OBSCENE CONTRACTS*: THE DOCTRINE OF UNCONSCIONABILITY AND HOSPITAL BILLING OF THE UNINSURED

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BY GEORGE A. NATION III

PART I: INTRODUCTION

A recent headline in a national newspaper read “Full Price: A Young Woman, An Appendectomy, and a $19,000 Debt.”¹ The story concerned Rebekah Nix, a 25-year-old college graduate and former magazine fact checker who spent two days in New York Methodist Hospital in Brooklyn for an appendectomy.² She was billed $19,000; $14,000 for the hospital stay and $5,000 for doctor’s fees.³ There is nothing surprising about the fact that medical services are expensive. What is shocking however is that such services are much, much more expensive for patients such as Ms. Nix who are uninsured. While Ms. Nix’s bill was $14,000, New York Methodist bills health maintenance organizations (“HMOs”) only about $2,500 for the same two-day hospital stay!⁴ Unfortunately, Ms. Nix’s story is not unusual. Consider, the case of Mr. Shipman, a 43-year-old former furniture salesman from Herndon, Virginia.⁵ He experienced severe chest pain one night and was taken by ambulance to a community hospital emergency room, and then to Inova

¹ As a general definition of the word “obscene” Black’s offers “Objectionable or offensive to accepted standards of decency (See, BLACKS LAW DICTIONARY 971 (5th ed. 1979). Thus, generally “obscene contracts” are those that are objectionable or offensive to accepted standards of decency. The legal doctrine most often used to prevent enforcement of such contracts is unconscionability. However, to determine whether a specific contract is unconscionable is difficult because the doctrine, like obscenity, is described in broad and general terms. As Justice Stewart noted, obscenity is tough to define "But I know it when I see it" (See Jacobellis v. State of Ohio 378 U.S. 184 (1964) at 197 (Justice Stewart concurring)) – so to with unconscionable contracts, exact definition is elusive but you know them when you see them – and hospital admission contracts that require uninsured patients to pay the hospital’s "full charges" are a case in point.
³ Id.
⁴ Id.
⁵ See Lucette Lagnado, Anatomy of a Hospital Bill, Uninsured Patients Often Face Big Markups on Small Items; Rules Are Completely Crazy, Wall St. J., September 24, 2004 (Marketplace) at B1, col. 2.
Fairfax Hospital where doctors performed a cardiac catheterization and inserted a stent. Mr. Shipman checked himself out of the hospital the next morning against medical advice because he lacked health insurance and was concerned about the expense. He was right to be concerned. Mr. Shipman’s two-day health crises left him with a $37,000 medical bill. However, the same services Mr. Shipman received would have been reimbursed by Medicaid at $7,165 and by Medicare at $16,047. Obviously the fact that Ms. Nix and Mr. Shipman are expected to pay for the medical services they receive is not surprising or unreasonable. What is shocking and unfair is that in each case the hospital involved would have accepted a fraction of the amount Mr. Shipman and Ms. Nix were expected to pay if the payor were Medicaid, Medicare, an HMO, or a private insurer. Effectively,

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6 Id.
7 Id.
8 Id.
9 Id.
10 Id.
11 Id. Even a patient who is in an emergency situation and is unconscious at the time of receiving medical services from a trained professional such as a doctor is obligated to pay for the services under the equitable doctrine of unjust enrichment. See, e.g., Engle v. Snyder, 604 A. 2d 253 (1992) (where there is no expresses agreement to pay, the law implies a promise to pay a reasonable fee for a health provider's services); JOHN EDWARD MURRAY JR., MURRAY ON CONTRACTS §19, 35 (3rd ed. 1990) (“To avoid unjust enrichment, the law permits the party who has conferred the benefit to recover the reasonable value of the benefit.”); JOHN D. CALAMARI AND JOSEPH M. PERILLO, CONTRACTS (West) 1977 at §1-12 (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. (citing Greenspan v. Slate 97 A. 2d 390 (1953)). Id.

However, the unconscious patient has a distinct advantage over uninsured patients such as Ms. Nix or Mr. Shipman because under the doctrine of unjust enrichment the unconscious patient is only obligated to pay the reasonable value of the service received, whereas uninsured patients are liable to pay many times the reasonable value of the service they receive. See Temple University Hospital, Inc. v. Healthcare Management Alternatives, Inc. 832 A. 2d 501 (PA 2003) (after their contract expired, Healthcare's subscribers continued to receive medical services at Temple; Temple billed Healthcare at its published rates or full charges for such services. The court held that Temple had a right to be paid the reasonable value of its services under a theory of unjust enrichment. However, the court held that Temple's full or published charges were not reasonable because they were paid by only 1 to 3% of patients.) Id. 508-509.

