credit service was not required for the plaintiff to qualify as a "buyer" under the Ohio CSA.¹⁸⁰

Next, in *Midstate Siding & Window Co. v. Rogers*,¹⁸¹ the Supreme Court of Illinois concluded that a home contractor, in obtaining credit for a customer who would not otherwise purchase the contractor's windows and siding, did not qualify as a CSO under the Illinois Credit Services Organizations Act (Illinois CSA).¹⁸² As in *Snook*, the *Midstate Siding* court rejected the facilitated sales theory of consideration, reasoning that the Illinois CSA's definition of CSO requires consideration specific to the provision of credit services, "not simply payment for other goods or services."¹⁸³

However, the dissent in *Midstate Siding* endorsed the facilitated sales theory of consideration in concluding that the home contractor qualified as a CSO.¹⁸⁴ The dissent reasoned that the home contractor received valuable consideration in return for its assistance with obtaining third-party credit for customers, as without this financing, the contractor would not have been able to sell its windows and siding to these customers.¹⁸⁵

services that included the vehicle, and so qualified as a "buyer" under the Ohio CSA. *See id.* at 381–83.

175. *See id.*

176. *See id.* at 383.

177. *See id.* at 384 (Wolff, P.J., dissenting).

178. *See id.*

179. *See id.* at 383 (majority opinion).

180. *See id.* at 384 (Wolff, P.J., dissenting).

181. *Midstate Siding & Window Co. v. Rogers*, 789 N.E.2d 1248 (Ill. 2003).

182. 815 ILL. COMP. STAT. ANN. 605/1–16 (West 2018); *see Midstate Siding*, 789 N.E.2d at 1250–51, 1253–54.

183. *See id.* at 1253–54; *cf. Snook*, 755 N.E.2d at 383–84. Soon after *Midstate Siding* was decided, it was cited as precedent by the Appellate Court of Illinois in deciding that the Illinois CSA did not apply to a car dealership that assisted customers with obtaining third-party financing. *See Cannon v. William Chevrolet/Geo, Inc.*, 794 N.E.2d 843, 849–51 (Ill. App. Ct. 2003).

184. *See id.* at 1257–58 (Kilbride, J., dissenting). On this issue, the dissent was in agreement with both the trial and intermediate appellate courts. *See id.* at 1251 (majority opinion).

185. *See id.* at 1257 (Kilbride, J., dissenting).

In contrast to the *Snook* and *Midstate Siding* courts, the Court of Appeals of Wisconsin concluded in *Premium Air, Inc. v. Luchinski*¹⁸⁶ that the defendant HVAC business qualified as a CSO under the Wisconsin CSA¹⁸⁷ by arranging third-party credit for customers to finance their purchase of a furnace and installation.¹⁸⁸ The *Premium Air* court accepted the facilitated sales theory of consideration, reasoning that the defendant qualified as a CSO because “the money it receives from furnace sales via the financing arrangements it facilitates is the valuable consideration.”¹⁸⁹

Thus, of the three jurisdictions that have addressed the facilitated sales theory of consideration relied on by the Pennsylvania Attorney General in its *Allcare* lawsuit,¹⁹⁰ only Wisconsin has accepted this theory.¹⁹¹ Although the leading Ohio and Illinois cases on this issue did not accept the facilitated sales theory,¹⁹² these cases are still not wholly unfavorable to the Attorney General’s argument. Both of these cases were arguably decided incorrectly, as both contained dissenting and lower court opinions in favor of the facilitated sales theory.¹⁹³ As the *Midstate Siding* dissenter noted, the plain language of the Illinois CSA did not require that a CSO receives separate monetary consideration for their credit services.¹⁹⁴ Similarly, the Pennsylvania CSA does not contain any express requirement of separate monetary consideration for credit services.¹⁹⁵

Notably, the *Midstate Siding* dissenter argued that the legislative intent of the Illinois CSA—to prevent financial harm to consumers—favors application of the statute to retailers that promote third-party credit products.¹⁹⁶ Like the Illinois CSA, the Pennsylvania CSA is remedial legislation aimed at preventing consumer harm,¹⁹⁷ and as such, it should

186. *Premium Air, Inc. v. Luchinski*, No. 2006AP2976, 2007 WL 1345839 (Wis. Ct. App. May 9, 2007). The fact that this case was unpublished is immaterial to the present issue, as its reasoning is not rendered any less persuasive by this fact, and in any event, none of the aforementioned out-of-state cases have binding effect on Pennsylvania courts.

