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Contracting for Healthcare: Price Terms in Hospital Admission Agreements

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Contracting for Healthcare: Price Terms in Hospital Admission Agreements

George A. Nation III*

“I should not agree with your young friends,” said Marcus curtly, “I am so old-fashioned as to believe in free contract.”

*“I, being older, perhaps believe in it even more,” answered M. Louis smiling. “But surely it is a very old principle of law that a leonine contract is not a free contract. And it is hypocrisy to pretend that a bargain between a starving man and a man with all the food is anything but a leonine contract.” He glanced up at the fire-escape, a ladder leading up to the balcony of a very high attic above. “I live in that garret; or rather on that balcony. If I fell off the balcony and hung on a spike, so far from the steps that somebody with a ladder could offer to rescue me if I gave him a hundred million francs, I should be quite morally justified in using his ladder and then telling him to go to hell for his hundred million. Hell, indeed, is not out of the picture; for it is a sin of injustice to force an advantage against the desperate. Well, all those poor men are desperate; they all hang starving on spikes. If they must not bargain collectively, they cannot bargain at all. You are not supporting contract; you are opposing all contract; for yours cannot be a real contract at all.”***

ABSTRACT

This article discusses the application of contract law principles to the relationship between hospitals and patients to determine how much patients owe for the health care they receive. For patients who are covered by in-network health insurance the exact nature of the contract created with the hospital usually is not relevant to the patient’s financial obligation because the patient’s contract with the hospital is superseded by the contract between the patient’s health insurer and the hospital. Nevertheless, even in-network patients are financially impacted, via increased insurance premiums, by the contract analysis discussed here, and for

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** G.K. CHESTERTON, *The Unmentionable Man*, in *THE PARADOXES OF MR. POND* 84, 96 (Indo-European Publishing 2011) (1936).

the increasing number of patients who are self-pay the contract entered into with the hospital will determine the amount that the patient is obligated to pay. Self-pay patients include patients who have insurance but are receiving care out-of-network or have so-called high-deductible plans, which do not apply until the deductible has been met, and uninsured patients. As networks become narrower the number of self-pay patients increases dramatically. Moreover, the ability of hospitals to threaten to bill out-of-network patients for exorbitant list prices forces insurers to agree to excessive payments for in-network hospitals, thereby driving up premiums for in-network patients.

Contract law determines the financial relationship between self-pay patients and providers. For example, depending on the facts and circumstances surrounding a patient's admission to the hospital, the patient's financial obligation may be determined by an express contract, if an admission type agreement is signed and found to be enforceable, an implied-in-fact contract, based on the conduct of the parties, or a quasi-contract, sometimes called an implied-in-law contract, if the patient was unable to contract because, for example, the patient was unconscious when admitted.

Self-pay patients, who enter the hospital through the emergency department, simply lack capacity to contract due to the rushed, stressful and tension-laden emergency circumstances. As a result, most contracts signed by or on behalf of patients in the emergency department are not enforceable and the obligation of these patients to pay for the medical care they have received is based quasi contract. With respect to patients who enter the hospital other than through the emergency department, the admission agreement they sign is an adhesion contract presented on a take-it-or-leave-it basis that does not contain an actual price but only an ambiguous price formula tied to the hospital's list prices. As a result, even in a non-emergency context where the patient may be capable of giving assent, true assent by the patient is lacking, and the courts must closely scrutinize such contracts for violations of public policy such as unfair price terms. A hospital's exercise its prodigious bargaining power to extract a promise from a self-pay patient to pay exorbitant billed charges or list prices is an example of an unfair term that courts should refuse to enforce.

Thus, notwithstanding the type of contract created in a particular case, this article concludes that the proper application of contract law principles dictates that patients are usually required to pay no more than the reasonable market-based value of the health care they receive. The determination of reasonable value is based on the market value—the average actual reimbursement

the hospital receives for the care in question—and not on the hospitals unilaterally-set list price or billed charge.

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INTRODUCTION

The amount that hospitals claim to be owed for medical services varies dramatically based on the entity paying the bill.¹ Speaking generally, there are three levels of payment. The first, and highest, is the chargemaster price, which is the hospital's list

1. See George A. Nation III, *Determining the Fair and Reasonable Value of Medical Services: The Affordable Care Act, Government Insurers, Private Insurers and Uninsured Patients*, 65 BAYLOR L. REV. 425, 446–49 (2013) [hereinafter Nation, *Fair and Reasonable*] (discussing price discrimination by hospitals based on the entity paying the hospital).

price.² These list prices are contained in a computer file called a Charge Description Master (CDM).³ Chargemaster price rates are excessive; on average they are about 500 percent higher than the amount that Medicare pays for the same care!⁴ This disparity is due to the fact that CDM prices are set unilaterally by hospitals without any market constraint.⁵ CDM rates are used by hospitals primarily as a cudgel to threaten commercial health insurance companies with exorbitant prices unless they agree to the reimbursement rates demanded by the hospital.⁶ In other words, if the insurance com-

2. See George A. Nation III, *Hospital Chargemaster Insanity: Healing the Healers*, 43 PEPP. L. REV. 745, 746–47 (2016) [hereinafter Nation, *Chargemaster*] (explaining that today chargemaster prices are insanelly high, often running 10 times the amount that hospitals routinely accept as full payment from insurers); *id.* at 748; George A. Nation III, *Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured*, 94 KY. L.J. 101, 105 (2005) [hereinafter Nation, *Obscene Contracts*] (arguing that the admission agreement between a hospital and a patient, in which the patient agrees to pay the hospital’s “full charges” for necessary medical services, is unenforceable because it is unconscionable).

3. Nation, *Chargemaster*, *supra* note 2, at 746–47. A chargemaster is a list of all goods and services provided by the hospital and the hospital’s list price, or charge, for each item.

4. See, e.g., Steven I. Weissman, *Remedies for an Epidemic of Medical Provider Price Gouging*, 90 FLA. B.J. 22, 24 (2016) (noting that “[a]verage charge master pricing at Florida hospitals is a minimum of 500 percent of Medicare allowable amounts”); see *id.* at 24 n.21 (citing *Medicare Provider Utilization and Payment Data*, CNTRS. FOR MEDICARE & MEDICAID SERVS., <https://go.cms.gov/2NloKVr> [<https://perma.cc/8WQC-44KH>] (last visited June 30, 2019)) (discussing Center for Medicare and Medicaid Services data revealing hospital list prices (*i.e.*, charges) and Medicare actual payments for the 100 most common inpatient services by state averages and specific hospitals).

5. See Nation, *Chargemaster*, *supra* note 2, at 76. Importantly, [t]he single most important reason that chargemaster rates remain so high is that competitive forces in the healthcare market have broken down, and as a result, many hospitals may raise their chargemaster rates with impunity. Moreover, such rate increases are associated with increases, albeit much smaller ones, in revenues. Finally, hospitals currently have absolutely no reason to reduce their chargemaster rates. That is, hospitals suffer no competitive disadvantage by setting their rates ever higher because no market participants with any market power pay CDM rates.

Id.

6. See George A. Nation III, *Healthcare and the Balance-Billing Problem: The Solution Is the Common Law of Contracts and Strengthening the Free Market for Healthcare*, 61 VILL. L. REV. 153, 154–55, 163 (2016) [hereinafter Nation, *Balance Billing*] (noting that the hospital’s bargaining power is increased by the fact that if the insurance company fails to agree to the reimbursement rates desired by the hospital, then all of the insurance company’s customers will be balance billed at exorbitant chargemaster rates); Nation, *Chargemaster*, *supra* note 2, at 748 (“The purpose of these fictitious list prices is to serve as a starting or anchoring point for negotiations with third-party payers regarding the amount that they will actually pay the hospital for goods and services.”). In addition, excessive CDM rates are beneficial to hospitals in other illegitimate ways. For example, they allow hospitals to overstate their charitable care. See Nation, *Chargemaster*, *supra* note 2, at

pany does not agree to pay the reimbursement prices that are acceptable to the hospital, then patients with that company's insurance will be out-of-network with respect to that hospital, and the hospital will demand its excessive CDM prices from those patients by "balance billing" them.⁷ Obviously, this practice will upset those patients and may cause them to buy insurance from a different insurance company that is in-network with that hospital.⁸ From the hospital's perspective, however, there is every reason to set chargemaster prices ever higher as there is no penalty for doing so.⁹

757–58. Exorbitant CDM rates also allow hospitals to increase their revenue from sources other than in-network insurance companies by enabling hospitals to price gouge self-pay patients, especially in third-party liability cases where the ability to use hospital lien statutes greatly increases the hospital's ability to recover these insanely high prices. See George A. Nation III, *Hospitals Use the Pernicious Chargemaster Pricing System to Take Advantage of Accident Victims: Stopping Abusive Hospital Billing*, 66 *DRAKE L. REV.* 645, 699 (2018) [hereinafter Nation, *Accident*] ("Hospitals unilaterally set their charges at grossly excessive levels that the market rejects, and thus the vast majority of patients do not pay, which is why these exorbitant chargemaster-based rates are not a proper measure of the price anyone should pay for healthcare."). However, "because of the complexities involved in healthcare billing and payment systems and the confusion they cause, hospitals are permitted to enforce these excessive and market-rejected rates against self-pay patients." *Id.* at 699. Finally, "even worse, in the [third-party liability] situation, hospitals may use (misuse) the force of a government-granted lien to enforce these unilaterally set excessive charges." *Id.* at 699–70.

7. See Nation, *Balance Billing*, *supra* note 6, at 154–55 (describing balance billing and noting that because an out-of-network patient's insurer has no contract with the hospital, the hospital is not obligated to accept the payment from the insurance company as full payment and, therefore, the hospital bills the patient for the balance—the difference between the exceedingly high hospital list price and the reasonable amount paid by the insurer). In addition, this means that exorbitant chargemaster based prices are really set to be discounted and not paid. However, if a hospital sees a chance to collect these enormous prices, it usually pursues the opportunity aggressively and relentlessly, causing a tremendous amount of financial hardship and pain in the process. The media has covered many cases of abusive conduct by hospitals trying to collect their excessive "full charges." See also, e.g., Nation, *Obscene Contracts*, *supra* note 2, at 101–05 (recounting examples of harsh conduct by hospitals against patients to collect bills); Nation, *Chargemaster*, *supra* note 2, at 761–63 (same); George A. Nation III, *Non-Profit Charitable Tax-Exempt Hospitals—Wolves in Sheep's Clothing: To Increase Fairness and Enhance Competition in Health Care All Hospitals Should be For-Profit and Taxable*, 42 *RUTGERS L.J.* 141, 177–78 (2010) [hereinafter Nation, *Wolves*] (discussing harsh collection tactics used by many charitable hospitals).

8. See Gerard F. Anderson, *From 'Soak the Rich' to 'Soak the Poor': Recent Trends in Hospital Pricing*, 26 *HEALTH AFF.* 780, 785 (2007) [hereinafter Anderson, *Soak the Rich*] (noting that hospitals set high charges as a negotiating strategy with managed care plans and explaining that "[i]f a plan does not have a contract with the hospital then it is expected to pay full charge"; "[t]he higher the charges, the greater the incentive to sign a contract with hospital").

9. See Nation, *Balance Billing*, *supra* note 6, at 160 (noting that "[a]s hospitals consolidate, more large healthcare systems are created, and these dominant systems do not feel any competitive pressure to contract with insurance companies at

The second highest payment level is the price paid by in-network commercial health insurance companies pursuant to contracts formed between insurance companies, hospitals, and other providers.¹⁰ On average, these health insurance companies pay a little less than one third of the CDM list price, and hospitals willingly agree to accept this amount as full payment.¹¹ In other words, the chargemaster-based price is more than three times higher than the price hospitals agree to accept as full payment from commercial insurance companies.¹² The prices paid by in-network commercial insurers are, on average, about 160 percent of the Medicare reimbursement rate.¹³ Another very important aspect of the contracts executed between commercial health insurers and hospitals, pursuant to which hospitals become “in network,” is that these contracts require the hospital to accept the agreed-upon reimbursement amount as full payment. Accordingly, the hospital is prohibited from billing the patient for any amount in excess of the

reasonable reimbursement rates”); Nation, *Chargemaster*, *supra* note 2, at 760 (stating that “hospitals currently have absolutely no reason to reduce their chargemaster rates—that is, hospitals suffer no competitive disadvantage by setting their rates ever higher”).

10. Importantly these are the only prices that can be said to be market derived. See Nation, *Fair and Reasonable*, *supra* note 1, at 460–61 (noting that these rates reflect most strongly and effectively operating free-market).

11. Today, on average, hospital chargemaster prices exceed payments by more than a factor of three. Michael Batty & Benedic Ippolito, *Mystery of the Chargemaster: Examining the Role of Hospital List Prices in What Patients Actually Pay*, 36 HEALTH AFFAIRS 689, 689 (2017). For example, if Medicare reimbursed for a particular procedure at \$100.00, then the average commercial insurance payment, agreed to by the hospital, would be \$160.00. But the CDM based rate would be three times the commercial insurance rate, totaling \$480.00. Moreover, since hospitals willingly agree to accept this amount from commercial insurance, it is reasonable to conclude that it represents not only coverage of their costs but also a reasonable profit as well. See Michael K. Beard & Dylan H. Marsh, *Arbitrary Healthcare Pricing and the Misuse of Hospital Lien Statutes by Healthcare Providers*, 38 AM. J. TRIAL ADVOC. 255, 255–57 (2014).

12. See Nation, *Accident*, *supra* note 6, at 651–52 (noting that “[o]n average, hospitals receive only 33 percent of their chargemaster prices from all payers”). However, in many instances, chargemaster rates can be even higher. For example, California Pacific Medical Center, owned by Sutter Health, has a chargemaster rate of \$96,642.00 to treat a stroke while the Medicare reimbursement for this treatment is \$9,583.00. See Nation, *Chargemaster*, *supra* note 2, at 762 (discussing this and other examples of egregious chargemaster rates). In other words, Medicare reimbursed less than 10 percent of the billed chargemaster rate. See *id.*

13. Nationwide, commercial insurance companies pay hospitals an average of approximately 160 percent (1.6 times) allowable Medicare reimbursement rates, which is equivalent to approximately 150 percent of hospital costs. See MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 67 (2015).

agreed-upon reimbursement with the exception of co-payments, deductibles, and coinsurance amounts.¹⁴

Finally, the lowest payment amounts are those set by government insurers, Medicare and Medicaid.¹⁵ As noted, Chargemaster-based rates are, on average, about 500 percent above Medicare reimbursement levels.¹⁶ Medicare rates are set by the Center for Medicare Services (CMS) to provide hospitals with a reasonable reimbursement.¹⁷ Although some have argued that Medicare reimbursements represent only about 90 percent of hospital costs,¹⁸ others have argued that efficiently run hospitals do make a profit on Medicare reimbursements.¹⁹ Hospitals agree to accept the Medicare reimbursement amounts when they sign a Provider Agreement with CMS.²⁰ Hospitals are not required to sign a Provider Agreement with CMS. However, if the hospital does not sign

14. See Nation, *Balance Billing*, *supra* note 6, at 154–155 (discussing balance billing and comparing it to the billing practices used when a contract exists between the patient’s insurer and the hospital).

15. See Nation, *Fair & Reasonable*, *supra* note 1, at 459–460. In fact, some have argued that the government insurers reimburse below cost. However not all Medicare reimbursement rates are unprofitable for hospitals. *Id.*; Matthew Yglesias, *Do Health Care Providers Lose Money on Medicare Patients?*, SLATE: MONEYBOX (Feb. 22 2013, 3:10 PM), <http://bit.ly/2YnyfVh> [<https://perma.cc/VSH9-ZS8D>] (suggesting such claims are dubious and noting that even though Medicare reimbursement rates may be below fully allocated costs for some hospitals, the rates are in excess of marginal costs and, therefore, add significant profits once fixed costs are covered).

16. See *supra* note 4 and accompanying text.

17. See Nation, *Chargemaster*, *supra* note 2, at 767 (discussing Medicare and Medicaid reimbursement procedures); see also *Mercy Catholic Med. Ctr. v. Thompson*, 380 F.3d 142, 144–45 (3d Cir. 2004) (summarizing developments in setting reimbursements in the Medicare program).

18. Virgil Dickson, *Slumping Medicare Margins Put Hospitals on Precarious Cliff*, MOD. HEALTHCARE (Nov. 28, 2017, 12:00 AM), <http://bit.ly/2XfRkHo> [<https://perma.cc/B7NE-2LHU>] (“In 2015, the aggregate margin hit a negative 7.1% across hospitals, according to the Medicare Payment Advisory Commission; margins are expected sink to a negative 10% this year.”); cf. Yglesias, *supra* note 15.

19. See generally William O. Cleverley, *Making Money with Medicare Payments*, HFMA, <https://bit.ly/2kR3Tfa> [<https://perma.cc/V7X9-38WZ>] (last visited Sept. 2, 2018).

20. CMS develops Conditions of Participation (COPs) and Conditions for Coverage (CFCs) that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs. See *Conditions for Coverage (CfCs) & Conditions for Participations (CoPs)*, CNTRS. FOR MEDICARE & MEDICAID SERVS., <https://go.cms.gov/2mhAuev> [<https://perma.cc/DY6N-L646>] (last visited June 20, 2019). Also, a hospital may terminate its participation at any time. See CNTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE GENERAL INFORMATION, ELIGIBILITY AND ENTITLEMENT MANUAL, Ch. 5 § 10.6.1 (rev. 120, Nov. 2018), <https://go.cms.gov/2RKqOoj> [<https://perma.cc/7RN2-EF6H>] (“A provider may terminate its agreement . . . by filing with the Secretary a written notice of its intention to terminate the agreement”).

a Provider Agreement, the hospital cannot receive Medicare payments.²¹ Medicaid reimbursements are usually lower than Medicare reimbursements.²²

On average, chargemaster-based rates are 350 percent higher than the average reimbursement that hospitals receive from *all* payers.²³ It is important to recognize that there are no restrictions under federal law and very few state regulations controlling the level at which hospitals can set their CDM prices.²⁴ Because no private health insurance company or government insurer pays

21. See Mary Lou Weden, *Why Do Hospitals Get Accredited by The Joint Commission?*, R1 RCM BLOG (Sept. 15, 2016), <http://bit.ly/2xm7G6N> [<https://perma.cc/E8BN-7MC6>] (“Quite simply, hospitals pursue accreditation because it is required in order for their organizations to receive payment from federally funded Medicare and Medicaid programs.”).

22. See Nation, *Fair & Reasonable*, *supra* note 1, at 459 n.268 (citation omitted) (noting that “on average in the U.S. Medicaid’s payments to hospitals fall well short of fully allocated costs”).