11 See Lucette Lagnando, Medical Mark Up, California Hospitals Open Books, Showing Huge Price Differences, Wall St. J., December 27, 2004 at 1 col. 4 (“List prices are usually charged only to uninsured patients. Health plans negotiate big discounts and the government essentially dictates what it will pay.”) Id. The reasons for this are the result of the current third party reimbursement system. Id. Each hospital maintains a "Charge Master" or list of its retail or "full charge" prices for every good or service offered by the hospital. Id. The Charge Masters are updated frequently to capture price increases. Id. The systems and methods for creating a Charge Master are non-standardized among systems/hospitals. Id. Even within a hospital system each hospitals Charge Master may be different, reflecting different prices or different items. Id. However, only the uninsured are expected to pay these "full charges" or "list prices" because all of the
hospitals are engaged in an odd sort of price discrimination; the amount the hospital is willing to accept for its goods and services changes depending on who the patient is, or more precisely on the identity of the payor.

Ms. Nix and Mr. Shipman represent the common fate suffered by the 45 million uninsured Americans when they receive medical treatment; they get billed at the third party payors pay less. Id. Under Medicare, the federal program for the elderly and disabled, the hospital receives a flat rate, based on the diagnosis, for all care including drugs. Id. Medicaid, the federal-state program for the poor, pays a negotiated amount, which varies from state to state, but on average is about 40%-60% of the "full charge" amount. See, Mark H. Gallant and John R. Washlick, Charity Care and Patient Discounts...Love or Corruption in Love or Corruption: How or When Can Hospitals Discount Their 'Usual Charges'? (materials for a continuing legal education course) Pennsylvania Bar Institute (2004) (hereinafter Love or Corruption) ("Medicare/Medicaid typically dictates payment levels for 40-60% of patients" Id. at 1 (Why haven't hospitals heavily discounted fees to the "uninsured?"…because tiered charges are impractical administratively, pose issues under federal rules requiring uniform charges, and charge reductions can significantly undermine revenues under percentage of charge contracts.") Id. at 12. Health maintenance organizations pay about 60% of the list price. Id. at 1. Commercial insurers also pay negotiated rates which are contractually discounted. Id. See, Temple 832 A.2d 501 at 506. (In concluding that the hospitals published rates exceeded the reasonable value of its services the court stated: "In other words, ninety-four percent of the time, the Hospital received less than eighty percent of the Hospital's published rates.") Id.; (the court also noted that the hospitals full published charges in 1994 were approximately 172% of its actual costs, while in 1995 and 1996, the published rates were approximately 300% of its actual costs, and that private payors typically paid 121% of the cost of hospital services in 1994, 119% in 1995, and 112% in 1996, while government payors [Medicare and Medicaid] generally pay less) Id. at 509.

In addition to the uninsured, tortfeasors/automobile insurance and liability carriers may reimburse medical expenses based on the hospitals full charges though this has been criticized. See generally William R. Jones, Jr. Managed Care And The Tort System: Are We Paying Billions In Phantom Healthcare Charges? 32 Arizona Attorney 28 (March 1996) (Critiquing this practice and suggesting reforms.)

12 See Mark Klock, Unconscionability and Price Discrimination, 69 TENN. L. REV. 317 (2002) (discussing price discrimination as charging different prices to different customers for the same goods or services and arguing that price discrimination is unconscionable) Id. at 327, 354 and 366 (nt. 323).

The following quote from the article concerning Mr. Shipman is telling:

"Mr. Shipman negotiated a discount from at least one physician involved in his care. Joseph Kiernan, a cardiologist who practices at Inova Fairfax, billed Mr. Shipman more than $6,800, but when the Shipmans told him they couldn't afford to pay that much, he immediately slashed some $3,000 off the bill, bringing it down to about $3,800. That is still more than what big government payers such as Virginia Medicaid would have paid. A spokesman for the state agency says it would have reimbursed the doctor slightly over $1,000; Medicare says it would have paid about $900. "We feel that patients should be somewhat responsible for the medical costs," Dr. Kiernan says. For uninsured patients who are uninsured but not indigent, "we come up with a compromise solution." See Lagnado supra note 5 at B4 col. 5.

Clearly the doctor is involved in price discrimination – charging more to customers that they perceive as being able to pay the premium charge. Id. In addition to the obvious profit maximization incentive to engage in price discrimination there also appears to be a "cost shifting" incentive present in healthcare. For example, Jeff Laramie, the owner of the ambulance company that transported Mr. Shipman stated that "private payers generally pay along the lines of 70% to 80% of the charges...[and] he and other providers charge uninsured patients more to compensate for low reimbursements from the government and other big insurers." Id.