187. WIS. STAT. ANN. § 422.501–.506 (West 2018).

188. *See Premium Air*, 2007 WL 1345839, at *1.

189. *See id.* at *2.

190. *See Allcare Complaint*, *supra* note 18, at 10.

191. *See Premium Air*, 2007 WL 1345839, at *2.

192. *See Snook v. Ford Motor Co.*, 755 N.E.2d 380, 383–84 (Ohio Ct. App. 2001); *Midstate Siding & Window Co. v. Rogers*, 789 N.E.2d 1248, 1253–54 (Ill. 2003).

193. *See Snook*, 755 N.E.2d at 384 (Wolff, P.J., dissenting); *Midstate Siding*, 789 N.E.2d at 1257–58 (Kilbride, J., dissenting). Moreover, the *Snook* court did not actually address whether retailers could qualify as CSOs, but rather expressly reserved judgment on this point. *See Snook*, 755 N.E.2d at 383 (majority opinion).

194. *See Midstate Siding*, 789 N.E.2d at 1257–58.

195. *See* 73 PA. STAT. AND CONS. STAT. ANN. § 2182 (West 2018).

196. *See Midstate Siding*, 789 N.E.2d at 1258.

197. *See* 73 PA. STAT. AND CONS. STAT. ANN. § 2190 (West 2018) (declaring that any violation of the CSA is deemed to be a violation of the UTPCPL).

be construed liberally to accomplish this purpose.¹⁹⁸ At worst, the CSA's plain language is *ambiguous* with regard to whether the statute applies to healthcare providers that promote third-party medical credit in return for facilitated sales,¹⁹⁹ but this ambiguity should be resolved in favor of the broader definition that better serves the CSA's remedial aims.²⁰⁰

Furthermore, the public policy issues posed by healthcare providers engaged in third-party patient financing are unique and arguably create a more pressing need for regulation than the issues associated with other retailers' financing practices.²⁰¹ In light of these pressing public policy concerns, the Pennsylvania Attorney General's claims against Allcare Dental²⁰² under the CSA should be distinguished from the aforementioned out-of-state cases, which involved otherwise similar claims against car dealerships,²⁰³ a home contractor,²⁰⁴ and an HVAC company.²⁰⁵ In contrast, the unique consumer risks associated with unrestrained patient financing practices may justify a more liberal interpretation of the CSA to better serve its remedial objectives.²⁰⁶

3. Indirect Payment as Consideration for Healthcare Provider Credit Services

Several jurisdictions with statutes closely analogous to the Pennsylvania CSA have accepted an "indirect payment" theory of consideration to regulate businesses under their credit services statutes.²⁰⁷ This theory essentially holds that a business acts as a CSO by assisting its customers with obtaining credit in exchange for consideration paid by the

198. See *Commonwealth ex rel. Creamer v. Monumental Properties, Inc.*, 329 A.2d 812, 815–17 (Pa. 1974). (reasoning that the UTPCPL is remedial legislation that should be construed liberally to achieve its remedial aims).

199. See 73 PA. STAT. AND CONS. STAT. ANN. § 2182.

200. See *Monumental Properties*, 329 A.2d at 815–17; 82 C.J.S. *Statutes* § 523 (West 2019).

201. See *supra* Section II.A.

202. See *Allcare Complaint*, *supra* note 18, at 21–33.

203. See *Snook v. Ford Motor Co.*, 755 N.E.2d 380, 381 (Ohio Ct. App. 2001); *Cannon v. William Chevrolet/Geo, Inc.*, 794 N.E.2d 843, 849–51 (Ill. App. Ct. 2003).

204. See *Midstate Siding & Window Co. v. Rogers*, 789 N.E.2d 1248, 1250–51 (Ill. 2003).

205. See *Premium Air, Inc. v. Luchinski*, No. 2006AP2976, 2007 WL 1345839, at *1 (Wis. Ct. App. May 9, 2007).

206. See 73 PA. STAT. AND CONS. STAT. ANN. § 2190 (West 2018); *Commonwealth ex rel. Creamer v. Monumental Properties, Inc.*, 329 A.2d 812, 815–17 (Pa. 1974).