23. See Batty & Ippolito, *supra* note 11, at 689.

24. See Nation, *Chargemaster*, *supra* note 2, at 746–747 (noting that “[e]ach hospital maintains its own unique chargemaster, which it updates annually or more frequently as it sees fit, and extreme variation in list prices among hospitals, even those in the same geographic area, is common”); *cf.* *Banner Health v. Medical Sav. Ins. Co.*, 163 P.3d 1096 (2007). *Banner Health* sued patients for breach of contract for failing to pay for the services they received and based its claim on the Conditions of Admission (“COA”) signed by the patients upon entering a *Banner* hospital. *Id.* at 1098–99. The COA provided that “I will pay the hospitals [sic] usual and customary charges, which are those rates filed annually with the Arizona Department of Health Services” or will “pay the account of the patient.” *Id.* at 1098. It is important to note that the majority found that Arizona had a regulatory regime requiring hospitals to file their CDM rates with state regulators who had to approve them before they became effective. *Id.* at 1100. This was a point of contention for the dissent, who said that it was an informational requirement only and that there was no substantive review of the rates by the state. *Id.* at 1105. However, the majority’s opinion must be seen in light of its assumption that the CDM rates were required to be filed with and approved by the state and further that the CDM rates had to be published, posted, and available to the public in the lobby of each hospital. *Id.* at 1100. As a result, there was a significant issue regarding whether the COAs—which did not specifically mention that the rates referred to were the same rates filed with the Arizona Department of Health Services—sufficiently referred to those rates. See *id.* at 1102–04. The majority ultimately held that both types of COAs were sufficient in light of Arizona’s unique regulatory regime and distinguished the instant case from the case *Doe v. HCA Health Servs. Of Tenn., Inc.*, 46 S.W.3d 191 (Tenn. 2001), a case in which there was “no statutory scheme governing the setting, filing, and publishing of hospital rates and charges.” *Id.* at 1101. The *Banner Health* court went on to note that in *Doe*, “the hospital’s ‘Charge Master’ rates were in fact confidential and not ascertainable by a patient” and that “the contract with the patient contained no reference to the ‘Charge Master’ rates.” *Banner Health*, 163 P.3d at 1101 (citing *Doe*, 46 S.W.3d at 193–94). Finally, the court emphasized that “[t]he *Doe* court concluded that the contract was ‘indefinite’ and unenforceable because it did ‘not refer to a document or extrinsic facts by which the price will be determined.’” *Id.* (citing *Doe*, 46 S.W.3d at 197). The Majority felt it inappropriate to consider whether the rates set by the

CDM rates, there is no market constraint on the level of these rates.²⁵ CDM rates are exorbitant.²⁶

Contract law determines the financial relationship between hospital and patient.²⁷ Depending on the facts and circumstances surrounding a patient's admission, the rights and obligations between the patient and the hospital are determined either by an express contract, an implied-in-fact contract, or a quasi contract. If a patient signs an admission agreement and it is deemed enforceable, then an express contract is created. When a patient does not sign an admission agreement, or if a signed admission agreement is found to be unenforceable, the parties may have created an im-

hospital were excessive because the state had, in the Majority's view, approved those rates. *Id.* at 1103.

25. No market participants with any market power pay CDM based prices. See Nation, *Chargemaster*, *supra* note, 2 at 764 (“[N]o one—not hospital administrators, not government insurers, and not private insurers—expect the chargemaster rates to be paid”). As a result, hospitals suffer no competitive disadvantage by increasing their CDM rates. Moreover, in the case of self-pay patients, the only market participants expected to pay chargemaster rates, hospitals until recently treated their CDM prices as proprietary and kept them secret. A new rule took effect on January 1, 2019, requiring hospitals that accept Medicare patients to make their CDM available to the public. See Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2019 Rates, 83 Fed. Reg. 41,686 (Aug. 17, 2018) (to be codified at 42 C.F.R. Parts 4212–13, 424, 495). Unfortunately, published CDMs will not allow self-pay patients to determine the price they will actually have to pay for the healthcare they are going to receive and, as a result, the new rule will not create meaningful price transparency. See Julie Appleby & Barbara Feder Ostrov, *Hospitals Must Post Prices Online, But They May Be More Confusing Than Helpful*, CNN.COM (Jan. 7, 2019, 3:18 AM), <https://cnn.it/2FRd1aO> [<https://perma.cc/KPL2-F3MZ>]. A CDM contains between 20 and 30,000 separate line items. Even with access to the CDM, it is virtually impossible for the consumer to use it to calculate the amount that the patient will owe for a specific procedure. For example, a patient is in no position to determine the specific goods and services the hospital will use in performing a knee replacement. Nor do patients typically understand medical coding, which is the key to deciphering the CDM. Interestingly, however, government insurance as well as most commercial insurance companies reimburse hospitals based on procedures and not based on *à la cart* pricing. As I have argued elsewhere, if procedure-based pricing (the total amount the hospital is reimbursed on average for a knee replacement, an MRI, or a CAT scan, etc.) was made readily available to consumers, this would be useful transparency. Such transparency would, in turn, lead to price competition among hospitals. See Nation, *Chargemaster*, *supra* note 2, at 773–780 (proposing procedure-based reimbursement transparency).

26. See generally Nation, *Chargemaster*, *supra* note 2 (giving examples of exorbitant chargemaster rates and discussing how and why chargemasters came to reflect grossly excessive rates divorced from real prices).

27. Nation, *Accident*, *supra* note 6, at 687 (noting that “fundamentally, a hospital’s claim to payment from a patient is based on contract law”); see also Nation, *Balance Billing*, *supra* note 6, at 175–181 (discussing contract principles and contracting in the context of healthcare).

plied-in-fact contract based on their conduct. Finally, if no express contract or implied-in-fact contract has been created, then a quasi contract, sometimes called an implied-in-law contract, will define the rights and obligations of the patient and the hospital. For example, a quasi contract would exist in cases where the patient was unable to consent because of the circumstances surrounding his or her admission, as in the case of admission for an emergency medical condition.²⁸ For patients who are covered by in-network health insurance²⁹ that the hospital chooses to accept,³⁰ the exact nature of the contractual obligation created with the hospital is usually not relevant to the financial obligation incurred by the patient; the terms of the patient's contract with the hospital (whether express, implied-in-fact, or quasi) are usually superseded by the agreement between the patient's health insurer and the hospital.³¹

For the increasing number of patients who are self-pay,³² however, the exact nature of the contract entered into with the hospital is of critical importance because it will determine the rights and obligations between the patient and the hospital, including the amount that the patient is obligated to pay for the care received.³³

28. See, e.g., *infra* pp. 12–13 (discussing the case of Mr. Dennis, an emergency patient).

29. Health insurance is considered to be “in-network” when the health insurance company has entered into a contract with the hospital pursuant to which the hospital has agreed to accept specific reimbursement amounts as full payment for treatment of insured patients. A very important benefit to the patient from receiving treatment in-network is that the hospital has agreed to accept the insurance payment as full payment and not to seek any additional amount from the patient. If a patient is covered by health insurance, but that health insurance is not in-network with the hospital that provided treatment, then the hospital is free to bill the patient for the difference between the hospital's excessive CDM based charges and the reimbursement amount received from the patient's health insurance. This practice is called balance billing.

30. Hospitals, in order to increase profits, sometimes refuse to submit a patient's bill to the patient's health insurance, even in cases where that insurance is otherwise accepted by the hospital. For example, if a Medicare patient presents at a Medicare participating hospital and the patient's injuries are the result of a motor vehicle accident, it is not uncommon for the hospital to refuse to submit the patient's bill to Medicare and instead file a hospital lien against the patient's cause of action against or settlement with the third-party who was responsible for the accident. See generally Nation, *Accident*, *supra* note 6 (discussing this practice by hospitals and suggesting ways to prevent it).

31. See Nation, *Fair & Reasonable*, *supra* note 1, at 443–446 (noting that hospitals agree to accept the rates negotiated with in-network insurers as full payment and not to bill the insured patients for any additional amounts beyond the co-pays, co-insurance, and deductible amounts for which patients are responsible pursuant to their health insurance policy).

32. See Nation, *Fair & Reasonable*, *supra* note 1, at 430 (defining self-pay patients).

33. See *infra* Part II.A, II.B.

Self-pay patients include patients who are uninsured, patients who are insured but receive care out-of-network (“OON patients”), or patients who have their in-network insurance rejected by the hospital because the injuries being treated were the result of a third-party’s negligence, such as a patient who was the victim of a motor vehicle accident.³⁴ In these cases, there is either no superseding contract between the hospital and the patient’s health insurer, or the hospital chooses to ignore the superseding contract and treat an insured in-network patient as uninsured.³⁵

Practically speaking, this means that the price that self-pay patients owe the hospital can vary significantly depending on the type and interpretation of the contract the self-pay patient entered into with the hospital.³⁶ Hospitals typically claim that self-pay patients owe the exorbitant CDM-based price, but, depending on the application of contract law, the patient may be responsible to pay only the reasonable market value of the medical care received, which is much lower than the excessive CDM price.³⁷

As noted, in the case of self-pay patients, hospitals claim that they have a right to be paid their exorbitant CDM prices.³⁸ This claim is often based on the patient’s signature on the admission agreement. Consider, for example, the following facts taken from a recent Virginia case³⁹:

[Glenn] Dennis arrived at Carter Bank and Trust, his place of employment, on May 29, 2014. Karen Pratt, Misty Powell, and Kathy Gravely, Mr. Dennis’s coworkers, stated that Mr. Dennis was not functioning normally on that day. Ms. Pratt testified that Mr. Dennis was “not focusing, not concentrating . . . [and] fidgety.” She believed Mr. Dennis to be distracted from his work, upset and scared. Ms. Powell similarly stated that Mr. Dennis appeared “very upset. His face was kind of flushed. His eyes were kind of watery. He seemed very fidgety. He couldn’t seem to concentrate.” Ms. Gravely’s testimony was consistent with the

34. See Nation, *Fair & Reasonable*, *supra* note 1, at 430 (defining self-pay patients).

35. *Id.*

36. See *infra* Part II.B.

37. See *infra* Parts IV, V.

38. See Nation, *Fair and Reasonable*, *supra* note 1, at 430.

39. *Dennis v. PHC-Martinsville, Inc.*, 93 Va. Cir. 111, 112–13 (Va. Cir. Ct. 2016). On appeal, the Supreme Court of Virginia concluded that the circuit court erred in ruling that the hospital failed to prove mutual assent to the contract and as a result reversed the judgment of the Circuit Court and remanded the case to the Circuit Court for findings related to the patient’s affirmative defenses. See *PHC-Martinsville, Inc. v. Dennis*, No. 161019, 2017 WL 40533898, at *2–3 (Va. Sept. 14, 2017) (*Dennis II*).

other witnesses, as she stated Mr. Dennis “was very agitated. I could see in his demeanor, his expression, there was some pain in his face. He acknowledged that he was having chest pain’s that were like he had had before [during a previous heart attack].” Ms. Gravely did not trust Mr. Dennis to be in the bank that day, and Ms. Pratt drove him to Urgent Care because she did not think Mr. Dennis capable of driving himself.

Mr. Dennis was seen by medical personnel at an Urgent Care facility, where he was joined by Patricia Dennis, his wife, who testified that Mr. Dennis was “crying . . . upset . . . [and] agitated.” The staff at Urgent Care quickly determined that Mr. Dennis should be transferred to the hospital. Mr. Dennis arrived at Memorial Hospital in an ambulance, in acute emotional and physical distress. Throughout this ordeal, Mr. Dennis was suffering from chest pains similar to those he had experienced while having a heart attack some years earlier. Nitroglycerin did not seem to relieve his pain, and Mr. Dennis was agitated, tearful, illogical, less-than-normally coherent, and fearful.

Some 45 minutes after Mr. Dennis arrived at the hospital, Virginia Ramsey, a hospital registrar, brought papers for him to sign. He was lying prone in a room in the emergency department, and monitors were attached to his person. He had undergone a preliminary assessment by the medical staff. Mr. Dennis believed he was having a severe heart attack and, as he lay there, began to fear that he was going to die. (In testimony, he employed euphemisms to say so: he said he hoped he would not “go away,” and wondered “what would be left behind.”) He was eager for treatment to begin.

Ms. Dennis, who was in the room while Ms. Ramsey was there, testified that, while she did not recall Ms. Ramsey’s exact words, their essence, as she understood it, was that these were the papers that Mr. Dennis had to sign in order to be treated. She also testified that Mr. Dennis was unable to concentrate or read when given the consent form to sign. Ms. Ramsey (who does not specifically recall Mr. Dennis on this occasion) testified that her habit or practice is simply to tell the patient that by signing these documents he gives the hospital permission to treat him, verifies the information that the hospital has about him, and guarantees that his bills will be paid. She does not read the documents to the patient.

Mr. Dennis testified that, though he does not specifically recall Ms. Ramsey, he knew the hospital wanted him to sign something, and he wanted to “move on so I could get treated.” Ms. Ramsey

was in the room for an estimated two minutes. Mr. Dennis signed the documents that she had brought.

An important question addressed by this article is what impact, if any, circumstances like those surrounding Glenn Dennis's signing of the hospital's admission agreement should have on the enforceability of hospital/patient contracts.⁴⁰ Specifically, when an admission agreement is signed by a patient in the emergency department, should the court blindly apply the doctrine of objective intent and enforce the writing simply because it was signed?⁴¹ Or, should the court refuse to enforce the admission agreement because a patient like Mr. Dennis is in no position to give free and knowing assent to the agreement's terms?⁴² Alternatively, should the court find some middle ground, such as reviewing the agreement with special scrutiny to make sure that the terms are fair?⁴³

In addition, in the context of both emergency and non-emergency admissions, the admission agreement presented to patients is a contract of adhesion.⁴⁴ That is, patients have no ability to negotiate the terms of the admission agreement. Rather, patients are

40. See, e.g., *St. John's Episcopal Hosp. v. McAdoo*, 405 N.Y.S.2d 935, 936 (N.Y. Civ. Ct. 1978). The court recognized the trauma and anxiety experienced by those confronted with an emergency medical crisis and concluded that a hospital emergency room is certainly not a place where a reasonable person could be expected to exercise "calm and dispassionate judgment." *Id.* According to the court, a reasonable person would give a hospital admission contract at most "cursory attention." *Id.* The court concluded that a hospital "should not be permitted to enforce a contractual obligation entered into under such tension-laden circumstances." *Id.* See also *infra* Part II.A.

41. See *Dennis II*, 2017 WL 4053898, at *1. The Supreme Court of Virginia engaged in a blind application of the doctrine to reverse the Circuit Court's holding that no mutual assent existed stating: "[C]ontrary to the circuit court's ruling, the evidence established the Dennis assented to the terms of the contract. Whatever Dennis's unexpressed intentions may have been, his signature on the contract was clearly a manifestation of his intent to agree to its terms." *Id.* at *2 (emphasis added). See also *infra* notes 79–140 and accompanying text.

42. See *Dennis II*, 2017 WL 4053898, at *1–4 (holding that under the circumstances of the case the parties held that no mutual assent and thus no contract existed). *infra* notes 79–140 and accompanying text.

43. See, e.g., *Phx. Baptist Hosp. & Med. Ctr., v. Aiken*, 877 P.2d 1345, 1349 (Ariz. Ct. App. 1994) (finding that in a contract of adhesion only provisions within the reasonable expectations of the parties under the circumstances should be enforced); *McAdoo*, 405 N.Y.S.2d at 938; *infra* notes 79–140 and accompanying text.

44. See, e.g., *Banner Health v. Medical Savings Insurance Co.*, 163 P.3d 1096, 1108 (Ariz. Ct. App. 2007) (Kessler, J., concurring in part and dissenting in part). The opinion stated:

The contracts in this case [Conditions of Admission (COAs) signed by the patients] were clearly contracts of adhesion. Contracts of adhesion are generally fully enforceable according to their terms. Courts will not, however, enforce a contract or a term of a contract if the contract or term exceeds a party's reasonable expectations. Additionally, as a matter of

presented with a “take-it or leave-it” situation where they must either sign the admission agreement presented to them by the hospital or, in the non-emergency context, seek care elsewhere.⁴⁵ What

equity, the courts will not enforce a contract or a term thereof if it is unconscionable.

According to the “reasonable expectation” rule, while a party is typically bound by the terms of an adhesion contract even when they do not know the details of the terms of the contract, they are not bound by the unknown terms of the contract that are beyond the range of reasonable expectation. A term may be deemed to exceed the party’s reasonable expectation when the party enforcing the term has reason to believe the party against whom the agreement is enforced would not have accepted the agreement had he or she known the agreement contained that term. In determining whether a party enforcing an agreement had reason to believe the term exceeded the other party’s reasonable expectations, courts may examine factors including: whether the term is bizarre or oppressive, whether the term eviscerates non-standard terms specifically agreed to, whether the term eliminates the dominant purpose of the contract, whether the other party had an opportunity to read the term, and whether the term is illegible or otherwise hidden from view.

Id.

But even if the provision in question does not exceed the parties’ reasonable expectations this does not end the inquiry. The opinion went on to state that:

Courts may refuse to enforce a term within a party’s reasonable expectations if that term is unconscionable. A contract or term therein may be procedurally unconscionable — wrong in the bargaining process—or substantively unconscionable — wrong in the contract terms per se. A contract may be deemed procedurally unconscionable when it is entered into hastily and/or in an emergency situation, when its terms are not explained at the time it is signed, and when the document does not call attention to terms to be enforced against the signing party. Indications of substantive unconscionability include gross disparity in the values exchanged, unduly oppressive terms, and overall imbalance in the rights and protections of the parties. . . .

In opposition to Banner’s motion for summary judgment . . . the patients argued the price terms of the COAs were unconscionable. In support of this argument, the patients. . . stat[ed] that they signed the COAs in emergency situations, while they were under stress caused by their medical conditions. . . . Several of the patients stated in their affidavits that the COAs were not explained to them by the hospital personnel when they signed them, and that they believed that signing the COAs was a prerequisite to treatment. Furthermore, Banner’s Vice President of Finance, indicated that the cost-to-charge ratio for some medical treatments at Banner hospitals was as low as 19.77% [this means that the *lowest* mark-up with respect to CDM prices was about 500%].

These facts raise at least the specter of unconscionability as to the price terms in the COAs.

Id. at 1109 (citations omitted). See also Nation, *Obscene Contracts*, *supra* note 2, at 127–28 (discussing “planned” as opposed to “emergency” medical services and concluding that admissions agreements signed in both cases are adhesive contracts that are procedurally unconscionable); *infra* notes 225–249 and accompanying text.

45. Emergency patients cannot be turned away by the hospital regardless of their ability to pay or their refusal to sign the hospital’s admission agreement.

impact should the adhesive nature of hospital admission agreements have on their enforceability?⁴⁶ Of particular interest in this article is the enforceability of the price term contained in these agreements.⁴⁷

Consider these additional facts from the *Dennis* case:

The hospital bases its contract claim on the “Financial Responsibility Agreement” that Mr. Dennis signed in the emergency department. The fourth numbered paragraph of this document says, in part, that the patient is “obligated to promptly pay the hospital in accordance with the charges listed in the hospital’s charge description master and, if applicable, the hospital’s charity care and discount policies and state and federal law.” The same paragraph contains an acknowledgement that “except where prohibited by law, the financial responsibility for the services rendered belongs to [Dennis, the patient].”

The financial responsibility agreement is a form document, prepared by the hospital, and presented by a hospital employee to all patients (or, for those not capable of signing, their representatives), to be signed before treatment is rendered. According to counsel for the hospital, “[t]he terms of the FRA [financial responsibility agreement] signed by Mr. Dennis are the same as

However, many emergency patients do not realize that this regulation exists and often believe that they must sign the forms presented to them in order to receive treatment. See Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd (2012) (requiring hospital emergency departments to medically screen every patient who seeks emergency care and to stabilize or transfer those with medical emergencies, regardless of health insurance status or ability to pay); Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, 42 U.S.C. § 403 (West 2010); (*EMTALA*) *Emergency Medical Treatment and Active Labor Act*, AM. COLL. EMERGENCY PHYSICIANS, <https://bit.ly/2RdnK3C> [<https://perma.cc/XC57-PKEE>] (last visited Jul. 14, 2019); *infra* notes 225–237 and accompanying text.