207. *CashCall, Inc. v. Md. Com'r of Fin. Regulation*, 139 A.3d 990, 1004–05 (Md. 2016); *Fugate v. Jackson Hewitt, Inc.*, 347 S.W.3d 81, 85–86 (Mo. Ct. App. 2011); *Harper v. Jackson Hewitt, Inc.*, 706 S.E.2d 63, 71 (W. Va. 2010). Each of these cases involve similar fact patterns and legal reasoning; thus, rather than discussing each case in detail, *Harper* will be used as an example to explain the indirect payment theory.

customer to the business *through* the third-party creditor.²⁰⁸ This indirect payment theory of consideration would likely be satisfied by healthcare providers who promote medical credit products as long as they receive some portion of patient funds collected by the creditor.

To illustrate, in *Harper v. Jackson Hewitt*,²⁰⁹ plaintiff customers brought claims under the West Virginia CSA²¹⁰ against a tax preparer that assisted them in obtaining a tax refund anticipation loan (RAL).²¹¹ Although the plaintiffs did not directly pay the defendant for arranging this loan, the plaintiffs did pay documentation fees to the bank that issued their RALs as part of their total loan balance.²¹² The bank would subsequently pay these fees forward to the defendant as compensation for facilitating the issuance of RALs.²¹³ Notably, the plaintiffs alleged that the bank later changed its compensation scheme so that the defendant would only be paid periodic lump sums, rather than a fee for each RAL issued.²¹⁴

The Supreme Court of Appeals of West Virginia concluded that, according to “the plain and broad sweeping language contained [in] the statute,”²¹⁵ this form of indirect payment constituted “valuable consideration,” and so the defendant qualified as a CSO.²¹⁶ Moreover, the court did not condition its holding on whether the compensation scheme between the bank and defendant consisted of fees paid for each RAL issued, versus periodic lump-sums not associated with any particular customer.²¹⁷ This omission suggests that the indirect payment theory of consideration does not require an alleged CSO to receive payments from a creditor that can be traced to specific customers. Whenever a CSO is paid some amount for referring customers to the creditor, this amount presumably reflects a fraction of the creditor’s revenue from each of the CSO’s referrals.

In applying this indirect payment theory to healthcare providers who facilitate third-party financing for patients, one must ask whether any form of indirect payment to the provider is common in the medical credit industry. As it happens, CareCredit has a practice of entering “retailer share arrangements” with its partners that “provide for payments to our

208. See *Harper*, 706 S.E.2d at 69, 71.

209. *Harper v. Jackson Hewitt, Inc.*, 706 S.E.2d 63 (W. Va. 2010).

210. See W. VA. CODE § 46A–6C (West 2018).

211. See *Harper*, 706 S.E.2d at 69.

212. See *id.*

213. See *id.*

214. See *id.*

215. W. VA. CODE § 46A–6C–2(a). This West Virginia statute is virtually identical to the Pennsylvania CSA in all material respects. Compare *id.*, with 73 PA. STAT. AND CONS. STAT. ANN. § 2182 (West 2018).

216. See *Harper*, 706 S.E.2d at 71.

217. See *id.* at 69, 71–72.

partners if the economic performance of the program exceeds a contractually defined threshold.”²¹⁸ Similarly, CareCredit provides “other economic benefits to our partners such as royalties on purchase volume or payments for new accounts All of these arrangements are designed to align our interests and provide an additional incentive to our partners to promote our credit products.”²¹⁹ In 2017 alone, CareCredit paid out \$9 million pursuant to these retailer share arrangements.²²⁰

Applying the logic of *Harper*, payments that healthcare providers receive from CareCredit in exchange for referring patients likely constitute consideration via indirect payment so as to bring these providers within the scope of the CSA.²²¹ Likewise, this assertion probably holds true whether a provider receives fees for new accounts that are associated with specific patients, or a payment based on CareCredit’s economic performance exceeding some contractual benchmark; in either case, the provider’s payment is contingent on referring patients to CareCredit.

The Commonwealth never even alleged the indirect payment theory of consideration in its suit against Allcare Dental, but instead relied solely on the facilitated sales theory.²²² However, if the Commonwealth had proven that Allcare did accept such indirect payments from medical creditors in exchange for referring patient business, this fact would constitute the consideration needed for Allcare to qualify as a CSO.

B. Evaluation of the Commonwealth’s Claims Against Allcare Dental

As previously discussed, the Pennsylvania Attorney General brought claims against Allcare under two separate provisions of the CSA.²²³ First, the Attorney General alleged that Allcare violated Section 2186(c) by failing to provide patients with notice of their right to cancel credit service contracts within five days of entering them.²²⁴ Second, the Attorney General alleged that Allcare violated Section 2183(1) by charging patients for dental work prior to fully performing its obligations under the

218. See Synchrony Financial, Annual Report (Form 10-K) at 86 (Feb. 22, 2018). CareCredit notes that “[t]he vast majority of our partners are individual and small groups of independent healthcare providers.” *Id.* at 14.

219. See *id.* at 86.

220. See *id.* at 91. CareCredit is actually barred from such practices in New York as a result of its 2013 settlement with the New York Attorney General, which provided that CareCredit could no longer give “rebates, compensation, or in-kind services to any provider in exchange for a provider’s success in generating business for CareCredit.” See N.Y. A.G. Press Release, *supra* note 6.

221. See *Harper*, 706 S.E.2d at 69, 71.

222. See Allcare Complaint, *supra* note 18, at 22, 25, 29, 32.

223. See Allcare Complaint, *supra* note 18, at 21–33.

224. See *id.* at 27–33; 73 PA. STAT. AND CONS. STAT. ANN. § 2186(c) (West 2018).

contract.²²⁵ The following paragraphs aim to show that, if the Commonwealth had brought this case to trial, its likelihood of success—at least under Section 2183(1)—would have depended upon whether Allcare qualified as a CSO under the facilitated sales or indirect payment theory of consideration.²²⁶

Under the facilitated sales theory of consideration, a provider receives consideration for its credit services through a patient's use of credit to purchase the provider's healthcare goods or services.²²⁷ In contrast, under the indirect payment theory, a provider receives consideration for its credit services through the creditor's payment of money collected from the patient.²²⁸ This distinction is important because, under the facilitated sales theory, a patient's purchase of healthcare goods and services becomes part of the credit services contract, whereas under the indirect payment theory, it does not. This distinction indicates that, if Allcare qualified as a CSO according to the facilitated sales theory alleged by the Attorney General,²²⁹ the CSA's requirements would apply to the combined transaction for Allcare's dental work and credit services. However, under the indirect payment theory, the CSA's requirements would only apply to Allcare's credit services.

With regard to the Attorney General's claim against Allcare under Section 2186(c),²³⁰ either theory of consideration would require Allcare to provide patients with the Notice of Cancellation required by Section 2186(c).²³¹ However, a potential difference could arise with regard to a patient's exercise of the right to cancel her credit service contract, as Section 2186(c) specifies that the patient will be entitled to a refund of any consideration paid under the contract upon cancellation.²³² Under the facilitated sales theory, if a patient were to exercise this right to cancel her credit services contract with Allcare, but already purchased the dental goods and services contemplated by the contract, the patient would be entitled to a refund for these goods and services. Allcare would likely lose money if this happened, as a dental patient cannot simply return a filling or crown. As a result, one would expect Allcare to wait for the five-day cancellation period to expire before accepting medical credit to provide

225. See Allcare Complaint, *supra* note 18, at 21–27; 73 PA. STAT. AND CONS. STAT. ANN. § 2183(1) (West 2018).

226. See *supra* Section III.A.

227. See *supra* Section III.A.2.

228. See *supra* Section III.A.3.

229. See Allcare Complaint, *supra* note 18, at 22, 25, 29, 32.

230. *Id.* at 27–33.

231. 73 PA. STAT. AND CONS. STAT. ANN. § 2186(c) (West 2018).