46. See *supra* note 49 at *x*; *infra* notes 79–189 and accompanying text.

47. In *Doe v. HCA Health Servs. of Tenn.*, 46 S.W. 3d 191 (Tenn. 2001), the Tennessee Supreme Court held that, by failing to refer to the chargemaster rates in the agreement the price term was left open. *Id.* at 197. The court then held that, given that indefiniteness, a court would have to determine the price term by the quasi-contractual remedy of quantum meruit, that is, the reasonable value of the services provided. *Id.* at 198–99. But see *Allen v. Clarian Health Partners*, 980 N.E. 2d 306 (Ind. 2012) (finding that the phrase “the undersigned guarantees payment of the account” was a clear and definite reference to chargemaster rates and therefore the admissions agreement was not missing a price term and thus there was no need to impute a reasonable price); *Holland v. Trinity Health Care*, 791 N.W. 2d 724, (Mich. App. 2010) (concluding the phrase “usual and customary charges” in hospital’s contract with a patient “unambiguously refers to the ‘Charge Master’”); *Shelton v. Duke Univ. Health Sys. Inc.*, 633 S.E. 2d 113,114 (N.C. App. 2006) (finding the language “regular rates and terms of the Hospital” not to be an open price term where the prices were set forth in the hospital’s chargemaster).

those of every other patient agreement in the same timeframe—whether elective or emergency, whether inpatient or outpatient.”⁴⁸

Notice that there is no actual price (dollars and cents amount) included in the agreement. This omission is very common and, at least in the context of emergency admissions, is understandable; at the time of admission, neither the hospital nor the patient knows at this time the full extent of medical care that will be needed to treat the patient.⁴⁹ However, it is neither understandable nor fair that this ambiguous pricing language is used to justify charging the patient many times the amount that the hospital receives from the majority of its patients for identical care. Until recently, most hospitals treated their CDM as proprietary and refused to reveal it to anyone, including patients. Even now when patients do have access to the CDM, patients still do not know how much the admission agreement is asking them to pay.⁵⁰

For example, in the *Dennis* case the court notes that the hospital charged Mr. Dennis \$111,115.37 based on its CDM.⁵¹ By contrast, an in-network commercial insurer like Anthem would have paid a mere \$23,389.00 pursuant to the rates negotiated between the insurer and the hospital for the exact treatment that Mr. Dennis received.⁵² Similarly, had Mr. Dennis been covered by Medicare, the government would have reimbursed approximately \$20,000.00.⁵³ In other words, Mr. Dennis was charged, based on his signature on the FRA, at least 4.75 times the amount that insured patients would have paid! It is important to note that even though commercial insurance companies may provide some benefits to hospitals that self-pay patients do not provide, such as access to an increased volume of patients and quick and assured bill payment, the expense to the hospital of treating a patient is exactly the same regardless of whether the patient has private insurance, commercial insurance, or no insurance.

Mr. Dennis was in fact covered by commercial insurance, but his insurance was out-of-network—his insurance company had not

48. *Dennis v. PHC-Martinsville, Inc.*, 93 Va. Cir. 111, 113 (Va. Cir. Ct. 2016).

49. *See, e.g., DiCarlo v. St. Mary Hosp.*, 530 F.3d 255, 264 (3d Cir. 2008) (holding that omitting a specific dollar figure is the only practical way in which the obligations of the patient to pay can be set forth, given the fact that nobody yet knows just what condition the patient has, and what treatments will be necessary to remedy what ails him or her).

50. *See infra* notes 56–60 and accompanying text.

51. *See Dennis*, 93 Va. Cir. at 114, 119.

52. *Id.* at 120.

53. *Id.* at 119–20.

entered into a contract with the hospital where Mr. Dennis was treated.⁵⁴ Mr. Dennis's insurance company did actually pay the hospital \$27,254.95. However, because there was no contract between the hospital and his insurance company, the hospital claimed it was not required to accept the insurance company's payment as payment in full and billed Mr. Dennis for \$83,860.42, the difference between the hospital's CDM based rate and the amount received from Mr. Dennis's insurer.⁵⁵

This article focuses on the application of contract law principles to the relationship between hospitals and self-pay patients to determine how much self-pay patients owe the hospital for the health care they have received.⁵⁶ For example, in the case of Mr. Dennis, should his signature on the FRA legally bind him to pay the hospital's chargemaster rates?⁵⁷ This article argues, based on the proper application of contract law principles, that Mr. Dennis must pay only the reasonable market-based value of the health care that he received (about \$27,000.00).⁵⁸ Moreover, the determination of reasonable value must be based on the market value—the actual

54. *Id.* at 119.

55. *Id.* This is commonly referred to as balance billing. See *infra* notes 6–14 and accompanying text; Tara Bannow, *Hospitals' Solution to Surprise Out-of-Network Bills: Make Physicians Go In-Network*, MODERN HEALTHCARE (Jan. 12, 2019, 12:00 AM), <https://bit.ly/32qdmel> [<https://perma.cc/QU5U-L8DA>] (discussing hospitals adopting a policy of requiring in-hospital physician groups to contract with the same insurance carriers as the hospital in response to patient complaints about receiving surprise balance bills).

56. See Christopher N. Osher, *A Denver-area Hospital Sued a Patient for Nearly \$230,000 Over Her Surgery Bill. A Jury Said Not So Fast*, DENVER POST (June 29, 2018, 10:07 AM), <https://dpo.st/2Kyge2E> [<https://perma.cc/X2W5-LJ3C>] (discussing the case of Lisa French who underwent spinal-fusion surgery in 2014 and was sued by the hospital three years later for \$229,112.13, but a jury found that the bills were unreasonable). According to the jury's special verdict form, the jury found that Lisa French had entered into a contract with the hospital to pay "all charges of the hospital not otherwise paid by my health insurance or other payor". The jury decided that the phrase "all charges of the hospital" did not refer to the predetermined charges for goods and services contained in the hospital's chargemaster, but instead referred to the reasonable value of the goods and services provided to Ms. French. The jury found specifically that the hospital's CDM rates were not reasonable. The hospital's bill based on CDM rates was \$303,709.49 and Ms. French's out-of-network insurer paid \$74,597.35. The jury found that Ms. French owed the hospital and additional \$766.74 more than half of which was the unpaid portion of her deductible. (Cite to Jury Form) (on file with author).

57. *Id.* See also *infra* notes 79–189 and accompanying text.

58. This amount is derived as follows: assuming the Anthem rate is about equal to the average commercial insurer reimbursement rate then this would be increased by 10 to 15 percent to account for the benefits that commercial insurers provide to providers that self-pay patients do not. Thus, $\$23,389 \times 1.10 = \$25,728$ and $\$23,389 \times 1.15 = \$26,897$. See *infra* notes 225–249 and accompanying text.

reimbursements that the hospital receives—and not on the hospitals unilaterally-set CDM prices.⁵⁹

In the case of self-pay patients who enter the hospital through the emergency department, they, like Mr. Dennis, usually simply lack capacity to contract due to rushed, stressful, and tension-laden emergency circumstances.⁶⁰ As a result, most contracts signed by patients in the emergency department are not enforceable and the obligation of these patients to pay for the medical care they have received is based on quasi contract.⁶¹

With respect to patients who enter the hospital other than through the emergency department, the admission agreements they sign, like those signed by emergency patients, are adhesion contracts—often called leonine, standard, or form contracts—presented to patients on a take-it or leave-it basis.⁶² As a result, even in a non-emergency context where the patient is capable of giving assent, true assent by the patient is lacking, and the courts must closely scrutinize such contracts to ensure that the weaker party, the patient, is not taken advantage of by the stronger party, the hospital.⁶³ A hospital exercising its prodigious bargaining power to extract a promise from a self-pay patient to pay more than 300 percent of the price the hospital usually receives and accepts for the same services from the majority of its patients is a prime example of a grossly unfair term that courts should refuse to enforce.⁶⁴

This article concludes that the misapplication of contract law principles in cases involving hospitals and self-pay patients has effectively resulted in hospitals price-gouging self-pay patients.⁶⁵ Under the application of contract law principles argued for here, self-pay patients should rarely be obligated to pay more than a reasonable market-based value for the healthcare they receive.⁶⁶ Finally, if courts apply contract law as suggested here to cases

59. The U. S. Congress has taken notice that CDM prices do not reflect market forces. Thus, the ACA requires tax-exempt hospitals to collect from low income uninsured patients not more than the amount generally billed to individuals with insurance. Patient Protection and Affordable Care Act of 2010 § 9007(a), 26 U.S.C. § 501(r)(5)(A) (2016). This is discussed in *Nation Fair & Reasonable*, *supra* note 1 at 467–470). *See also infra* notes 190–224 and accompanying text.

60. *See infra* notes 225–237 and accompanying text.

61. *See infra* notes 225–237 and accompanying text. Also, there may be no consideration and thus no contract when a hospital provides stabilizing treatment to a patient in an emergency. *See infra* notes 235–237 and accompanying text.

62. *See supra* note 49 and *infra* notes 79–140 and accompanying text.

63. *See supra* note 49 and *infra* notes 79–140 and accompanying text.

64. *See supra* note 49 and *infra* notes 79–140 and accompanying text.

65. *See supra* note 52 and *infra* notes 225–249 and accompanying text.

66. *See infra* notes 225–249 and accompanying text.

involving hospitals and self-pay patients, it will help to ameliorate excessive health care prices which are one of the most significant causes of exorbitant healthcare costs in the United States.⁶⁷

This article begins with a discussion of the basic contract law principles that are relevant to contracts formed between hospitals and patients.⁶⁸ Next, the article discusses why admission agreements and their common price-formula terms are usually unenforceable.⁶⁹ This discussion is followed by an analysis of why self-pay patients are obligated, pursuant to either an implied-in-fact contract or a quasi contract, to pay the hospital a reasonable market-based price for the healthcare they receive.⁷⁰ The next section includes a brief summary of other work by the author outlining the process courts should use to calculate the fair and reasonable price for health care received by self-pay patients.⁷¹ Finally, the article concludes by arguing that the proper application of contract law principles by courts can help to solve the pressing problem of hospitals demanding exorbitant prices from self-pay patients.⁷²

67. See Gerard F. Anderson et. al., *It's Still the Prices, Stupid: Why the US Spends So Much on Health Care, And A Tribute to Uwe Reinhardt*, 38 HEALTH AFF. 87, 87–95 (2019) (concluding in part that the sizable differences in health spending between the US and other countries were explained mainly by health care prices); Zack Cooper et. al., *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, 134 QUARTERLY J. ECON. 51, 51–107 (2018) (finding that the commercial prices among US health care providers varied within regions, across regions, and within hospitals, and that variation in providers' prices explained a large-share of the three-fold variation in commercial health spending across the US, and also found that hospital mergers raised prices and that hospitals in concentrated markets had higher prices and were able to negotiate more favorable payment terms with insurers.); Michael Batty & Benedic Ippolito, *Mystery of the Chargemaster: Examining the Role of Hospital List Prices in What Patients Actually Pay*, 36 HEALTH AFF. 689, 689–696 (2017) (reasoning that even though most patients do not pay hospital chargemaster prices, these excessive prices still can drive up health spending and increase hospital revenue).

68. See *infra* notes 79–189 and accompanying text.

69. See *infra* notes 190–224 and accompanying text.

70. See *infra* notes 225–249 and accompanying text.

71. See *infra* notes 250–314 and accompanying text.

72. See *infra* note 314 and following text.

I. BACKGROUND: CONTRACT LAW IN HOSPITAL/PATIENT CONTRACTING

A. *Freedom of Contract, Mutual Assent, Objective Intent & The Duty to Read*

Contract law is the law of voluntary agreement.⁷³ No one may force another to enter into a contract; each party must knowingly and freely choose to enter into the contract.⁷⁴ The law of contracts—its rules and doctrines—must always reflect this fundamental principle.⁷⁵ The doctrine of freedom of contract provides that contracting parties are free to mutually assent to any terms they desire, within the parameters established by the law. Thus, the primary role of the courts, when they are convinced that mutual assent has been given, is to enforce agreements voluntarily made by the parties.⁷⁶

The fundamental necessity of mutual assent begs the question of how courts are to determine, in specific cases, whether the requisite assent exists? Part of the answer to this question is found in the requirements that courts consider essential to the creation of a valid and enforceable contract.⁷⁷ These requirements include offer and

73. See JOHN D. CALAMARI & JOSEPH M. PERILLO, *THE LAW OF CONTRACTS* §§ 1-3 to 1-4 (2d ed. 1977) (discussing freedom of contract and the philosophical foundation of contract law, respectively).

74. *Id.* at § 1-3 (“Most of Contract law is premised upon a model consisting of two alert individuals, mindful of their self-interest, hammering out an agreement by a process of hard bargaining.”).

75. *Id.* See also RESTATEMENT (SECOND) OF CONTRACTS (AM. LAW INST. 1981) § 17 (the formation of a contract requires a bargaining in which there is a manifestation of mutual assent).

76. See, e.g., Mark Klock, *Unconscionability and Price Discrimination*, 69 TENN. L. REV. 317, 343 (2002).

The consideration can be as nominal as a peppercorn for the agreement to be legally enforceable. Courts do not inquire into the distribution of benefits between the parties. This legal fact is deeply rooted in a strong faith in the efficiency of free markets. Individuals do not voluntarily enter into agreements that they expect to make them worse off than before the agreement. If the agreement was made voluntarily, everyone is presumed to have been made better off by the agreement. This presumption can be justified by economic thought which, given a few simple axioms, demonstrates that markets will channel resources to their most valued use and maximize society's wealth when all market participants are permitted to freely make their own decisions. Government intervention cannot improve the allocation of resources and can even impede it. *Id.* at 343-44 (citations omitted).

77. See RESTATEMENT (SECOND) OF CONTRACTS §§ 9-94 (AM. LAW INST. 1981) (discussing formation of contracts).

acceptance, consideration, capacity of the contracting parties, and a legal contract objective.⁷⁸

Generally, to have a valid contract, there must first be an offer.⁷⁹ An offer exists when one party communicates to another the intent to contract by indicating a willingness to exchange one thing for another according to reasonably definite and certain terms.⁸⁰ The requirement of reasonably definite and certain terms means that the parties must agree on all of the essential terms related to their contract so that the court can properly enforce the parties' agreement.⁸¹ Acceptance requires the person who received the offer to communicate his intent to enter into a contract on the exact terms offered.⁸² The requirement of consideration, reflecting the importance of the economic function served by contracts, requires that the parties have agreed to a bargained-for-exchange for something of value.⁸³ An individual has the capacity to enter into a contract if, at the time of contracting, the individual can understand in a reasonable manner the nature and consequences of the transaction.⁸⁴

While the foregoing requirements help to establish what the law means by mutual assent in the context of contracts, contract law also relies heavily on the concepts of agreement and intent.⁸⁵ Thus, courts must determine the intent of the parties and whether they have agreed on the necessary terms of the contract.⁸⁶ Contract law plays an important modern role in facilitating the operation of our economy based on free market capitalism. Consequently, in the interest of certainty and predictability, the law determines contractual

78. *Id.* §§ 24–94.

79. *Id.* §§ 24–34.

80. *Id.* §§ 24, 33.

81. *Id.* § 33.

82. *Id.* §§ 50–70.

83. *Id.* §§ 71–94.

84. *Id.* § 15.

(1) A person incurs only voidable contractual duties by entering into a transaction if by reason of mental illness or defect (a) he is unable to understand in a reasonable manner the nature and consequences of the transaction, or (b) he is unable to act in a reasonable manner in relation to the transaction and the other party has reason to know of his condition.

Id. Comment c. states: “Age, *bodily infirmity or disease*, use of alcohol or drugs, and illiteracy may bolster other evidence of incompetency.” (emphasis added). *Id.* at § 15 cmt. c.

85. See *supra* notes 82–89 and accompanying text.

86. See *supra* note 80.

intent by using the concept of *objective* intent as a proxy for actual, *subjective* intent.⁸⁷

Under the doctrine of objective intent, a party's actual, subjective intent is deemed to be consistent with that party's objective manifestations as interpreted by a reasonable person.⁸⁸ The unexpressed, hidden, or secret intentions of a party are irrelevant to the determination of objective intent precisely because the other party is unaware of them.⁸⁹ When determining objective intent, the law instead looks at a person's conduct and interprets its meaning from of the perspective of a reasonable person dealing with that person.⁹⁰ In other words, in the context of contracts, the law concludes that a patient's intent is the same as the intent that a hypothetical reasonable person in the hospital's position and endowed with the same knowledge as the hospital would ascribe to the patient.⁹¹ Under the objective theory of contracts, a person is bound by the impression that he or she reasonably creates, even if he or she had an unexpressed intent that was different.⁹²

In the context of *negotiated* voluntary agreements, where two parties of relatively equal bargaining power and knowledge confer back and forth and finally come to an agreement, the justness of the objective intent doctrine is virtually unassailable.⁹³ Contract law

87. See, e.g., CALAMARI & PERILLO *supra* note 73 at § 2-2 (discussing objective and subjective intention).

A party's intention will be held to be what a reasonable man in the position of the other party would conclude his manifestations to mean. By testing the meaning to be given to a party's words from the point of view of the reasonable man in the second party's position, the subjective element of this party's particular knowledge is incorporated into the objective test. In other words, the test considers what the second party knows or should know about the intention of the first party.

The objective theory is strongly supported by those who place the basis of contract law upon the promisee's justified reliance upon a promise or upon the needs of society and trade. An objective test is believed to protect "the fundamental principle of the security of business transactions." Even those who espouse intention as the basis of contract obligations are generally willing to hold a promisor to the reasonable meaning of his words, basing such liability on a theory of negligence, but are inclined to wish that the objective theory be held on a short leash, and to allow subjective intention a high degree of relevance in the resolution of many contractual issues.

Id. (notes omitted).

88. *Id.*

89. *Id.*

90. *Id.*

91. *Id.*

92. *Id.*

93. A negotiated contract is the type that courts have traditionally had in mind when developing the rules of contract law. As noted by John D. Calamari

could not function effectively if it was necessary to be concerned with the possible unexpressed or secret intentions of the party with whom one was doing business.⁹⁴

However, in the context of contracts of adhesion, the validity of the conclusions drawn from the objective intent doctrine may be suspect and rote application of the doctrine may fail to produce just results.⁹⁵ The hallmarks of a contract of adhesion are unequal bargaining power between the contracting parties, an imbalance of knowledge that favors the party who drafted the agreement or otherwise dictated the terms of the agreement, and an inability of the weaker party to meaningfully negotiate the terms of the agreement.⁹⁶ The result of these characteristics is that the weaker party is faced with a take-it or leave-it situation;⁹⁷ the weaker party must either agree to the terms demanded by the stronger party, find a different seller who is willing to negotiate, or do without the goods or services in question.⁹⁸ Theoretically, it would be possible for the weaker party to seek the goods or services from another seller more amenable to negotiation. Practically, however, locating alternative

and Joseph M. Perillo in *The Law of Contracts*, “[M]ost of contract law is premised upon the model consisting of two alert individuals, mindful of their self-interest, hammering out an agreement by a process of hard bargaining.” *Supra* note 73 at § 1-3. Those authors also note that there has been increasing recognition and legal literature that the bargaining process has become more limited in modern society. *Id.*

94. See CALAMARI & PERILLO, *supra* note 73 at § 2-2 (noting that an objective test is believed to “protect the fundamental principle of the security of business transactions”).

95. CALAMARI & PERILLO, *supra* note 73 at § 9-44 (“There has been a tendency, particularly in recent years, to treat contracts of adhesion or standard form contracts differently from other contracts.”); see also *Banner Health v. Med. Sav. Ins. Co.*, 163 P.3d 1016, 1104 (Ariz. Ct. App. 2007) (Kessler, J., dissenting in part).

96. See Friedrich Kessler, *Contracts of Adhesion—Some Thoughts About Freedom of Contract*, 43 COLUM. L. REV. 629, 632 (1943).

The weaker party, in need of the goods or services, is frequently not in a position to shop around for better terms, either because the author of the standard contract has a monopoly (natural or artificial) or because all competitors use the same clauses. . . . [C]ontractual intention is but a subjection more or less voluntary to terms dictated by the stronger party, terms whose consequences are often understood only in a vague way, if at all.

Id.; *Wheeler v. St. Joseph Hosp.*, 133 Cal. Rptr. 775, 783 (Cal. Ct. App. 1976).

The term ‘adhesion contract’ refers to standardized contract forms offered to consumers of goods and services on essentially a ‘take it or leave it’ basis without affording the consumer a realistic opportunity to bargain and under such conditions that the consumer cannot obtain the desired product or services except by acquiescing in the form contract.

Id.

97. See *supra* note 102. [?]

98. *Id.*

services is not possible because the same considerations that gave rise to the contract of adhesion in the first instance usually result in all sellers of such goods or services presenting customers with very similar contracts of adhesion.⁹⁹

In the case of hospitals and patients, hospitals argue that the offer is contained in the admission agreement presented to the patient. Thus, when the patient signs the agreement, hospitals contend that the patient has assented to the terms of the agreement. Consideration is argued to be the hospital's promise to give health care in exchange for the patients promise to pay for the care pursuant to the terms outlined in the admission agreement. However, the question becomes what to make of the hospital's claim that the patient—the weaker party—has *objectively* agreed to the terms dictated by the hospital—the stronger party?¹⁰⁰ Is this claimed *objective* agreement indicative of real assent by the patient?¹⁰¹

99. *Id.*

100. *See, e.g.,* Broemmer v. Abortion Servs. of Phx., Ltd., 840 P.2d 1013, 1017 (Ariz. 1992) (concerning an agreement to arbitrate included in the admissions documents provided to a patient at a clinic). In *Broemmer*, the court cited with approval the Restatement (Second) of Contracts, Section 211 (Standardized Agreements): “Although customers typically adhere to standardized agreements and are bound by them without even appearing to know the standard terms in detail, they are not bound to unknown terms which are beyond the range of reasonable expectation.” *Id.* Further, the court concluded that “[c]ontracts of adhesion will not be enforced unless they are conscionable and within the reasonable expectations of the parties.” *Id.* at 1018. It stated: “This is a well-established principle of contract law; today we merely apply it to the undisputed facts of the case before us.” *Id.* *But see* Rory v. Cont'l Ins. Co., 703 N. W. 2d 23, 35 (Mich. 2005) (“An ‘adhesion contract’ is simply that: a contract. It must be enforced according to its plain terms unless one of the traditional contract defenses applies.”). *Rory* was a 4-3 decision; Justice Kelly in dissent, joined by two other dissenting Justices, stated: “[T]he majority of the courts in this country has disavowed the strict construction policy in construing contracts of adhesion.” *Id.* at 52 (Kelly, J., dissenting).

101. Regarding contracts of adhesion, that is contracts that are not negotiated but instead prepared by the stronger party and presented to the weaker party on a take it or leave it basis as a condition of treatment, at best the weaker party has assented only to conscionable terms that are within the reasonable expectations of the parties. *See Broemmer*, 840 P.2d at 1016. The Restatement notes that standardized agreements are enforceable except where a “party [stronger party] has reason to believe that the party manifesting . . . assent [weaker party] would not do so if he knew that the writing contained a particular term” RESTATEMENT (SECOND) OF CONTRACTS, *supra* note 77 at § 211(3). The Comment goes on to state that: “Such a belief or assumption may be shown by prior negotiations or inferred from the circumstances. Reason to believe may be inferred from the fact that the term is bizarre or oppressive” *Id.* at cmt. f. In the context of hospital admissions agreements, those signed in the Emergency Department are signed under *circumstances* which would prevent a reasonable person from interpreting the patient's signature as a manifestation of assent. *See infra* notes 108–140 and accompanying text. Moreover, the price term contained in these agreements,

When the weaker party signs a written contract of adhesion, some courts have used—really misused—objective intent and a related concept, the duty to read,¹⁰² as excuses to enforce all of the terms of the writing against the weaker party without first closely examining those terms to ensure that the weaker party is not being taken advantage of by the stronger party.¹⁰³ Essentially, the duty to read stands for the proposition that a party who signs a written contract is bound by the party's signature whether the party chose to read the document or not.¹⁰⁴ That is, a signature creates the impression that the signer has agreed to all the terms contained in the writing and, therefore, the signer is bound by that impression.¹⁰⁵ The idea behind the duty to read rule is that without it, one could not rely on a signed document because the party who signed it could avoid the transaction by saying that he or she had not read it, did not understand the writing, or secretly disagreed with its terms.¹⁰⁶

Like the objective intent doctrine, the duty to read concept makes good sense in the context of *negotiated* contracts but may produce pernicious consequences in the context of adhesion contracts.¹⁰⁷ This article and others argue that applying objective intent and the duty to read in the context of contracts of adhesion is a fundamental misapplication of the doctrine of freedom of contract.¹⁰⁸ As one court noted, “failure to read an instrument is not

whether signed in the emergency department or otherwise, is *oppressive*, requiring the patient pay many times the market value of the care received. As a result, no properly informed patient who had a choice would ever agree to sign it. *See infra* notes 190–203 and accompanying text.

102. *See* CALAMARI & PERILLO, *supra* note 73 at § 9-41 to 9-46. Many commentators have questioned the appropriateness of the doctrine in the context of contracts of adhesion. *See generally* Charles L. Knapp, *Is There a “Duty to Read”?*, 66 HASTINGS L. J. 1083 (2015); Ian Ayres & Alan Schwartz, *The No-Reading Problem in Consumer Contract Law*, 66 STAN. L. REV. 545 (2014); Randy E. Barnett, *Consenting to Form Contracts*, 71 FORDHAM L. REV. 627, 635 (2002); John D. Calamari, *Duty to Read—A Changing Concept*, 43 FORDHAM L. REV. 341 (1974); Stewart Macaulay, *Private Legislation and the Duty to Read—Business Run by IBM Machine, the Law of Contracts and Credit Cards*, 19 VAND. L. REV. 1051 (1966); KARL N. LLEWELLYN, *THE COMMON LAW TRADITION: DECIDING APPEALS* 370 (1960).

103. *See, e.g.*, *Allen v. Clarian Health Partners*, 980 N.E.2d 306 (Ind. 2012); *Holland v. Trinity Health Care*, 791 N.W. 2d 724 (Mich. App. 2010); and *Shelton v. Duke Univ. Health Sys. Inc.*, 633 S.E. 2d 113, 114 (N.C. App. 2006).

104. *See* CALAMARI & PERILLO, *supra* note 73 at § 9-42.

105. *Id.*

106. *Id.*

107. *Id.* § 9-44.

108. *See, e.g.*, *Kessler, supra* note 96 at 642.

[T]he “law” will [not] protect the public against any abuse of freedom of contract . . . so long as we fail to realize that freedom of contract must

negligence per se but must be considered in light of all surrounding facts and circumstances.”¹⁰⁹ The adhesive nature of the contract and the context in which it is signed are very important facts and circumstances indeed.¹¹⁰

For example, in the *Dennis* case discussed above, Mr. Dennis signed the admission agreement and the other papers presented to him by the hospital’s representative when he clearly was in no position to read, understand, or negotiate the terms contained in those writings.¹¹¹ Moreover, even if he had attempted to negotiate the terms of the agreement, the hospital’s representative who presented the forms to Mr. Dennis did not have the authority to agree to change the terms.¹¹² To force Mr. Dennis to pay more than three times the market value of the care received based solely on his signature on the admission agreement is a pernicious consequence.¹¹³ If a court finds that the rules associated with objective intent and the duty to read dictate such a result then the court is misapplying the rules.¹¹⁴

The correct (not rote) application of objective intent and the duty to read would result in Mr. Dennis being liable to pay fair market value for the care received and no more.¹¹⁵ For example, the hypothetical reasonable person who is the focus of the objective intent analysis is deemed to be aware to the same extent as the actual contracting party—the hospital—of the circumstances sur-

mean different things for different types of contracts. Its meaning must change with the social importance of the type of contract and the degree of monopoly enjoyed by the author of the standardized contract.

Id.

109. See *Chandler v. Aero Mayflower Transit Co.*, 374 F.2d 129, 136 (4th Cir. 1967) (concerning a bill of lading).

110. See, e.g., *St. John’s Episcopal Hosp. v. McAdoo*, 405 N.Y.S.2d 935, 936 (N.Y. Civ. Ct. 1978) (“There are circumstances [the court was discussing an emergency hospital admission and a signature on an admission agreement] under which a reasonable person might sign a contract, without reading it or understanding it, so that requiring adherence to its terms would be grossly unfair.”). See also *infra* note 113.

111. See *supra* notes 44–45 and accompanying text.

112. See *supra* notes 44–45 and accompanying text.

113. See *supra* notes 1–26 and accompanying text.

114. See *Kessler supra* note 96, at 640. When referring to the traditional application of freedom of contract doctrine to contracts that are *not* negotiated contracts—e.g., contracts of adhesion—Kessler stated: “Freedom of contract enables enterprisers to legislate by contract and, what is even more important, to legislate in a substantially authoritarian manner without using the appearance of authoritarian forms. Standard contracts in particular could thus become effective instruments in the hands of powerful industrial and commercial overlords enabling them to impose a new feudal order of their own making up on a vast host of vassals.” *Id.*

115. See *infra* notes 122–124 and accompanying text.

rounding Mr. Dennis's signing of the admissions agreement. This is because the objective intent doctrine places the hypothetical reasonable person in the position of the other party—here, the hospital—and assumes that the hypothetical reasonable person has the same specific knowledge as the actual contracting party. In Mr. Dennis's case, the hospital was clearly aware that the documents were signed in the emergency department by a patient who believed that he was having a heart attack and could die if treatment was not provided quickly.¹¹⁶ As a result, it is likely that the hypothetical reasonable person would conclude that Mr. Dennis's signature indicates a desire to receive treatment rather than agreement with any unusual or oppressive terms contained in the document.¹¹⁷ Specifically, Mr. Dennis's signature would not be interpreted as his assent to the payment formula that required him to pay an unreasonable and excessive amount for his treatment.¹¹⁸

Under the correct application of the objective intent doctrine, a hospital has a somewhat limited ability to contract with emergency patients.¹¹⁹ The correct analysis suggests that emergency patients lack the ability to enter into a valid contract, or, at the very least, that emergency patients lack the ability to agree to any unusual or oppressive terms.¹²⁰ Essentially, patients in the emergency department lack, at least temporarily, the full capacity to contract due to the emergency circumstances surrounding their admission to the hospital.¹²¹

116. See CALAMARI AND PERILLO *supra* note 73 (1977) at §2-2 (“By testing the meaning to be given to a party’s words from the point of view of the reasonable man in the second party’s position, the subjective element of this party’s particular knowledge is incorporated into the objective test. In other words, the test considers what the second party knows or should know about the intention of the first party.”).

117. *Id.*

118. *Id.*

119. See *supra* notes 121–124 and accompanying text.

120. See *supra* notes 121–124 and accompanying text.

121. See CALAMARI AND PERILLO, *supra* note 73 at § 8-10 (noting other forms of mental infirmity resulting in a loss of capacity such as temporary delirium deriving from physical injuries sustained in accidents.) (notes omitted); Murray v. Ready 292 P.2d 87, 88 (Colo. 1930) (noting that a person being in great pain and/or being under the influence of drugs can help reach a conclusion that the person is not competent to contract); see also Broemmer v. Abortion Servs. of Phx., Ltd., 840 P.2d 1013, 1017 (Ariz. 1992) (quoting RESTATEMENT (SECOND) OF CONTRACTS, *supra* note 77 at 1016). It seems quite likely that a patient in the emergency department, like Mr. Dennis, would have a difficult time understanding in a reasonable manner the nature and consequences of the transaction. Moreover, the hospital would certainly have reason to know the patient’s condition and that it would renders a patient like Mr. Dennis unable to act in a reasonable manner in relation to the transaction.

This patient incapacity creates some limitations for the hospital that the hospital may consider problematic. But the solution is not to misapply the doctrine of objective intent and, in so doing, treat patients like Mr. Dennis unfairly.¹²² Moreover, the problem is not one unique to the hospital setting but in fact is very common due to the abundance of adhesion contracts in use today.¹²³ For example, when using the Internet it is common to encounter websites that require the user to agree to the site's terms and conditions before proceeding.¹²⁴ Typically, the user indicates their agreement by placing a check in the box provided and hitting the enter key.¹²⁵ However, these are clearly adhesion contracts because the user's only choice is to agree or disagree; there is no ability to negotiate terms.¹²⁶ Moreover, while the voluminous terms and conditions are

122. That is, by leaving patients like Mr. Dennis at the mercy of the hospital's demand for an exorbitant fee. Something that Mr. Dennis and every patient like him would refuse to agree to if they had the knowledge and ability to do so.

123. See Sierra David Sterkin, *Challenging Adhesion Contracts in California: A Consumer's Guide*, 34 GOLDEN GATE U. L. REV. 285, 285 (2004) (“[A]dhesion contracts are infused in the lives of all consumers.”).

124. See, e.g., TermsFeed, *5 Reasons Why You Need Terms and Conditions* (Jan. 14, 2019) <https://bit.ly/2vGs81h> [<https://perma.cc/KVW8-YTT4>] (noting that a *Terms and Conditions agreement is a set of regulations which users must agree to follow in order to use a service. Terms of Use is often named Terms of Service, Terms and Conditions, or Disclaimer when addressing website usage, and that it is recommended to have a Terms and Conditions agreement for your website in order to, prevent abuses, own your content, terminate accounts, limit liability, and set the law that will govern any disputes.*)

125. See, e.g., TermsFeed, *Add “I agree to terms” Checkbox* (Mar. 29, 2017) <https://bit.ly/2YONVB3> [<https://perma.cc/6YYL-RZGX>] (*It's pretty clear that including a Privacy Policy or a Terms and Conditions section on your website is important. However, it's just as important to be able to enforce these legal agreements, as they will do you no good if they're found to be unenforceable. However, the most recommended method to make these legal agreements enforceable is called the click-wrap method. This method requires users to read and agree to the presented legal agreement by making it mandatory to check a checkbox with the text “I Agree to The Terms” or “I Agree To The Privacy Policy”.*)

126. See, e.g., Schnabel v. Trilegiant Corp., 697 F.3d 110 (2012) (2d Cir. 2012). The court refused to enforce an arbitration provision alleged to have been included in the terms and conditions of the website and in the course of the opinion stated:

To be sure, the “duty to read” rule combined with the “standardized form” contract makes it unlikely in many contexts that a consumer will actually read such an agreement beyond a quick scan, if that. A party who makes regular use of a standardized form of agreement does not ordinarily expect his customers to understand or even read the standard terms. One of the purposes of standardization is to eliminate bargaining over details of individual transactions, and that purpose would not be served if a substantial number of customers retained counsel and reviewed the standard terms. But inasmuch as consumers are regularly and frequently confronted with non-negotiable contract terms, particularly when entering into transactions using the Internet, the presentation of these terms at

only a few clicks away, I suspect that many users simply do not bother to read the terms and conditions, but simply check the box so they can proceed.¹²⁷ But, what are the owners of the website to do in order to secure the user's agreement to its desired terms and conditions?¹²⁸ Notwithstanding this dilemma, it seems unlikely that a reasonable person would believe that the checked box indicates that the user has agreed to any unusual, unexpected, unfair, or oppressive provisions, or even that the checked box indicates the user's willingness to take the risk that any such provisions may be included in the terms and conditions.¹²⁹

When dealing with contracts of adhesion, modern courts have applied the doctrine of objective intent so that it indicates assent to reasonable, conscionable, expected, or usual terms only.¹³⁰ Mr. Dennis's signing of the agreement should, at most, be interpreted as agreement only to terms and conditions that a hospital patient would expect and that are fair, reasonable, and conscionable, rather than agreement to any unexpected, unusual, unfair, or oppressive terms.¹³¹ That is, those terms and conditions that typical hospital patients would expect, rather than agreement to any unexpected, unusual, unfair or oppressive terms.¹³² A full discussion of this matter is not necessary here and is beyond the scope of this article. The author has discussed in other work the issues involved in deter-

a place and time that the consumer will associate with the initial purchase or enrollment, or the use of, the goods or services from which the recipient benefits at least indicates to the consumer that he or she is taking such goods or employing such services subject to additional terms and conditions that may one day affect him or her.

Id. at 127 (cleaned up).

127. *Id.*

128. *Id.*

129. *Id.*

130. See CALAMARI AND PERILLO, *supra* note 73 at §9-46. Thus, some of the more modern cases search not only for apparent objective assessment but also for a true assent. Under this view true assent does not exist unless there is a genuine opportunity to read the clause in question and its impact is explained by the dominant party and understood by the other party who has a reasonable choice under the circumstances, of accepting or rejecting the clause. . . . The Restatement (Second) goes one step further when it indicates that what is important, at least in contracts of adhesion, is whether a reasonable man would have expected to find such a clause in the contract. RESTATEMENT (SECOND) OF CONTRACTS, *supra* note 77 at 1016. The Restatement Second seems to be suggesting a new kind of objective approach to standardized agreements. Rather than seeking out true assent on a case-by-case basis it places the duty upon the courts to consider the essential fairness of the printed terms, both from the viewpoint of surprise and inherent one-sidedness. *Banner Health v. Med Sav. Ins. Co.*, 163 P.3d 1096, 1104 (Ariz. Ct. App. 2007) (Kessler, J., concurring in part & dissenting in part).

131. See *Broemmer v. Abortion Servs. of Phx., Ltd.*, 840 P.2d 1013 (1992).

132. See *id.* at 1016.

mining whether CDM based prices are conscionable or unconscionable.¹³³ With regard to emergency health care, legal recognition of the full or partial inability of a patient seeking emergency care to contract does not leave hospitals at a tremendous disadvantage. As discussed below, even when the hospital has no real contract with the patient, the hospital will have the right under quasi contract to recover the fair market value of the goods and services provided to the patient.¹³⁴

B. *Types of Contracts: Quasi Contracts*

Contracts may be entered into based on the parties' words—either written or oral—or actions.¹³⁵ The law also recognizes a cause of action for unjust enrichment under the doctrine of quasi contract. In a quasi contract, or an implied-*in-law* (as opposed to an implied-*in-fact*) contract,¹³⁶ the law imposes a contract-like duty to prevent one party from being unjustly enriched (receiving a benefit that in fairness the benefitted party should pay for) at the expense of another.¹³⁷

133. See generally Nation, *Obscene Contracts*, *supra* note 2 (discussing the use of the doctrine of unconscionability to prevent the enforcement of excessive chargemaster prices against uninsured or out-of-network patients).

134. See, e.g., *Bingham Mem'l Hosp. v. Boyd* 8 P.3d 664 (Idaho Ct. App. 2000) (discussing medical services rendered to decedent who never signed the admissions agreement, where the lower court found that the medical services provided to the decedent were necessary and voluntarily accepted, and that the decedent was not admitted to the hospital against his will and finding an implied-in-law contract obligating the decedent's estate to pay the reasonable value of the care provided and noting: where necessary and reasonable medical services are rendered by a hospital and received by a patient, a contract implied in law is formed to mandate remuneration) (citing *Landmark Med. Ctr. v. Gauthier*, 635 A.2d 1145 (R.I. 1994) (holding that an implied-in-law contract is formed when medically necessary services are rendered even without mutual assent.)); *Dennis v. PHC-Martinsville, Inc.*, 93 Va. Cir. 111, 119 (Va. Cir. Ct. 2016) (“[E]ven if the court finds—as it has—no express contract existing, Dennis is still obligated mine implied contract to pay the reasonable value of the services rendered.”). See also *infra* notes 225–237 and accompanying text.