232. See *id.*

dental work, which would best advance the regulatory objectives set out in this Comment.²³³

In contrast, under the indirect payment theory, a patient who decided to cancel her credit service contract after purchasing dental work would probably not be entitled to a refund from Allcare under Section 2186(c). Instead, this patient would only be entitled to a refund or waiver of any indirect payment due to Allcare by way of the third-party creditor. The amount of this refund would almost certainly be much less than the cost of dental work purchased,²³⁴ and so the prospect of losing this amount would be unlikely to deter Allcare from charging the patient's credit account during the five-day cancellation period. Thus, Section 2186(c) would likely fail to establish a five-day "cooling off" period for patient use of medical credit where the provider only qualifies as a CSO under the indirect payment theory.

Moreover, the Commonwealth only would have succeeded in its claims against Allcare under Section 2183(1)²³⁵ if the facilitated sales theory of consideration had been accepted. Again, Section 2183(1) would prohibit Allcare from accepting any consideration from patients until it has fully performed its obligations under the credit service contract.²³⁶ If Allcare qualifies as a CSO according to the facilitated sales theory, its dental work would be part of the performance due to the patient under their credit service contract. As such, Allcare would not be permitted under Section 2183(1) to charge the patient for this dental work until after it has been provided in full. Thus, the Commonwealth could have likely succeeded in proving that Allcare violated Section 2183(1) under these circumstances.

In contrast, if Allcare qualifies as a CSO under the indirect payment theory of consideration, its only obligation under a credit service contract would be to assist the patient in obtaining an extension of credit. As a result, Section 2183(1) would not prevent Allcare from charging patients for dental work prior to providing them, as the contract for dental goods and services would constitute a distinct transaction. In light of this distinction, the Commonwealth's Section 2183(1) claims against Allcare²³⁷ would have likely failed under the indirect payment theory.

233. See *supra* Section II.B.1.

234. To illustrate, consider that in 2017, CareCredit paid out only \$9 million pursuant to retailer share arrangements, compared to the almost \$9 billion in medical debt that it was owed at the end of the year. See Synchrony Financial, Annual Report (Form 10-K) at 91 (Feb. 22, 2018). The indirect payments exchanged for a provider's credit services are likely only substantial in the aggregate.

235. See Allcare Complaint, *supra* note 18, at 21–27.

236. 73 PA. STAT. AND CONS. STAT. ANN. § 2183(1) (West 2018).

237. See Allcare Complaint, *supra* note 18, at 21–27.

While the facilitated sales theory of consideration appears more favorable to the Commonwealth's claims against Allcare,²³⁸ it has been rejected in most of the jurisdictions that have addressed it.²³⁹ The indirect payment theory seems more likely to succeed, as it has been accepted in every jurisdiction that has considered it.²⁴⁰ Even if Allcare only qualified as a CSO under the indirect payment theory, the Commonwealth still could have likely succeeded in its Section 2186(c) claim, which in turn would have opened the door to remedies provided by the UTPCPL.²⁴¹

Moreover, with the exception of restitution, these remedies are not dependent on the extent of patient harm.²⁴² Indeed, liability in public enforcement actions under the UTPCPL does not require proof of *any* actual harm to consumers.²⁴³ The civil penalties provided by the UTPCPL can be quite steep,²⁴⁴ and an award of penalties against Allcare would send a clear message to other providers that their promotion of medical credit may give rise to liability under the CSA. Presumably, such penalties will lead providers to err on the side of caution when facilitating third-party financing for patient care.

C. *Recommendation for Future Enforcement Efforts Under the CSA*

While the *Allcare* litigation was an admirable first step toward regulation of this problematic conduct, it had two major shortcomings that should be corrected in future enforcement efforts. First, the Pennsylvania Attorney General relied solely on the facilitated sales theory of consideration in its case against Allcare²⁴⁵—a more legally questionable theory than indirect payment.²⁴⁶ Future enforcement under the CSA or

238. More importantly, the facilitated sales theory is the only one raised by the Commonwealth in its complaint. *See id.* at 22, 25, 29, 32.

239. *See supra* Section III.A.2.

240. *See supra* Section III.A.3.

241. *See* 73 PA. STAT. AND CONS. STAT. ANN. § 2190(a) (West 2018).