135. See CALAMARI & PERILLO, *supra* note 79, § 1.12, at 19–20 (discussing express, implied, and quasi contracts).

136. *Id.* See also, e.g., *Boyd*, 8 P.3d at 668; *River Park Hosp., Inc. v. BlueCross BlueShield of Tenn., Inc.*, 173 S.W.3d 43, 57 (Tenn. Ct. App. 2002) (discussing the fact that contracts can be either express, implied in fact or implied in law and finding that when parties are forced to deal with each other and could not come to an agreement an implied-in-law contract exists); *Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alts, Inc.* 832 A.2d 501, 508 (Pa. Super. Ct. 2003) (noting that how much a hospital typically receives for its services is more probative of reasonable value than its published rates).

137. See, e.g., *Boyd*, 8 P.3d at 669 (noting that such implied-in-law contracts formed in order that a person needing help in an emergency and not able to ask for it should obtain it, the attainment of such result being created by assuring compen-

It is important to note that while both express and implied-in-fact contracts are real contracts, a quasi contract is not a real contract.¹³⁸ That is, both express and implied-in-fact contracts require mutual assent between the contracting parties.¹³⁹ A quasi contract lacks mutual assent, and thus it is not a contract.¹⁴⁰ The term “quasi contract” is a misnomer resulting from historical necessity.¹⁴¹ That is, the cause of action associated with unjust enrichment fit more closely within contract law than tort law.¹⁴² As a result, the word “contract” became associated with the doctrine.¹⁴³ All three types of contracts—express, implied-in-fact, and quasi—are relevant to healthcare contracting.¹⁴⁴

The law recognizes a quasi contract if three requirements are met.¹⁴⁵ First, there must be a benefit conferred on one party by another.¹⁴⁶ Second, the party receiving the benefit must retain and be aware of the benefit.¹⁴⁷ Third, and most importantly, the court must be convinced that, under the circumstances, fairness and justice will be served by requiring the benefitted party to pay the other

sation to the person rendering aid) (citing *Estate of Crisan*, 107 N.W.2d 907 (Mich. 1961)).

138. See CALAMARI & PERILLO, *supra* note 73, § 1.12, at 19–20 (discussing express, implied, and quasi contracts).

139. *Id.*

140. *Id.*; See *Landmark Med. Ctr. v. Gauthier*, 635 A.2d 1145, 1148–49 (R.I. 1994) (holding that an implied-in-law contract is formed when medically necessary services are rendered even without mutual assent).

141. See CALAMARI & PERILLO, *supra* note 73, § 1.12, at 19–20 (discussing express, implied, and quasi contracts).

142. *Id.*

143. *Id.*

144. See *infra* notes 225–250 and accompanying text.

145. See *Bingham Mem’l Hosp. v. Boyd* 8 P.3d 664, 668 (Idaho Ct. App. 2000).

In order to establish a *prima facie* case for an implied in law contract, the plaintiff must show that there was (1) a benefit conferred upon the defendant by the plaintiff; (2) appreciation by the defendant of such benefits; and (3) acceptance of the benefits under circumstances that would make it inequitable for the defendant to retain the benefit without payment to the plaintiff of the value thereof.

Id. at 668 (citation omitted); *Van Zanen v. Qwest Wireless, LLC* 522 F.3d 1127, 1130 (10th Cir. 2008) (“[T]o establish a claim of unjust enrichment a plaintiff must show that (1) at plaintiff’s expense (2) defendant received a benefit (3) under circumstances that would make it unjust for defendant to retain the benefit without paying.”).

146. See *supra* note 150.

147. See *supra* note 150.

party for the benefit received.¹⁴⁸ The amount that the benefitted party must pay is the fair value of the benefit received.¹⁴⁹

If there is an actual contract between the parties, the doctrine of quasi contract cannot be applied.¹⁵⁰ In addition, the law usually does not look favorably on one party foisting their goods or services upon another.¹⁵¹ For example, if I were stopped at a red traffic light and someone came out and cleaned my windshield without my consent or request, the doctrine of quasi contract could not be used to require payment for the service.¹⁵²

However, there is a well-settled exception for emergency medical care.¹⁵³ That is, if a doctor happens upon an injured party and provides medical care, the doctor may recover under quasi contract

148. See *supra* note 150.

149. See CALAMARI & PERILLO, *supra* note 79, §1.12 (noting that if a physician gives a child necessary medical care in the face of parental neglect, the physician may recover from the parents, in quasi contract, the value of his services) (note omitted).

150. See, e.g., *Boyd*, 8 P.3d at 668 (“Where an express contract exists, an implied contract between the same parties for the same contractual purpose is precluded from enforcement.”); *Indus. Lift Truck Serv. Corp. v. Mitsubishi Int’l Corp.*, 432 N.E.2d 999, 1002 (Ill. Ct. App. 1982) (“The general rule is that no quasi-contractual claim can arise when a contract exists between the parties concerning the same subject matter on which the quasi-contractual claim rests.”).

151. See, e.g., *Boyd*, 8 P.3d at 668 (“The services must be rendered under such circumstances as to indicate the person rendering an expected to be paid, and that the recipient expected, or should have expected to pay for them.”).

152. See *id.* Cf. *Unordered Merchandise*, FED. TRADE COMM’N, <https://bit.ly/2eQuaDn> [<https://perma.cc/ST2J-4LY4>] (last visited July 11, 2019) (“If you receive merchandise that you didn’t order, you have a legal right to keep it as a free gift.”).

153. See, e.g., *Boyd*, 8 P.3d at 669 (citing *In re Estate of Crisan*, 107 N.W.2d 907 (Mich. 1961)); *Landmark Med. Ctr. v. Gauthier*, 635 A.2d 1145, 1148–49 (R.I. 1994). See also FREDERIC CAMPBELL WOODWARD, *THE LAW OF QUASI CONTRACTS* § 201 (1913), <https://bit.ly/2xAhAC4> [<https://perma.cc/4UUA-RY37>].

It seems to be taken for granted that at the common law there is no legal obligation, independent of contract, to pay for *non-professional* services rendered, in an emergency, in the preservation of life. The intervention may be dutiful; the conduct of the intervener may be heroic. But . . . there is an irrefutable presumption, based either upon considerations of policy or upon knowledge of normal human conduct, that the service is intended to be gratuitous.

The considerations which underlie the irrefutable presumption just referred to have no application in the case of *professional* services—as of a physician or nurse. For while such services are usually prompted, in greater or less measure, by motives of humanity, they are generally rendered with the expectation of compensation. Moreover, in the case of a physician or nurse, there is nothing unworthy in such an exception. It follows that for professional services, unless there is evidence either that credit was extended to the third[-]party or that there was no intention to charge, the beneficiary should be required to pay reasonable value.

Id.

for his or her services even if the patient was unconscious during the treatment.¹⁵⁴ In other words, the law takes the position that an injured party would have consented to emergency medical care had the party been able to consent to the care offered.¹⁵⁵ As a result, both public policy and fairness require that the doctor receive reasonable compensation for the services provided.¹⁵⁶ A doctor providing emergency services will be able to recover the fair or reasonable market value of the medical care provided.¹⁵⁷

C. *Types of Contracts: Express and Implied-In-Fact Contracts*

As noted, express contracts are based upon the words, either oral or written, that the parties have exchanged.¹⁵⁸ In a hospital admission contract, these words are written; therefore, the hospital attempts to enforce an express contract with the patient.¹⁵⁹ Establishing an express contract requires mutual assent between the parties.¹⁶⁰ As discussed above, in an emergency admission situation like that involving Mr. Dennis, there is usually no real mutual assent.¹⁶¹ As a result, courts should either reject the written contract notwithstanding the fact that the patient signed it (in which case the hospital would have the right to recover the fair market value of its services under a quasi contract theory),¹⁶² or closely scrutinize the written contract to identify and prevent enforcement of any unex-

154. See *Landmark Med. Ctr.*, 635 A.2d at 1148–49 (stating that because an implied-in-law contract is formed when medically necessary services are rendered even without mutual assent, the recipient of such services is liable to the service provider).

155. See, e.g., *In re Estate of Crisan*, 107 N.W.2d at 914 (“[Implied-in-law contracts are formed so] that a person needing help in an emergency and not able to ask for it should obtain it[;] the attainment of such a result [is] aided by assuring compensation to the person rendering aid . . .”) (citing to RESTATEMENT (FIRST) OF RESTITUTION: PRESERVATION OF ANOTHER’S LIFE OR HEATH § 116 (AM. LAW INST. 1937)).

156. *Id.*

157. See, e.g., *Boyd*, 8 P.3d at 669 (“The measure of damages in a claim for unjust enrichment is the value of the benefits bestowed upon the defendant which, in equity, will be unjust for him or her pain without compensating the plaintiff.”). It is important to note that in *Boyd*, the court awarded the Hospital an amount equal to the principal cost of rendering services, but the court noted specifically that this was due to the fact that the amount of the charge was not challenged, rather only liability on the account was challenged. *Id.*

158. See *supra* note 141.

159. *Id.*

160. See *supra* notes 79–140 and accompanying text.

161. See *supra* notes 79–140 and accompanying text.

162. See *supra* notes 79–140 and accompanying text.

pected, unusual, unfair, or oppressive terms such as a payment formula tied to the hospital's CDM rates.¹⁶³

In non-emergency admissions, including voluntary inpatient and outpatient admissions, patients are often capable of giving real assent. However, for the reasons discussed below, this rarely occurs with respect to price.¹⁶⁴ In the non-emergency context, hospital admission agreements are still contracts of adhesion; they are written solely by the hospital, the dominant party that possesses much more bargaining power and knowledge regarding the contract and its meaning than the patient. Even if a patient understood the price formula, which is very unlikely, the patient has no meaningful ability to negotiate with the hospital.¹⁶⁵ Finally, the price terms included in these contracts (e.g. the patient is obligated to pay the hospital in accordance with the hospital's "regular rates," "charges," "billed charges," or "charge description master"), as discussed in more detail below, are indefinite, confusing, and misleading to patients; most importantly, they provide for a price that is grossly excessive.¹⁶⁶ As a result, when courts scrutinize these contracts looking for unexpected, unusual, unfair, or oppressive terms, they should pay particular attention to the price term.¹⁶⁷ In the alternative, a court may decide that no contract has been entered into based on the written agreement, because true mutual assent to the writing is lacking due to its adhesive nature; its indefinite, confusing, and unfair terms; or both.¹⁶⁸

If a court decides, in the non-emergency context, that no contract exists based on the written admission agreement, then in all likelihood the court will find that an implied-in-fact contract exists based on the actions of the hospital and the patient.¹⁶⁹ That is, medical care is provided by the hospital and accepted by the pa-

163. See *supra* notes 79–140 and accompanying text.

164. See *supra* notes 79–140 and accompanying text.

165. See *supra* notes 79–140 and accompanying text.

166. See *infra* notes 204–24 and accompanying text.

167. Recall that the patient's agreement to pay the hospital's charges is really an agreement to pay an exorbitant amount, on average more than three times the price the hospital has agreed to accept in full payment from the majority of its patients. See *supra* notes 1–26 and accompanying text.

168. See *supra* notes 204–24 and accompanying text.

169. See *Portercare Adventist Health Sys. v. Lego*, 312 P.3d 201, 203 (Colo. App. 2010), *rev'd on other grounds*, 286 P.3d 525 (Colo. 2012). This case involved a breach of an implied-in-fact contract to pay a hospital for medical services provided to a patient. The implied-in-fact contract was established by the actions of the patient and her husband. The hospital specifically stated "(1) Ms. Lego's decision to remain at the hospital after her insurance coverage ceased, knowing that the hospital would charge her for services provided after October 1, and (2) the hospital's provision of services after that date—created a contract implied in fact."

tient; the hospital reasonably expects payment; and the patient reasonably expects to pay for the care received.¹⁷⁰ As a result, the court is likely to recognize that the parties have entered into a contract based on their actions even though there was no mutual assent to the written admission agreement.¹⁷¹

If the court recognizes that an implied-in-fact contract exists, then the court must provide the price that the patient is required to pay because there would have been no express agreement on a price formula.¹⁷² The court will likely decide that the price that should be provided is that upon which a prudent buyer and seller would agree if they had the time and knowledge to properly negotiate: the fair market value of the medical care received.¹⁷³ As discussed below, the court can easily and readily determine the reasonable market value of medical care by consulting the average amount the hospital has agreed to accept as full payment from in-network private health insurers.¹⁷⁴

In summary, courts should recognize that providers of emergency health care have a right to recover fair market value under the doctrine of quasi contract.¹⁷⁵ For non-emergency care where the patient has signed an admission agreement, the court must determine whether to enforce the agreement or reject it as lacking real mutual assent.¹⁷⁶ Courts deciding to enforce the admission agreement in this context should recognize that it is a contract of adhesion and scrutinize it for any unusual, unexpected, oppressive, or unfair terms, such as price terms that require the patient to pay exorbitant CDM-based list prices.¹⁷⁷ These terms should be struck from the contract and—for CDM-based price formulas—replaced with a reasonable price equal to the fair market value of the health-care services received by the patient.¹⁷⁸ Courts refusing to enforce the admissions agreement after medical care has been provided and

Id. at 203. CALAMARI & PERILLO, *supra* note 73, §1.12 at 19–20 (2d ed. 1977) (discussing implied-in-fact contracts).

170. *Lego*, 312 P.3d at 206. (“Several courts have found the contract implied[-]in[-]fact where a patient accepts medical services understanding that those services must be paid for by the patient, and have held that the measure of recovery is the reasonable value of those services.”) (citations omitted).

171. *Id.*

172. *Id.*

173. *Id.*

174. *See infra* notes 250–314 and accompanying text.

175. *See supra* notes 79–140 and accompanying text. In addition, it is very important to note that CDM-based prices are not a reflection of reasonable value.

176. *See supra* notes 79–140 and accompanying text.

177. *See supra* notes 79–140 and accompanying text.

178. *See supra* notes 141–63 and accompanying text.

accepted will likely find that an implied-fact-contract exists and will find, as in the quasi contract situation, that the patient owes the fair market value of the health care provided.¹⁷⁹

This article focuses next on price terms in hospital admissions contracts and specifically on how they should be interpreted.¹⁸⁰ As discussed below, it is argued here that the patient has agreed to pay only the market-based fair value of the care received.¹⁸¹ Market-based fair value is the amount that the hospital actually receives in payment from the majority of its patients for the same care that has been provided to the patient in question.¹⁸² A hospital's argument that, under the terms of the admissions agreement, a patient has agreed to a CDM-based price formula that requires the patient to pay the hospital's list price—which, as noted, is on average three and a half times the market value—should be rejected.¹⁸³

II. THE PRICE FORMULA IN PATIENT/HOSPITAL CONTRACTS (INCOMPLETE CONTRACTS, MISSING PRICE TERM CONTRACTS, AND ILLUSORY CONTRACTS)

A. *Missing Price Term Versus Price Formula*

When a court decides to enforce the admission agreement, one issue that arises is whether the agreement is missing a price term.¹⁸⁴ This is important because if the court finds that a contract based on the admission agreement exists, but also finds that the parties have not agreed on a clear, definite, and fixed price, then the court must provide the price. Courts typically do so by determining a reasonable price based on the market value of the goods or services in

179. See *supra* notes 141–63 and accompanying text.

180. See *infra* notes 190–224 and accompanying text.

181. See *infra* notes 225–249 and accompanying text.

182. See *infra* notes 278–294 and accompanying text.

183. See *supra* notes 1–26 and accompanying text.

184. See, e.g., *Allen v. Clarian Health Partners, Inc.*, 980 N.E.2d 306, 309 (Ind. 2012). The admissions agreement stated: “In consideration of services delivered by Clarian North Medical Center and/or the physicians, the undersigned guarantees payment of the account, and agrees to pay the same upon discharge if such account is not paid by a private or governmental insurance carrier . . . If the amounts due [to] Clarian North Medical Center for services rendered become delinquent and the debt is referred to an attorney for collection, it is understood and agreed that I shall be responsible for reasonable attorneys’ fees, court costs, and pre-judgment interest.” *Id.* Patients argued that the chargemaster rates imposed by Clarian were unreasonable and constituted a breach of contract. *Id.* at 308–309. The Court noted that the breach of contract claim depended on a critical underlying premise, namely, that the contract lacked the material term of price, and because no price term was present the court needed to impute a “reasonable price” to the contract. *Id.* at 309. However, the court noted that a contract need not declare a specific dollar amount for goods or services in order to be enforceable. *Id.* at 310.

question.¹⁸⁵ As a result, if a court finds that the admission agreement does not contain a reasonably definite, certain, and fixed price, then the patient will be obligated to pay far less than the provider's exorbitant CDM-based list price.¹⁸⁶

Hospital admissions agreements refer to price in a variety of ways. In the case of Mr. Dennis, the financial responsibility agreement stated, “[T]he patient is obligated to pay the hospital in accordance with the hospital’s charge description master.”¹⁸⁷ Other common price term formulations contained in admissions agreements refer to the patient’s obligation to pay the hospital its “regular rates,” “list charges,” “billed charges,” “list prices,” or “all amounts billed by the provider.”¹⁸⁸ What all of these various formulations have in common is that they do not state a specific dollars-and-cents price and they all, regardless of whether they specifically mention the CDM, purport to require the patient to pay the hospital’s CDM-based list price for the medical care received.¹⁸⁹

The law does not require that the parties always agree to a dollars-and-cents price. The parties may agree to a price formula.¹⁹⁰

185. See, e.g., *Ind. Bell Tel. Co. v. Ice Serv. Inc.*, 231 N.E. 2d 820, 824 (1967) (“Where there is an agreement that compensation is to be paid but the price is not fixed, the party furnishing services and materials in performance of the contract is entitled to the reasonable value thereof.”).

186. See, e.g., *Doe v. HCA Health Servs. of Tenn.*, 46 S.W.3d 191, 199 (Tenn. 2001) (holding that a patient’s agreement to be “financially responsible to the hospital for charges not covered by” insurance was indefinite and hospital was entitled to the reasonable value of the medical goods and services it provided to patient). *Id.*

187. See *supra* note 52 and accompanying text.

188. See, e.g., *Allen*, 980 N.E.2d at 308 (noting that the contract guaranteed payment on the account); *Doe*, 46 S.W.3d at 197 (finding that the agreement required the patient to be “financially responsible to the hospital for charges not covered by” insurance); *Phx. Baptist Hosp. & Medical Ctr. v. Aiken*, 877 P.2d 1345, 1347 (Ariz. Ct. App. 1994) (noting that the patient was obligated to pay the account of the hospital in accordance with the regular rates and terms of the hospital); *St. John’s Episcopal Hosp. v. McAdoo*, 405 N.Y.S.2d 935, 935 (N.Y. Civ. Ct. 1978) (finding that a contract obligated a patient to pay for charges not covered by insurance).

189. See *Doe*, 46 S.W.3d at 194 (The hospital demanded its chargemaster-based prices.); see also *Allen*, 980 N.E.2d at 310 (The hospital used chargemaster-based price to negotiate with insurance companies.).

190. See, e.g., *Allen*, 980 N.E.2d at 310. (A contract need not declare a specific a dollar amount for goods or services in order to be enforceable.). However, the formula agreed to must be reasonably definite and certain. See, e.g., *Doe*, 46 S.W.3d at 197 (holding that an admission agreement that referred to the patients “being financially responsible to the hospital for charges not covered by insurance” was not clear that it intended the hospital’s CDM to be used as the formula to set the price and therefore finding the contract contained no price term). *Id.* at 197. Moreover, the formula used must be set at the time of the contract and not be illusory. See *CALAMARI & PERILLO*, *supra* note 73 at § 2.13 (discussing indefinite-

The agreed-upon formula can be used subsequently to determine the dollars-and-cents price.¹⁹¹ For example, in a requirements contract, the buyer may agree to pay \$3.00 per gallon for all heating oil requested and delivered during a particular heating season.¹⁹² The actual dollars-and-cents amount that the customer will owe at the end of the season for heating oil under the contract is not stated, but once the customer requests and receives a delivery, the amount owed can be determined by applying the formula contained in the contract (\$3.00 multiplied by the number of gallons requested and delivered).

As noted, hospital admission agreements virtually never contain an actual dollars-and-cents price.¹⁹³ A possible legitimate reason for this in the emergency admission context is that at the time of admission neither the hospital nor the patient knows with certainty the exact type and quantity of healthcare that will be needed by the patient.¹⁹⁴ The question for the court is whether the admis-

ness as it relates to mutual assent). To do so, they provided the following illustration:

B promised to work as a foreman of a plant for one year in exchange for a fair share of the profits, and the promise was held to be too vague and indefinite to be enforced, but if B performs under the agreement he may obtain a quasi-contractual recovery measured by the reasonable value of his services.

Id. As discussed below, CDMs change frequently and many hospitals keep no record, at least records ascertainable by patients as to the history of the prices contained in the CDM. *See infra* notes 203–04 and accompanying text.

191. *See infra* notes 198–199 and accompanying text.

192. *See Note, Requirements Contracts Under the Uniform Commercial Code*, 102 U. PA. L. REV. 654, 654–655 (1954) (“More recent authority, however, recognizes that in the bargained-for exchange of promises each party has limited his freedom to some extent and that the terms “requirements” or “needs” supply a sufficiently objective standard to be enforceable. Thus, today, the typical requirements contract is generally held valid.”).

193. As noted, an exception would be non-medically necessary cosmetic procedures such as certain non-medically necessary face-lift, hair-plugs, breast augmentation, or liposuction.

194. *See, e.g., DiCarlo v. St. Mary Hosp.*, 2006 WL 2038498, 2006 U.S. Dist. LEXIS 49000 at *11 (D.N.J. 2006) (discussing admissions to the emergency department) the court stated,

[T]he price term ‘all charges’ is certainly less precise than price term of the ordinary contract for goods or services in that it does not specify the exact amount to be paid. It is, however, the only practical way in which the obligations of the patient to pay can be set forth, given the fact that nobody yet knows just what condition the patient has, and what treatments will be necessary to remedy what ails him or her.

Id. It must be noted, however, that in the non-emergency admissions context, it is likely very possible for hospitals to give a precise and accurate price quote for the medical care the patient is scheduled to receive. For example, the hospital agrees in advance with its in-network insurers the price it will accept for the medical procedures it provides. Further, for non-medically necessary procedures that are not

sion agreement, notwithstanding the fact that it does not contain a dollars-and-cents price, contains a price formula that is both fixed, reasonably definite, and certain enough to be used to determine the price.¹⁹⁵ If it does not, then the contract is missing an enforceable price term.¹⁹⁶ Given the adhesive nature of admission agreements, even if the court finds a price formula sufficiently fixed and clear and definite, the court still needs to look closely at the resulting price to ensure its fairness.¹⁹⁷ These issues are discussed next.

B. CDM-Based Prices Are Illusory, Unknown, and Unknowable

As discussed above, at least in the context of emergency admissions, neither the patient nor the hospital knows at the time of contracting the exact amount of medical care the patient will require.¹⁹⁸ As a result, a price formula, rather than a dollars-and-cents price, is needed in the admission agreement used for emergency patients.¹⁹⁹ Like in a requirements contract, the hospital is agreeing to provide all of the medical care the patient requires, but the exact amount and nature of the care required is unknown at the time of contracting.²⁰⁰

This article argues that a CDM-based price formula is very unlikely to be enforceable in an admission agreement. This is true for

covered by insurance, for example, non-medically necessary plastic surgery, an exact price is commonly set in advance. It seems possible, perhaps even likely, that hospitals could provide such a price quote but choose not to in order to preserve their pricing flexibility and maximize their revenue.

195. *See, e.g., Doe*, 46 S.W.3d at 190 (holding that a patient's agreement to be "financially responsible to the hospital for charges not covered by" insurance was indefinite and hospital was entitled to the reasonable value of the medical goods and services it provided to patient). *But see Allen*, 980 N.E.2d at 310 (holding that the promise to pay the account for treatment is, while imprecise, not sufficiently indefinite to justify imposition of a reasonable price standard and noting further that in the context of a contract for the provision of and payment for medical services, a hospital's chagemaster rates serve as the basis for its pricing).

196. *See CALAMARI & PERILLO, supra* note 73, § 2.13 (2nd ed. 1977) (discussing indefiniteness as it relates to mutual assent). They provided the following illustration:

[I]f A and B agree that A will perform a service for B and no mention is made of price, it will be implied that the parties intended that a reasonable price should be paid and received. The same is true if goods are involved. It will be assumed that the parties contracted in terms of a reasonable price which will ordinarily be the market price.

Id.

197. As noted above, it is very unlikely that any price resulting from the application of CDM-based prices would be fair, in fact, such prices are likely to be unconscionable.

198. *See supra* notes 31 and 32 and accompanying text.

199. *Id.*

200. *Id.*

several reasons. First, especially in the emergency context, it is likely that no mutual assent exists with respect to the admission agreement. Because there is no contract between the hospital and patient, the hospital's recovery will be based on quasi contract.²⁰¹ Second, many of the references in admission agreements are too indefinite to be enforceable. For example, when an admission agreement requires a patient to pay "the account of the hospital," "regular rates," "all charges," "billed charges," or words of similar import, it may not contain a clear and definite reference to the hospital's CDM-based price formula.²⁰² Third, even when the admission agreement clearly provides for a price based on the hospital's CDM, it is likely that the CDM is illusory: too indefinite to be used as a price formula.²⁰³ This is because the CDM is completely under the control of the hospital; the hospital may unilaterally change its prices at any time.²⁰⁴ Thus, at the time of contracting, the CDM prices are not fixed but in flux. Finally, even if the court finds that the parties gave mutual assent to an admission agreement; finds that the agreement contains a clear and definite price formula tied to the hospital's CDM; determines that the CDM published at the time the patient signed the admission agreement is the one that is referenced in the formula (so that the CDM-based prices were fixed on that date); and further finds somehow that the CDM's gibberish of codes and numbers is meaningful to a patient,²⁰⁵ even then the

201. See *supra* notes 79–140 and accompanying text discussing the proper application of objective intent.

202. See, e.g., *Doe*, 46 S.W.3d at 195.

203. See, e.g., *Cape Reg'l Med. Ctr. v. Sanchez*, No. CPM DC 109-11, at *9 (N.J. Super. Ct. Law Div. Mar. 26, 2012) (noting that most patients, upon entering hospital, sign "Authorization for Treatment," "Statement of Financial Responsibility," or another similarly open-ended agreement pursuant to which patient purports to agree to pay for all medical goods and services provided by hospital at hospital's list (chargemaster) prices; in reality, however, this type of agreement amounts to blank check given by patients to hospitals with amounts to be unilaterally filled in by hospitals later).

204. *Id.* This problem has been ameliorated somewhat, at least in theory, by the recent requirement (as of January 1, 2019) that hospitals publish their CDMs. However, in practice these published CDMs provide very little useful information to patients and certainly do not allow patients to have any awareness of the price that they will be charged. Moreover, the issues related to price changes and keeping records of previous prices to determine the prices that apply to a particular patient (is it the prices in effect when the patient signs the admission agreement, those in effect when the goods and services are provided to the patient, or those in effect when the final bill is calculated; and once any of the 30 or 40 thousand prices contained in the CDM changes, how is the patient to access the old prices to be sure the charges were accurately calculated?) have not been addressed by the new requirement that hospitals publish their CDMs.

205. See Robert Pear, *Hospitals Must Now Post Prices. But It May Take a Brain Surgeon to Decipher Them*, (N.Y. TIMES) (Jan. 13, 2019) <https://nyti.ms/>

biggest problem with CDM-based prices remains: the price arrived at by application of the formula is likely to be so grossly excessive and unfair to patients as to be unconscionable.²⁰⁶ Because the admission agreement is an adhesion contract,²⁰⁷ the unconscionable price term will not be enforced.²⁰⁸

As noted, price formulas tied to CDM-based prices are not fixed at the time of contracting. This presents a potentially fatal problem from the perspective of contract law. Unlike the requirements contract example above, a hospital using a CDM-based price formula is not agreeing to a price formula that is either fixed²⁰⁹ or discernable by the patient.²¹⁰ As a result, courts may decide that CDM-based price formulas are illusory and therefore unenforceable.

CDM-based prices remain solely under the control of the hospital. Hospitals can change the prices contained in their CDMs at any time, and they frequently do.²¹¹ Moreover, there is no require-

2QN0CHx, [<https://perma.cc/85PQ-KPNB>] (“This is gibberish, totally meaningless, a foreign language to me,” said Sara Stovall, 41, of Charlottesville, Va., after looking at price lists for hospitals in her area.”)

206. See *supra* notes 1–26 and accompanying text.

207. See *supra* notes 79–140 and accompanying text.

208. See *supra* notes 79–140 and accompanying text.

209. As noted, hospitals may change these prices at any time, and the admission agreement does not state the date on which prices contained in the CDM will be fixed. One could argue that the published CDM, assuming there is only one, on the date the admission agreement was signed contains the prices that must be used to determine the price under that admission agreement. However, if prices are subsequently changed in the CDM, which is essentially assured, and this were to occur prior to the goods and services being used for the patient, then one could argue that those more recent prices should be used in calculating the price due under the admission agreement. Finally, a case could be made for using the CDM published at time the patient’s bill is calculated. (I would guess that this is the method actually used by most hospitals.) The very fact that there are a variety of options possible is what destroys the certainty required to make a price formula based on CDM prices enforceable.

210. The recent federal requirement that hospitals publish their CDMs online does not change the fact that CDM-based prices are still not determinable by patients. CDMs contain 30,000 to 40,000 individual line items. They do not contain procedure-based prices. For a patient to use the published CDM to calculate the price they would owe, the patient would have to have medical expertise and be fluent in medical coding. For example, the patient would have to know how much emergency room time would be necessary, how much suture material would be used, etc., and would need to know the billing code for each item. Of course, if all of this were knowable, then the hospital could calculate the bill and simply insert the dollars-and-cents price into the admission agreement! No patient can successfully use the CDM to calculate the price he or she will owe.

211. Nation, *Chargemaster*, *supra* note 2 at 746–747

Each hospital maintains its own unique chargemaster, which it updates annually or more frequently as it sees fit, and extreme variation in list prices among hospitals, even those in the same geographic area, is com-

ment that a hospital keep a record of prices previously contained in the CDM. Nor is it clear what date hospitals will use to determine the CDM to apply when billing the patient.²¹² That is, which CDM rates will be used to calculate the amount the patient owes? The CDM rates that were in effect at the time the patient was admitted to the hospital? Those in effect when the patient received treatment? Those in effect when the patient was released from the hospital? Or those in effect when the patient's bill was finally calculated and sent (a process that can take months)?²¹³ Thus, the amount a patient owes can vary significantly depending on which CDM prices a hospital chooses. The result is that the hospital is not limited in any way by this formula; it may charge the patient virtually any amount it wishes!²¹⁴

As noted, a hospital may change its CDM at any time. In most cases, the patient has no way of determining what the CDM prices were at the time of contracting. This is vastly different from a requirements contract requiring a buyer to pay \$3.00 per gallon for heating oil.²¹⁵ The key to that contract's enforceability is that the \$3.00 price is fixed at the time of contracting, even though the quantity is not.²¹⁶ As a result, the buyer knows exactly how much money they will owe based on the contract rate and the amount of oil they request.²¹⁷ In contrast, when patients agree to pay a hospital's CDM-based list prices, they are essentially agreeing to allow the hospital to charge any amounts that the hospital wishes—without limitation—at the time it bills the patients.²¹⁸ As a result, courts should find CDM-based price terms unenforceable: there is no free and knowing assent to them; they are illusory; and the prices they set are unconscionably excessive. Enforcement of CDM-based price formulas is shockingly unfair to patients.

mon. The list prices contained in the chargemaster are truly arbitrary and capricious from the point of view of pricing except in one respect – the higher the list price, the higher the hospital's revenue. (notes omitted).

Id.

212. *See supra* notes 198 – 208 and accompanying text.

213. The fact that there are a variety of options, each of which may have a valid claim to being the proper one to use, is what destroys the certainty necessary to making a price formula based on a CDM enforceable. *See supra* note 209.

214. *See supra* note 209.

215. *See supra* notes 192 –197 and accompanying text.

216. *See supra* notes 192 – 197 and accompanying text.

217. *See supra* notes 192 – 197 and accompanying text.

218. *See supra* note 214.

III. CONTRACTING FOR HEALTH CARE

A. *Emergency Department Admissions and Implied-in-Fact or Quasi Contracts*

When patients enter the hospital through the emergency department, most patients are not able to assent to the written admission agreement even if they are able to sign it, for the reasons discussed above.²¹⁹ Whether the court finds an implied-in-fact contract or a quasi contract depends on the facts and circumstances of the specific case. All patients in the emergency department are experiencing extreme and distressing circumstances, but their levels of cognitive ability may vary. For example, a patient who arrives unconscious has no ability to assent. In this case, the only option is a quasi contract, pursuant to which, as discussed above, the patient is required to pay the hospital the reasonable market value of the medical care received.²²⁰ This is true notwithstanding the fact that many hospitals in this situation will require the family member or Good Samaritan who brought the patient to the hospital to sign the admission agreement.²²¹ The signature of anyone other than the patient, with the exception of an authorized agent of the patient (and very few patients arrive at the emergency department with an

219. See *supra* notes 119 – 121 and accompanying text.

220. Cf. *Phx. Baptist Hosp. & Med. Ctr., Inc. v. Aiken*, 877 P.2d 1345, 1347 (Ariz. Ct. App. 1994) (denying the hospital's request for summary judgment and concluding there was a material issue of fact concerning the conscionability of the procedure used to obtain the agreement where a patient was unable to sign the admissions agreement so patient's husband signed the admission agreement, which provided, "[T]he undersigned agrees (whether signing as agent, representative, or as patient, and whether or not insured or a member of the health maintenance organization) that, in consideration of the services to be rendered to the patient, he or she is hereby individually obligated to pay the account of the hospital in accordance with the regular rates and terms of the hospital. . ." and the hospital claimed that husband was liable from his personal assets to pay for the hospital care provided to the patient); *St. John's Episcopal Hosp. v. McAdoo*, 405 N.Y.S.2d 935, 937 (N.Y. Civ. Ct. 1978) (finding similarly, noting the trauma and anxiety experienced by those confronted with an emergency medical crisis and concluding that the hospital emergency room is certainly not a place where a reasonable person could be expected exercise "calm and dispassionate judgment" and that a reasonable person would give a hospital admission contract at most "cursory attention."). The court in *St. John's Episcopal Hosp.* concluded that a hospital should not be permitted to enforce a contractual obligation entered into under such tension-laden circumstances. *Id.*

221. See *supra* note 226.

agent authorized to enter into contracts on their behalf),²²² cannot bind the patient to the contract.²²³

Other patients may arrive at the emergency department legally capable of entering into an implied-in-fact contract.²²⁴ However, few, if any, patients arrive at the emergency department capable of reading and negotiating an express contract due to the stressful and tension-laden circumstances surrounding admission through the emergency department. As discussed above, these circumstances prevent the patient from giving free and knowing assent to the admission agreement they are forced to sign.²²⁵ However, depending on the exact circumstances, a court may find that some of these patients are sufficiently conscious that they are entering the hospital and that the hospital expects payment, such that a patient's co-

222. See Nation, *Accident supra* note 6 at 647–650 (discussing the circumstances surrounding a patient's signing of an admission agreement and some of the terms commonly included in such agreements and noting that:

Another sleazy provision says if the patient is physically unable to sign the agreement, then the Good Samaritan who brought the patient to the ED must sign as a “duly authorized agent” of the patient. Does this make any sense? Very few people as a normal course happen to have duly authorized agents. Moreover, it seems very unlikely that after the occurrence of the emergency precipitating the trip to the ED, the patient would have the capacity to duly authorize an agent any more than the patient would have the capacity to freely and knowingly accept the Admissions Agreement.

Id. at 648–49 (notes omitted).

223. It is important to note that entering into a contract is different than providing informed consent to receive medical treatment, which hospitals are required to get and which may be, in certain cases, provided by appropriate family members. See Raphael J. Leo, M.D., *Competency and the Capacity to Make Treatment Decisions: A Primer for Primary Care Physicians*, PRIM. CARE COMPANION J. CLIN. PSYCHIATRY 1999;1(5), 131 (“To ensure that individuals retain as much autonomy or self-determination as is legally possible, the court makes a determination of one's competence in a task-specific manner. For example, one can be determined to be incompetent to execute a will, but may be deemed competent to make treatment decisions.”). See also *When is Informed Consent Needed?*, AMERICAN CANCER SOCIETY, <https://bit.ly/2xJQpVj> [<https://perma.cc/XYU4-8JSX>] (last visited July 19, 2019) (“Many states have passed family agency acts that choose which family members [(in a listed order of priority)] may act on behalf of a person who cannot speak for her- or himself. This option may be used if you don't have an advance directive or court-appointed proxy. Depending on your family situation and which state you are in, that person may be your legal guardian, spouse, parent, child, sibling, or other relative.”); *Informed Consent*, AMA, <https://bit.ly/2XGIMhR> [<https://perma.cc/JW33-KG5A>] (last visited July 19, 2019) (“In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient's surrogate is not available, physicians may initiate treatment without prior informed consent.”).

224. See CALAMARI & PERILLO, *supra* note 73, § 8.10 at 250–51 (discussing the test for contractual capacity as whether the party understands the nature and consequences of his act time of the transaction).

225. See *supra* notes 121 – 124 and accompanying text.

operation with and acceptance of the medical care provided can reasonably be interpreted as accepting an obligation to pay (a fair and reasonable amount) for the care received.²²⁶

If a court finds that an implied-in-fact contract exists based on the actions of the parties, the court must provide the price for the parties because there has been no agreement between the parties on a specific price.²²⁷ As a result, a patient in this circumstance, like the unconscious patient entering the emergency department, would be legally responsible to pay the reasonable market value of the medical care received, though in this case the obligation will be pursuant to an implied-in-fact contract rather than a quasi-contract.²²⁸

Finally, an argument can be made that there is no consideration (another essential requirement to create a contract)²²⁹ to support a patient's promise to pay for the care received in an emergency admission. This argument is based on the fact that, under the federal Emergency Medical Treatment and Active Labor Act statute (EMTALA requires any emergency room to evaluate, stabilize, and treat any patient that presents there regardless of the patient's ability to pay),²³⁰ hospitals have a pre-existing duty to pro-

226. See, e.g., *Portercare Adventist Health Sys. v. Lego*, 312 p.3d 201, 206 (Colo. App. 2010), *rev'd on other grounds*, 286 P.3d 525 (Colo. 2012). The court noted that "several courts have found a contract implied in fact where a patient accepts medical services understanding that those services must be paid for by the patient, and have held that the measure of recovery is the reasonable value of those services." *Id.* In other words, the patient may be able to understand in a broad way that he is agreeing to pay, a reasonable amount to the hospital for the care he will receive.

227. See *supra* notes 164 – 189 and accompanying text. See also, CALAMARI & PERILLO, *supra* note 73, §8.15 at 255 (discussing the exploitation of individuals that have a compromised capacity to enter into a contract and noting cases of this nature are often not decided on grounds of lack of capacity, but on the basis of the person's limited mental ability coupled with unconscionable exploitation by the other party). For example, a hard bargain aggressively pressed upon a sober alcoholic by a party who knows of his consuming desire for cash to obtain liquor has been found voidable for overreaching. As another example, the authors note releases extracted from injured persons at a time in their suffering great shock or pain. Finally, the authors note that: "Some degree of infirmity [compromised capacity to contract] coupled with the unfairness of the bargain will often result in a finding a fraud, undue influence, overreaching or even mental incapacity. The recent enlargement of the doctrine of unconscionability offers another and perhaps more forthright approach two cases of this kind." *Id.* It is not difficult to draw a close analogy between Mr. Dennis and his overwhelming desire to be treated for his perceived heart attack and the alcoholic's desire for cash to obtain liquor in the above example.