242. The availability of restitution would depend on actual financial harm to the patient resulting from the provider's CSA violation. *See* 73 PA. STAT. AND CONS. STAT. ANN. § 201-4.1 (West 2018). Such financial harm will likely be negligible unless the amount that a patient pays for dental work is deemed part of her consideration for the credit services contract, as under the facilitated sales theory. However, civil penalties and injunctive relief could plausibly be awarded regardless of which theory of consideration applies to qualify Allcare as a CSO. *See* 73 PA. STAT. AND CONS. STAT. ANN. §§ 201-4, 201-8 (West 2018).

243. *Potentially* misleading or deceptive business conduct, in itself, is a harm that the UTPCPL was designed to prevent. *See Commonwealth v. Peoples Benefit Servs., Inc.*, 923 A.2d 1230, 1236 (Pa. Commw. Ct. 2007).

244. A court can award up to \$1000 *per violation* in civil penalties under the UTPCPL, or up to \$3000 for each violation against a consumer who is sixty years of age or older. *See* 73 PA. STAT. AND CONS. STAT. ANN. § 201-8(b).

245. *See Allcare Complaint, supra* note 18, at 22, 25, 29, 32.

246. *See supra* Sections III.A.2-3.

cognate statutes in other states should take care to argue both theories of consideration, when applicable, in order to maximize the likelihood of success.

Second, the *Allcare* complaint only pleads violations of the CSA's notice of cancellation²⁴⁷ and prepayment²⁴⁸ provisions; however, the credit service contract requirement²⁴⁹ and broad prohibition of misleading conduct²⁵⁰ appear to be the most crucial for ensuring that patients are adequately informed when deciding to use medical credit. In order to more effectively counteract the behavioral biases that contribute to suboptimal patient borrowing decisions,²⁵¹ future enforcement efforts should specifically target providers who omit or misrepresent material facts in promoting medical credit. Of particular import are those facts bearing on patients' financial obligations and on relationships between providers and creditors.²⁵² Ideally, the credit service contract requirement should serve a cautionary function in alerting each patient to the risks of using medical credit and to any pecuniary interest of the provider in facilitating the credit transaction.

IV. CONCLUSION

The failure of current law to restrain healthcare providers that facilitate patient use of medical credit has allowed these providers to profit at the expense of their patients' financial welfare.²⁵³ While specialized legislation may provide the best long-term solution to this problem,²⁵⁴ the Pennsylvania CSA and analogous statutes in other states provide a means to protect patients' interests without completely eliminating a service that many patients may find valuable.²⁵⁵ In essence, the CSA will impose an affirmative legal duty on healthcare providers to ensure that patients have sufficient time and information to make prudent borrowing decisions.²⁵⁶

No court has yet approved application of the CSA to healthcare providers that facilitate patient use of medical credit. However, this practice of promoting medical credit appears to fall within the scope of the CSA when the relevant statutory text is interpreted in light of the common law of contract consideration.²⁵⁷ Providers that assist patients with using

247. 73 PA. STAT. AND CONS. STAT. ANN. § 2186(c) (West 2018).

248. 73 PA. STAT. AND CONS. STAT. ANN. § 2183(1) (West 2018).

249. 73 PA. STAT. AND CONS. STAT. ANN. § 2186(a).

250. 73 PA. STAT. AND CONS. STAT. ANN. § 2183(4).

251. *See supra* Section II.A.1.

252. *See id.*

253. *See supra* notes 69–80, 218–20 and accompanying text.

254. *See Hawkins, Doctors as Bankers, supra* note 16, at 891–96.

255. *See supra* Section II.B.1.

256. *See id.*

257. *See supra* Section III.A.1.

medical credit commonly receive “payment of money or other valuable consideration”²⁵⁸ in the form of increased sales revenue or payments from third-party creditors.²⁵⁹ Thus, these providers are ostensibly doing business as CSOs and should be held to the same standards as other entities that facilitate consumer lending. The *Allcare* litigation may have left this issue unresolved, but it still blazed a trail for future enforcement efforts, both in Pennsylvania and in other states dealing with the same problem.

258. 73 PA. STAT. AND CONS. STAT. ANN. § 2182 (West 2018).

259. *See supra* Sections III.A.2–3.