228. See *supra* Section III.B.

229. See *supra* notes 77 – 84 and accompanying text.

230. Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (1986).

vide a certain amount of care (stabilizing treatment) to all patients who enter the emergency room. As a result of this pre-existing duty, the hospital does not suffer a legal detriment in exchange for a patient's promise to pay. That is, the hospital is not doing something (providing treatment) that it was not already legally obligated to do (pursuant to the statute) in exchange for the patient's promise to pay. This argument may prevent formation of a contract based on either the express promise made in the admission agreement, if for some reason the court found that the written agreement was otherwise enforceable, or the implied-in-fact promise to pay based on the actions of the parties. However, it would not prevent recognition of a quasi contract, because a quasi contract is not a real contract.²³¹

Thus, all patients who arrive at the hospital through the emergency department should be required to pay no more than the reasonable market value for the medical care they receive. They should not be required to pay the exorbitant CDM-based price, regardless of whether they have signed an admission agreement containing a CDM-based price formula.

B. Non-Emergency Department Admissions, Contracts of Adhesion, and Unconscionable Prices

The legal situation of patients who arrive at the hospital other than through the emergency department is different. Some of these patients may have the time and presence of mind to read, understand, and—theoretically, at least—negotiate an admission agreement with the hospital.²³² The problem that many of these patients face is that they are presented with an adhesive contract that is confusing and provides for a grossly unfair price.²³³ That is, even if the circumstances allow the patient a meaningful opportunity to read the admission agreement, the patient will still have no ability to negotiate its terms or to understand the meaning of the ambiguous price term that it contains.²³⁴ As noted above, the CDM-based

231. See *supra* Part II.B.

232. See *supra* note 199 (discussing patients receiving non-medically necessary treatment).

233. See *supra* notes 204–224 and accompanying text (discussing that most hospitals use the same standard admission agreement for both emergency and non-emergency admissions).

234. Also, seeking treatment at another hospital is not a viable alternative for patients because they feel constrained to go to the hospital where their doctor is on staff. See, e.g., *Wheeler v. St. Joseph Hosp.*, 63 Cal. App.3d 345, 366 (1976) (“A patient like Mr. Wheeler realistically has no choice but to seek admission to the hospital to which he has been directed by his physician and to sign the printed forms necessary to gain admission.”).

price formula contained in admission agreements is illusory, and patients cannot possibly use it to determine how much they will owe the hospital (even if patients have access to CDMs).²³⁵ Moreover, admission agreements typically contain price formulas based on CDM prices; these prices are grossly excessive and shockingly unfair.²³⁶

As a result, if a court finds that an admission agreement signed by either an emergency or non-emergency patient is enforceable, then (due to the admission agreement's adhesive nature) the court should scrutinize it closely and refuse to enforce any price formula tied to CDM-based prices.²³⁷ As a result, the patient should be obligated to pay no more than the reasonable market value of the healthcare received.²³⁸ There are a number of reasons a court may refuse to enforce a CDM-based price formula even if the admission agreement in which it is contained is otherwise enforceable (that is, the court finds that under the circumstances the patient had the capacity to assent to the admission agreement and did in fact assent to it). These reasons include:

- The price formula in the admission agreement may not contain a clear and definite reference to the CDM.²³⁹
- Even a clearly-referenced CDM-based price formula is illusory, and the prices it calls for may not be fixed at the time of contracting, as the hospital retains the right to change the CDM prices used in the formula up to the point it sends the patient a bill.²⁴⁰
- Even if the court finds that the CDM published by the hospital fixed the CDM prices at the time of a patient's admission, patients cannot understand the CDM and therefore cannot use the CDM-based price formula to determine how much they are agreeing to pay even if the CDM is available to them. For this reason the patient may not have assented to the price calculated using the CDM.
- Even if all of these issues are overcome in a particular case, a CDM-based price formula will very likely yield a grossly ex-

235. See *supra* notes 203 – 204 and accompanying text.

236. Recall that these CDM-based prices are on average on average 500 percent of the Medicare rate and over 300 percent of the in-network commercial insurer reimbursement rate.

237. See *supra* notes 1–26 and accompanying text.

238. See *supra* notes 204–224 and accompanying text.

239. See, e.g., *Doe v. HCA Health Servs of Tenn.*, 46 S.W. 3d 191 (Tenn. 2001).

240. See *supra* notes 204 – 224 and accompanying text.

cessive price that is substantively unconscionable. As a result, a court may find that a hospital's attempt to enforce the price formula violates the hospital's obligation to perform and enforce the contract in good faith.²⁴¹

- CDM-based price formulas are usually contained in adhesion contracts, which are procedurally unconscionable. As a result, if the CDM price formula produces an unconscionable price, then both requirements for finding a contract unconscionable have been met, and the contract is unenforceable.²⁴²

241. See, e.g., *Nygaard v. Sioux Valley Hosp. & Health Sys.*, 731 N.W. 2d 184, 194 (S.D. 2007). Patients argue that the Hospitals breached the covenant of good faith and fair dealing by charging prices that did not relate to the cost of the services and were unreasonable and unexpected based on the Hospitals' representations. *Id.* The court noted that South Dakota does not recognize an independent cause of action, a tort, based on good faith. *Id.* However, the court cited with approval a provision of the Uniform Commercial Code (UCC 1-203) that provides that "Every contract or duty within this title imposes an obligation of good faith in its performance or enforcement." *Id.* at 193-194 (citing U.C.C. § 2-203 (AM. LAW. INST. & UNIF. LAW COMM'N (1977))). The court denied that the covenant of good faith had been breached because the patient in the pleadings claimed that the admission agreement called for the hospital to charge its "pre-set charges" and that the hospital had indeed charged the patient its pre-set charges:

In the instant cases the express language of the contracts addressed the price issue. As previously explained, although the price of every hospital service was not itemized in the contracts, the pleadings allege that the charges were pre-set. And because these pre-set charges were fixed and determinable, these contracts addressed the issue of price and there is no basis to supply different price terms.

Id. at 194. Very important in this case was the fact that the patients were the plaintiffs seeking to recover damages from the hospital. It seems as though the results would likely have been different had the hospital been suing the patients trying to recover its CDM-based prices under the contract. For example, the court stated:

Counsel acknowledged at oral argument that the nature of an adhesion claim does not give rise to an independent cause of action for damages. But even aside from this acknowledgement, and assuming that the contract was an unconscionable contract of adhesion, patients have no right to recover damages simply because they entered into an unconscionable contract.

Id. at 195 (notes omitted).

242. *Id.* at 194-95 (explaining that patients pleaded that the Hospitals did not provide an opportunity for negotiating the agreements and that there was greatly disparate and wholly unequal bargaining power. They further pleaded that such standardized contracts are contracts of adhesion that are unconscionable and contrary to public policy. In determining whether a contract is an unenforceable contract of adhesion, this Court looks not only at the bargaining power between the parties but also at the specific terms of the agreement. Thus, we focus on both "overly harsh or one-sided terms," *i.e.*, substantive unconscionability; and how the contract was made (which includes whether there was a meaningful choice), *i.e.*, procedural unconscionability. (notes omitted); Nation, *Obscene Contracts supra* note 2 at 110-115 (discussing the analytical framework for unconscionability and

As a result, courts should rarely, if ever, enforce CDM-based price formulas.²⁴³

C. *Determining the Fair and Reasonable Value of Healthcare*

There is no single, universally accepted method for determining the fair and reasonable price to be paid for healthcare services.²⁴⁴ However, two methods are most often recommended.

specifically addressing the two requirements of procedural and substantive unconscionability).

243. See *supra* notes 204–224 and accompanying text.

244. *Colomar v. Mercy Hosp. Inc.*, 461 F. Supp. 2d 1265, 1267–1268 (S. D. Fla. 2006). The court explained that the patient came to the hospital suffering shortness of breath and received treatment, her stay at the hospital lasted 26 hours. The patient received a bill for \$12,863. Prior to receiving any treatment or services from Mercy, patient signed an “Authorization and Guarantee” form (the “contract”) in which she agreed to pay all bills not otherwise covered by insurance or other means; the services she would need and the prices she would pay were unspecified in the contract. In support of an unreasonable pricing claim the patient made the following factual allegations: patient was charged nearly \$12,863 for medical services, while the actual costs of the services were only \$2,098; the hospital generally charged uninsured patients prices set at 450% of Medicare reimbursement rates; the hospital ranks among the top 13% of all hospitals nationwide in charges (including both for-profit and non-profit hospitals); the hospital’s cost-to-charge ratio is 394%, meaning that on average the hospital charges almost four times their costs to uninsured patients; the hospital ranks in the top 10% of hospitals nationwide in terms of cost-to-charge ratio. *Id.* at 1268. The court noted that the establishment of a reasonable price requires consideration of several factors; the prices charged by other hospitals in the area, the actually paid by the hospitals other patients, and the hospital’s cost structure. Importantly, the court noted that there is evidence that all hospital’s set greatly inflated charges and therefore even if the hospital’s charges are in line with the charges of other hospitals in the area this is no guaranty that the hospital’s charges are reasonable. The court stated:

In addition to a market analysis, the case law reveals that the price charged for the same services to other patients within the same hospital is also relevant to the question of reasonableness. . . . This factor is important in the analysis because the prices charged to other patients, and the amounts received from them, within the same system often differ, and this difference may offer some insight into the value of the actual services provided. Indeed, as the Temple University court [see Temple *supra* note 140 at 510] explained, the reality is that the rates hospitals charge for services do not always accurately reflect the value of the services, especially when the hospital routinely accepts much less for them.

Id. at 1271 – 72.

When that is the case, then simply looking at the rates charged relative to other hospitals can give a false sense of value. That is, if other hospitals grossly overcharge for services relative to their costs, then a mere side-by-side comparison of hospitals’ unreasonable charges would make them appear reasonable. Such consistency, standing alone, is not synonymous with reasonableness. Here, Plaintiff alleges that patients with insurance and government benefits receive significant discounts in the price they pay for Mercy’s services. This suggests that the value of the services charged to Plaintiff may be significantly less than what Mercy asked her

The first and best approach is to use a market-based reimbursement price.²⁴⁵ If, with respect to the hospital or other provider in question, there is a reasonably well-functioning free market for health-care, then that market will determine the appropriate price.²⁴⁶ The other approach, which must be used in cases where there is not a properly-functioning market, is the Medicare-based approach.²⁴⁷ Under this approach, the person seeking to determine the price starts with the price that Medicare would pay the hospital for the care in question.²⁴⁸ These two approaches are discussed below at subsections 2 and 3, respectively.²⁴⁹

to pay. This allegation, if borne out during discovery, would be evidence in support of the conclusion that the charges imposed on Plaintiff are unreasonable. (citations omitted)

Id. at 1272.

245. See Nation, *Fair & Reasonable*, *supra* note 1 at 460–465 (discussing both approaches and noting that the prices actually paid by private insurers are a good place to start in calculating the value of medical services because these contracts reflect most strongly an effectively operating free market.) (notes omitted).

246. *Id.* See also, e.g., *Nassau Anesthesia Assocs. P.C. v. Chin*, 924 N.Y.S.2d 252, 255 (N.Y. Dist. Ct. 2011) (referring to the average amount the hospital would have accepted as full payment from third-party payors such as private insurers and federal health programs and noting that the hospital’s billing manager calculated this amount as \$4252.11); *Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alts., Inc.*, 832 A.2d 501, 510 (Pa. Super. Ct. 2003) (“Reasonable value [of hospital services] . . . is the value paid by the relevant community. The relevant community in this case comprises the Hospital’s patients who are covered by insurance policies and federal programs.”); Barak Richman, et al., *Overbilling and Informed Financial Consent—A Contractual Solution*, N. ENGL. J. MED. 367, 396–97 (2012) (“The best proxy for informed bargaining is what similarly situated customers and providers actually bargain for – namely, the rate negotiated between providers and private insurers.”)

247. *A Review of Hospital Billing and Collection Practices Before the Subcomm. on Oversight and Investigations of the H. Comm. on Energy and Commerce*, 108th Cong. 22 (2004) (statement of Gerard F. Anderson, Director, Johns Hopkins Center for Center for Hospital Finance and Management) (suggesting that a fair and reasonable price can be arrived by taking the Medicare DRG based reimbursement and adding 25% to that amount; in other words, a reasonable price can be arrived by taking 125% of the Medicare DRG based reimbursement); see Nation, *Fair & Reasonable*, *supra* note 1 at 463 – 465 (discussing Professor Anderson’s approach); Richman et al *supra* note 246 at 397 (“Another useful proxy might be Medicare reimbursement rates, because those rates – offered by the government and accepted by providers, who were permitted to refuse –also approximate the lower end of the range of prices that a reasonably informed negotiation would produce.”)

248. See *supra* note 253.

249. Another approach to establishing a reasonable price is to determine the provider’s cost of providing the service and then add a reasonable profit to it. See *Colomar v. Mercy Hosp. Inc.*, 461 F. Supp. 2d 1265, 1272 (S. D. Fla. 2006). The court stated:

In addition to what a hospital charges others for the same services, and what the market charges in general, another relevant factor that emerges from the pertinent case law is the particular hospital’s internal cost struc-

1. *Why Courts Should Not Use CDM Rates*

It is important to note that neither the market approach nor the Medicare approach rely directly on the CDM prices established by providers. This is both intentional and important.²⁵⁰ In addition, it is also important to recognize that usual, customary, and reasonable charges (often referred to as UCR charges)²⁵¹ are based directly on CDM prices; for the reasons discussed below, UCR-based charges also should not be used to establish the fair and reasonable market value of healthcare.²⁵²

The great variation in the price that a patient may owe for healthcare is due to the bizarre chargemaster-based pricing system

ture. . . . On the other hand, rate increases untethered to any appreciable increase in costs would raise questions about the reasonableness of the rate increases and the overall reasonableness of the charges. . . . This means that Mercy, as alleged, charged Plaintiff six times what it cost Mercy to treat her. . . . the Court cannot conclude as a matter of law that charging 600% above costs is reasonable.

Id.

250. The most important information for courts and legislatures to understand is that paid charges, and not billed charges, represent usual, customary, fair, and reasonable healthcare prices. *Accident supra* note 12 at 695; *see generally*, Nation, *Chargemaster, supra* note 2 (explaining how and why billed charges are exorbitant and should not be used as a measure of reasonable value).

251. *Colomar* 461 F. Supp. 2d at 1272 (noting that if most hospitals have excessive charges comparing charges among hospitals is not a reliable indication of reasonable charges). I argue here that that is indeed the case today with respect to hospital chargemaster based prices. *See supra* notes 1–26 and accompanying text. Hospitals use a number of deceitful arguments to convince courts they should apply the hospital’s chargemaster rates to determine the usual, customary, and reasonable price. For example, hospitals commonly have their billing manager or other financial officer provide an affidavit or testimony stating, disingenuously, that all of the hospital’s patients are billed or charged at its chargemaster rates, and further that the patient’s billed charges, based on its chargemaster rates, represents the usual, customary, and reasonable charges of the hospital. This is very deceiving because hospitals use the word *charges* to confuse courts by implying *charges* are a proxy for *payments*. The hospital implies, without ever saying explicitly, its chargemaster rates are actually the rates most of the hospital’s patients pay. This of course is completely false. *See* Nation, *Accident supra* note 12 at 658–664 (discussing how hospitals take advantage of the fact that in most industries the price listed for a product is very close to the price usually paid for the product). In fact, on average, less than 5 percent of hospital patients ever pay excessive chargemaster rates. *Id.* Moreover, chargemaster rates are, on average, more than 300 percent of the amount hospitals are actually paid for their goods and services and are about 500 percent of Medicare rates. *Id.* Thus, chargemaster rates clearly are not reasonable, customary, or usual. *Id.*

252. *See infra* notes 256–277 and accompanying text. UCR chargers are simply another name for list or chargemaster prices—and these prices are excessive, set unilaterally by hospitals and not accepted by the marketplace. They should play no role in establishing the price of medical care. There is no percentage that can be applied to charges to ensure a reasonable price.

that is unique to the healthcare industry.²⁵³ Few people understand chargemaster-based pricing.²⁵⁴ Many providers take advantage of this ignorance to price gouge vulnerable patients.²⁵⁵ A large part of the confusion surrounding chargemaster-based pricing is due to the sleight of hand that occurs when providers use the word “charges” as a proxy for “prices.”²⁵⁶ In virtually every other context “the price” or “the charge” refers to the amount actually paid—that is, the reimbursement actually received by the seller.²⁵⁷ Healthcare, however, is unique in that there is a huge difference between what hospitals refer to as “list prices” or “billed charges” and actual payments or “reimbursements.”²⁵⁸ This is because, as noted, charges (CDM prices) are set unilaterally by hospitals, and these CDM prices are set not to be paid but to be discounted in negotiations with third-party payers.²⁵⁹ Reimbursements are the true measure of market value in the context of healthcare, as indeed they are in any other market.²⁶⁰ As courts begin to understand the misleading nature of chargemaster-based pricing, their opinions are beginning to reject the claim made by hospitals that chargemaster-based prices are reasonable and represent the market value of healthcare.²⁶¹

In the case of Medicare and Medicaid, the government sets the price it will pay.²⁶² These are set prices and not market-determined prices. Private health insurers negotiate contracts with hospitals, usually every year, and those contracts state specifically how much the health insurer will pay for services received by patients covered

253. See Nation, *Chargemaster*, *supra* note 2 at 446 – 457 (discussing the chargemaster based pricing system).

254. See *id.* at 446–457.

255. See Nation, *Accident*, *supra* note 6 at 647–58.

256. *Id.* at 680–82.

257. *Id.*

258. *Id.*

259. *Id.*

260. *Id.*

261. See, e.g., *In re North Cypress Med. Ctr. Operating Co.*, 559 S.W.3d 128 (Tex. 2018). The majority opinion held that it “defies logic” to conclude that the reimbursement rates paid by insurers and government payers “have nothing to do with the reasonableness of charges” for uninsured patients, particularly because insurance and government reimbursements “comprise the bulk of a hospital’s income for services rendered.” *Id.* at 135. The Majority went on to note that “[c]ommentators lament the increasingly arbitrary nature of chargemaster prices, noting that, over time, they have ‘lost any direct connection to costs or to the amount the hospital actually expect[s] to receive in exchange for its goods and services.’” *Id.* at 132 (quoting George A. Nation III, *Hospital Chargemaster Insanity: Healing the Healers*, 43 PEPP. L. REV. 745, 755 (2016)); *Bowden v. Med. Ctr. Inc.*, 773 S.E.2d 692, 697–99 (Ga. 2015) (making similar observations).

262. See *supra* notes 1–26 and accompanying text.

by that insurer. The reimbursement prices paid by commercial health insurers are the only truly market-derived prices for health care.²⁶³ As noted, self-pay patients are usually billed at excessive chargemaster prices.²⁶⁴ This practice is unfair and cruel to individual patients; at the same time, it contributes significantly to the excessive and ever-growing price of healthcare in the United States.²⁶⁵

I have discussed in detail elsewhere the reasons why CDM prices should play no part whatsoever in the establishment of the fair and reasonable market value of healthcare.²⁶⁶ In summary, CDM prices are wildly excessive. They are not market prices because they are set unilaterally by providers. They are rejected by the marketplace: no one knowledgeable about healthcare billing and payment agrees to pay these prices, and on average less than five percent of patients overall pay these extreme rates.²⁶⁷

Hospitals set CDM prices at an exorbitant level because their primary purpose is to create leverage in negotiations with commercial health insurers and to force insurers to agree to higher reimbursements by threatening to bill their insureds these excessive rates if the insurance company does not agree to the reimbursements the hospital demands.²⁶⁸ As an additional benefit, the CDM prices act as anchoring points so the actual reimbursement prices demanded by the hospital look reasonable and even attractive when compared to the ridiculously high CDM rates—and of course this is the hospital's negotiating plan.²⁶⁹ In other words, hospitals set CDM prices to be discounted and not to be paid by anyone.²⁷⁰

263. See *supra* notes 1–26 and accompanying text.

264. See *supra* notes 26–78 and accompanying text.

265. See, e.g., Anderson et al., *supra* note 73 (concluding that the sizable differences in health spending between the US and other countries were explained mainly by health care prices); Zack Cooper et al., *Hospital Prices Grew Substantially Faster Than Physician Prices For Hospital-Based Care in 2007–14*, 38 HEALTH AFF. 184, 186 (2019), <https://bit.ly/2STIayk> [<https://perma.cc/Z3QL-AZFN>] (suggesting from evidence that growth in providers' prices drives growth in health care spending on the privately insured and hospital prices increase faster than physician prices).

266. See Nation, *Fair & Reasonable*, *supra* note 1 at 457–70.

267. *Id.* It is important to note that this does not mean that many patients do not have their lives ruined by hospitals and other providers aggressive but ultimately unsuccessful efforts to collect these excessive rates and in that particular context of third-party liability, hospitals often misuse hospital lien statutes to recover either all for a large percentage of these excessive rates.

268. See *supra* notes 1–26 and accompanying text.

269. See *supra* notes 1–26 and accompanying text.

270. CDM-based prices are unconscionable. See, e.g., *Moran v. Prime Healthcare Mgmt. Inc.*, 208 Cal. Rptr. 3d 303 (Cal. Ct. App. 2016). The patient in *Moran* alleged that the admission agreements financial liability provision was unconscionable. *Id.* at 315. The plaintiff claimed that he did not expect to be billed

However, as noted elsewhere, hospitals never miss an opportunity to try to collect these unreasonable rates whenever possible; they pursue these exorbitant reimbursements aggressively, notwithstanding the pain and suffering it causes patients.²⁷¹

2. *Market-Based Pricing*

Unfortunately, there is not a properly-functioning free market for healthcare with respect to self-pay patients.²⁷² However, there is, in many cases, a well-functioning free market for healthcare with

at the artificial and grossly excessive rates for which he was subsequently billed. *Id.* Patient also alleged that the hospitals charges for medical treatment or not tethered to their actual costs but were 4 to 6 times those costs and far beyond any reasonable profit margin. *Id.* In addition, patient claimed that the hospitals charges were intended to boost hospital reimbursement rates interest like higher levels of charity contribution and financial assistance given to the local community. *Id.* In describing the unconscionability doctrine, the court stated:

The unconscionability doctrine ensures that contracts, particularly contracts of adhesion, do not impose terms that have been variously described as “overly harsh”, “unduly oppressive”, “so one-sided as to shock the conscience”, or “unfairly one-sided.” All of these formulations point to the central idea that unconscionability doctrine is concerned not with “a simple old-fashioned bad bargain”, but with terms that are “unreasonably favorable to the more powerful party.

Id. (citations omitted). The court noted that a claim of contractual unconscionability, has both a procedural and a substantive element, the former focusing on oppression or surprise due to unequal bargaining power, the latter on overly harsh or one-sided results. *Id.* The court also noted that the procedural element of an unconscionable contract generally takes the form of a contract of adhesion, which, imposed and drafted by the party of superior bargaining strength, relegates to the subscribing party only the opportunity to adhere to the contract or reject it, while substantively unconscionable terms may take various forms, but may generally be described as unfairly one-sided. *Id.* at 315–16. The court noted that the patient alleged that all emergency room patients had to sign the admission agreement before being treated, and that these allegations, in the context of a summary judgment motion, support a finding of procedural unconscionability. *Id.* at 316. As for substantive unconscionability, the court stated that the price term of a contract can establish substantive unconscionability. *Id.* The court noted that when evaluating the price charged courts consider, among other factors, not only the market price, but also the cost of the goods or services to the seller. *Id.* The court stated:

This case concerns the cost of medical care provided to uninsured patients visiting a defendants’ hospital emergency room. Plaintiff has alleged that defendants’ charge description master rates not only far exceed the actual cost of care and provide for a large profit margin, he further maintains the purpose of defendants’ charging excessive costs to self-pay patients is to increase the hospital’s reimbursement for medical care by dramatically increasing its profit margin for treatment to persons particularly vulnerable because they are in need of emergency medical care.

Id. The court concluded that the patient had alleged facts sufficient to claim that the price term in the admission agreement based on chargemaster rates was unconscionable. *Id.* See also *supra* notes 204–24 and accompanying text.

271. See *supra* notes 1–78 and accompanying text.

272. See Nation, *Fair & Reasonable*, *supra* note 1, at 458–59.

respect to in-network commercial insurance companies.²⁷³ Hospitals enter into contracts with various health insurance companies wherein they negotiate the reimbursement levels that the insurance company will pay for its members who receive care from the hospital.²⁷⁴ These contracts are typically renegotiated annually.²⁷⁵ Moreover, insurance companies and hospitals often have relatively equal bargaining power and knowledge regarding healthcare billing and reimbursement.²⁷⁶ As a result, these negotiated contracts often represent the true free market value for health care.²⁷⁷

As I have discussed in detail elsewhere, the average reimbursement price paid by in-network commercial health insurers is often the best starting point for determining the fair and reasonable market-based price of healthcare for self-pay patients.²⁷⁸ However, commercial health insurance companies provide benefits to hospitals that self-pay patients do not provide.²⁷⁹ These benefits include—for non-emergency patients²⁸⁰—the increased patient volume that results from gaining access to all of the insurer’s customers and—for all insured patients—quick and reliable payment of hospital invoices.²⁸¹ As a result, it may be appropriate to adjust the average commercial insurer reimbursement rate upward by ten to 15 percent²⁸² when determining the fair market-based value of health care for self-pay patients.²⁸³

Notwithstanding the fact that, as discussed, some adjustment may be necessary, a market-based rate is clearly preferable and eas-

273. *See Id.* at 460–61.

274. *Id.*

275. *Id.*

276. *Id.*

277. *Id.*

278. *Id.* at 461–62.

279. Nation, *Fair and Reasonable*, *supra* note 1 at 462.

280. For emergency care, the Medicare-based rate should apply because there is no market for emergency care; patients exercise no choice concerning the hospital to which they are taken.

281. Nation, *Fair and Reasonable*, *supra* note 1 at 462.

282. *Id.* at 463. Another commentator, using different methodology and arriving at a different formula, nonetheless arrives at a similar amount as representing a fair reimbursement amount for self-pay patients. *Id.* at 463–64 (discussing a proposal by Dr. Gerard Anderson to calculate the price for self-pay patients at the Medicare reimbursement rate plus 25 percent).

283. It is important to note that even with such an adjustment these rates are still far less than the excessive CDM rates. Specifically, if on average commercial insurers pay 160% of the Medicare rate, then with this adjustment self-pay patients would pay about 170% to 175% of the Medicare rate, or 34% to 35% of the CDM rate, given that, on average, the CDM rate is 500% of the Medicare! *See supra* note 11.

ily attainable.²⁸⁴ Hospitals have the necessary information readily available and can easily calculate their average commercial insurer reimbursement rate; courts are beginning to recognize patients' rights to discover this information.²⁸⁵ An additional benefit to using an average is that no proprietary information of any particular insurer or hospital need be disclosed.²⁸⁶ Finally, this approach would allow hospitals to continue to set their prices at any amount they wish, but would allow them to enforce those prices against self-pay patients only if the marketplace (commercial health insurers) accepts and pays those prices.²⁸⁷ It also would have the beneficial effect of encouraging providers to join insurers' networks and thereby decreasing the number of patients that are out-of-network and subjected to balance billing.²⁸⁸

284. And perhaps best of all, it triggers market solutions to address health care costs. *See, e.g.*, Barak D. Richman et al., *Battling the Chargemaster: A Simple Remedy to Balance Billing for Unavoidable Out-of-Network Care*, 23 AM. J. MANAGED CARE 2017;23(4):e100-e105, 103, <https://bit.ly/2XAkvoR> [<https://perma.cc/WN6N-8PD8>]. Tax exempt hospitals are required under the ACA to compute their "average billed amount" (AGB) each year. *See* I.R.C. § 501(r)(5) (West 2011), and Additional Requirements for Charitable Hospitals, 77 Fed. Reg. at 38,148–55 (for eligible patients, the billed charges must be reduced to AGB). *See supra* note 52 and accompanying text.

285. *See supra* note 257; Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy*, 25 HEALTH AFF. 57, 58 (2006) (noting that each private insurer negotiates the dollar level of payments with each hospital every year).

286. Hospitals typically claim that such information is proprietary. The litigation related discovery of such information can be accomplished by use of a protective order, but use of an average provides a better overall base. *See* Nation, *Fair & Reasonable*, *supra* note 1, at 460–61.

287. *See* Nation, *Balance Billing*, *supra* note 6, at 172–73 (discussing the importance of a free market where sellers are allowed to set their own prices and buyers are free to reject the prices if they are too high).

288. A number of states use a dispute resolution process as a reasonable approach to establish price. *See* Jack Hoadley, et al., *State Efforts to Protect Consumers from Balance Billing*, THE COMMONWEALTH FUND: TO THE POINT (Jan. 18, 2019), <https://bit.ly/2OHc7Rr> [<https://perma.cc/H82A-R3SH>] (noting that California, Florida, Illinois, New Hampshire, New York and New Jersey are among the states that provide a dispute resolution process); Kevin Lucia et al., *Balance Billing by Health Care Providers: Assessing Consumer Protections Across States*, THE COMMONWEALTH FUND 4 (June 13, 2017), <https://bit.ly/2O99HJA> [<https://perma.cc/R5MJ-D4FX>] (defining a dispute resolution process as: "An independent mediation or other process through which providers and insurers can negotiate or settle on a fair rate of payment for a claim."). A potential problem with arbitration is the increased administrative expense associated with it. *See* Loren Adler, et al., *State Approaches to Mitigating Surprise Out-of-Network Billing*, USC-BROOKINGS SCHAEFFER INITIATIVE FOR HEALTH POL'Y 24 (Feb. 2019), <https://brook.gs/2T3qOTJ> [<https://perma.cc/SE4L-NSCQ>] (noting that: "An arbitration approach also comes with administrative costs. If those administrative costs are high enough, they could undermine the effectiveness of the policy by leading insurers to simply accede to providers' demands rather than pursue arbitration."). Some proposed

3. Medicare-Based Pricing

Government insurers—Medicare and Medicaid—pay rates set by the Centers for Medicare and Medicaid Services (CMS); these rates are not the result of market competition.²⁸⁹ Technically, hospitals do not have to agree to accept government insurance.²⁹⁰ Hospitals agree to accept Medicare rates only when they sign a provider agreement with CMS.²⁹¹ Practically speaking, however, given that the U.S. government spends almost 20 percent of its budget on healthcare, it is unrealistic for most hospitals not to accept Medicare patients.²⁹²

The rates paid by government insurers typically represent the lowest rates that hospitals agree to accept as full payment; Medicaid rates are lower than Medicare rates.²⁹³ Many commentators have argued that Medicaid rates are actually too low: that is, that they are below hospital cost.²⁹⁴ Some commentators have also made that argument with regard to the Medicare rates.²⁹⁵ Although a thorough evaluation of these claims is beyond the scope of this article, it does seem likely, based on the available evidence that Medicare reimbursement rates may need to be adjusted upward in order to arrive at a fair and reasonable price.²⁹⁶

One expert has argued in favor of setting the reimbursement rate for hospitals at 125 percent of the Medicare reimbursement

billings address this problem by requiring that the arbitration results be made public. This type of arbitration is a good alternative, as long as the arbiters are instructed to consider negotiated in-network rates and Medicare rates, but not provider charges in any form. See George A. Nation III, *Congress Should Broaden Legislation to Curb Medical Price Gouging*, THE HILL (Nov. 8, 2018) <http://bit.ly/2SkqbT3> [<https://perma.cc/RR2D-8283>] (discussing legislative proposals).

289. See Nation, *Fair & Reasonable*, *supra* note 1, at 463–64 (discussing the proposal by Dr. Gerard Anderson to calculate the price for self-pay patients at the Medicare reimbursement rate, plus an additional 25%).

290. See Nation, *Chargemaster* *supra* note 2, at 661 (noting that when hospitals voluntarily agree to accept Medicare and Medicaid patients by signing a Provider Agreement, they also agree to accept the amount paid by Medicare and Medicaid as full payment).

291. *Id.*

292. See *Policy Basics: Where Do Our Federal Tax Dollars Go?*, CTR. ON BUDGET AND POL'Y. PRIORITIES, (Jan. 2019) <http://bit.ly/2YQtl3R> [<https://perma.cc/7F6T-MRQW>] (explaining that during fiscal year 2017, the federal government spent four trillion dollars, or about 21% of the country's gross domestic product).

293. See *supra* notes 1-26 and accompanying text.

294. See Nation, *Fair & Reasonable*, *supra* note 1, at 459–60 (stating that government insurers' reimbursement rates are thought to be below fully allocated costs).

295. See, e.g., Virgil Dickson, *Slumping Medicare Margins Put Hospitals on Precarious Cliff*, MODERN HEALTHCARE (Nov. 28, 2017), <http://bit.ly/2YPpgMG> [<https://perma.cc/HFQ5-XVRS>].

296. See *supra* note 294.

rate.²⁹⁷ The Medicare plus 25 percent-based rate is usually similar in amount to the average in-network commercial insurance company reimbursement rate plus ten to 15 percent, as discussed above.²⁹⁸ An important benefit to using Medicare rates is that they are readily available and updated regularly by CMS.²⁹⁹ The main drawback to using Medicare rates is that they are not market-based prices.³⁰⁰ As such, the Medicare approach denies hospitals the ability to establish their own prices.³⁰¹

It is important to note that under the market-based price argued for above, hospitals continue to have the power to set their own prices, but those prices must be accepted by the marketplace to be enforceable against self-pay patients.³⁰² In other words, hospitals may set their rates at any level they wish as long as they can entice insurance companies, the only other market participants with the knowledge and market power to negotiate fairly with them, to agree to pay those rates.³⁰³

However, it may not always be possible to use the market-based price approach because some markets are not adequately competitive.³⁰⁴ In those cases, using Medicare-based prices may be necessary.³⁰⁵ For example, there is no competitive market for patients who enter the hospital through the emergency department.³⁰⁶ These patients do not choose the hospital to which they are admitted; that choice is typically made by the ambulance company.³⁰⁷ Also, in the case of non-emergency admissions, if a hospital does

297. *Id.*

298. *Id.*

299. *Id.*; see Susannah Luthi, *California Hospitals Blast New Rate-Setting Proposal for Providers*, MODERN HEALTHCARE (Apr. 10, 2018) <http://bit.ly/30uJFa6> [<https://perma.cc/DMQ8-J9XM>] (discussing a California proposal that would mandate a regulated rate for providers and would use Medicare rates as the benchmark to calculate commercial insurance payments).

300. *Id.*

301. See Nation, *Accident*, *supra* note 12, at 686 (noting that using the average negotiated private insurance rate plus an additional 10 to 15% allows hospitals to continue to set their prices at any level they wish as long as they can get the insurance companies—the only other market participants with the knowledge and power to fairly negotiate with hospitals—to agree to pay those rates).

302. *Id.*

303. *Id.*; see Nation, *Balance Billing*, *supra* note 6, at 172–73.

304. See Nation, *Accident*, *supra* note 6, at 686 (noting that some markets are not adequately competitive and therefore, resorting to a Medicare based rate may be necessary).

305. *Id.*

306. *Id.* at 685 (“There is no benefit of new patients associated with emergency care.”).

307. *Id.*

not have at least three in-network insurance companies, then the only option is to use Medicare prices.³⁰⁸

CONCLUSION

Patients sign the same standard hospital admission agreement regardless of whether they enter the hospital under emergency circumstances through the emergency department or through a non-emergency admission. However, from a contracting perspective these two situations differ significantly. As a result, emergency and non-emergency situations must be analyzed separately. But, while the legal analysis applied to these two situations is different, the ultimate conclusion is the same. Admission agreements signed by self-pay patients should never be enforced in a way that requires a patient to pay a price greater than the fair and reasonable market value of the healthcare services received. Under contract law principles, self-pay patients should be required to pay an amount equal to the fair market value of the care that they received, regardless of whether the patient signed an admission agreement containing a CDM-based price formula.

When a hospital admission agreement is signed in the emergency department, the extreme circumstances under which it is signed prevent the patient from being able to give free and knowing assent. Moreover, proper application of the doctrine of objective intent and the duty to read reaches the same conclusion. This application dictates that the admission agreement is not a contract. The patient's only obligation to the hospital is based on quasi-contract, and pursuant to quasi-contract the patient is liable to pay the reasonable market value of the medical care received.

In a non-emergency admission, it is at least theoretically possible for a patient to give free and knowing assent to the admission agreement. For example, for elective surgery that is not medically necessary (for example, a cosmetic procedure that is not required to preserve or improve the patient's health), the admission agreement signed by the patient (which interestingly, for cosmetic procedures, typically contains an actual dollars-and-cents price) may be enforceable.

However, in the vast majority of non-emergency hospital admissions, the admission agreement that a patient is required to sign is a quintessential example of the modern contract of adhesion. It is a one-sided agreement drafted solely by the hospital, which is the stronger and much more well-informed party, presented to the pa-

308. *Id.* at 686.

tient on a take-it-or-leave-it basis wherein the patient has absolutely no ability to negotiate the terms of the agreement.

However, the fact that hospital admission agreements are adhesion contracts does not automatically make them unenforceable. Categorizing these contracts as adhesion contracts is significant because it signals to courts that they should approach hospital admission agreements with caution. Courts should closely scrutinize the contract formation process, to determine if an enforceable contract has been created. If it has, courts should look closely at the provisions of the contract to ensure that the stronger party is not taking advantage of the weaker party.

If the court concludes that a non-emergency admission agreement has not created an express contract, then the court will most likely find that an implied-in-fact contract *has* been created based on the conduct of the parties. In that case, recovery should be for the reasonable market value of the medical services. Again, while the legal analysis may be somewhat different for express and implied-in-fact contracts, the conclusion is the same: the patient is liable to pay no more than the reasonable market value of the medical care received.

If, notwithstanding the adhesive nature of the admission agreement, the court concludes that an enforceable express contract exists, then the court should refuse to enforce any payment formula contained in the admission agreement that results in an excessive price. Most admission agreements contain CDM-based price formulas, and in most cases applying these formulas will result in a grossly exorbitant price. Because of this, courts should refuse to enforce most CDM-based price formulas.

Thus, though the legal analyses are different, the conclusion for most self-pay patients will be the same. Whether patients are admitted to the hospital through the emergency department or not, and whether the standard admission agreement they may have signed is deemed to be a contract or not, they should be liable to pay the hospital no more than the fair and reasonable value of the healthcare that they have received. The burden placed on courts to determine the fair and reasonable market value of healthcare is not a difficult burden for the courts to bear. The information necessary to determine the fair and reasonable value of healthcare in specific cases is readily available and easily applied. Finally, judicial recognition and application of the analysis presented here will not only protect self-pay patients from price gouging but also help check the excessive and ever-increasing cost of American healthcare without eliminating hospital pricing autonomy.