13 See supra note 11.
hospital’s “regular rates,” “full charges” or “list prices.” These charges are at least
double and may be up to eight times what the hospital would accept in full payment for
the same services from Medicare, Medicaid, HMOs or private insurers. The labels for
these charges, “regular,” “full,” or “list” are misleading because in fact, there is nothing
regular about a hospital’s list prices as they are actually paid by less than five percent of
patients nationally. Moreover, medical bills are now a leading cause of personal
bankruptcies. As a result, the billing and debt collection practices of hospitals have
become a heated political and social issue.

This article argues that the admission agreement between a hospital and a patient
(poor or not) in which the patient agrees to pay the hospital’s “full charges” for necessary
medical services is unenforceable because it is unconscionable, and as a result the most

14 See generally Lagnado supra note 1; Lagnado supra note 5; Love or Corruption supra note 11.
15 See Lagnado supra note 5 B4, col. 6 (noting that Hal Cohen, a healthcare consultant who has studied
hospital markups in all fifty states, says some U.S. hospitals charge as much as ten times their costs.) Id.
The same article notes that Mr. Shipman was billed more than eight times the amount that Medicare would
have paid for the doctor charge. Id. B1 (table col. 3, 4). See William R. Jones Jr. supra note 11 at 29-30:
Unfortunately, the exact predetermined fixed rates paid by managed care plans are
carefully guarded secrets. Our research disclosed that every private managed care
contract contains a confidentiality provision. The providers in our locality who would
talk to us estimated that one-third to one-half of all of their patients' bills were paid by
some form of private managed care; and on average, their fixed fee for the services they
rendered to managed care patients was no more than 50 percent of their billed charges.
See Love or Corruption supra note 11 at 3 (noting that the national average full charge amount listed on a
hospitals charge master equals 345% of the hospitals costs and that Medicaid and large commercial insurers
reimbursement rates are often below cost; thus, if cost is five dollars the national average full charge would
be $17.25 and the hospital would accept as payment in full an amount less than five dollars).
16 See e.g., Temple 832 A. 2d at 508 (“...the hospital was paid its full published rates in only one to three
percent of the cases.”); Vencor, Inc. v. National States Insurance Co., 303 F. 3d 1024, 1029 n. 9 (9th Cir.
2002) (“It is worth noting that in a world in which patients are covered by Medicare and various other kinds
of medical insurance schemes that negotiate rates with providers, providers' supposed ordinary or standard
rates may be paid by a small minority of patients.”); Lagnado, supra note 11 at A6 col. 4 (noting that
almost no one other than the uninsured are asked to pay list prices) Id.
17 See Lucette Lagnado, Taming Hospital Billing, Wall St. J., June 10, 2003 B1, col. 2 (noting that
"...medical debt has emerged as a leading cause of personal bankruptcy.") Id. See Wall St. J., February 2,
2005 A1, col. 3 (noting that a Harvard study in the journal Health Affairs found that medical bills trigger
half of all personal bankruptcies).
18 Moreover, this is likely to continue given the ever increasing cost of health care. Glenn Menick, a
professor of health care finance at the University of Southern California expects health care costs to
increase by 8% to 9% per year over the next five years – more than double the expected rate of overall
economic growth. See Lagnado, supra note 11, at A1 col. 5.
that the patient is liable to pay the hospital is the reasonable value of the medical goods and services received. Moreover, reasonable value should be defined as the average reimbursement actually collected (not billed) by the hospital for the diagnostic code that applies to the medical services received by the patient.\textsuperscript{19}

Part II of this article provides an overview of the doctrine of unconscionability. Part III provides an overview of hospital billing practices. Part IV discusses case law regarding hospital admission contracts. Part V analyzes the applicability of the doctrine of unconscionability to hospital admission agreements. Part VI concludes.

\textbf{PART II: UNCONSCIONABILITY: AN OVERVIEW}

\textbf{A. HISTORY OF THE DOCTRINE}

The doctrine of unconscionability concerns fairness.\textsuperscript{20} The doctrine can be used to refuse to enforce all or part of an agreement that is deemed by a court to be sufficiently unfair as to be unconscionable.\textsuperscript{21} The doctrine has a long, if somewhat checkered, history.

\textsuperscript{19} The court in \textit{Temple} notes that: "Until 1984, payments [Medicaid reimbursements to hospitals] were based as actual costs. In 1984, due to spiraling health care costs a new method of payment was established based on diagnosis rather than length of stay or number of services provided. Reimbursement amounts are now based on diagnostic related group ("DRG"). Thus, a patient's diagnosis rather than the actual service provided determines reimbursement. \textit{See}, \textit{Temple} 832 A. 2d at 504.

\textsuperscript{20} See Friedrich Kessler \textit{et al.}, \textit{Contracts: Cases and Materials} 554 (3d ed. 1986) (noting that courts of equity developed the doctrine of unconscionability to protect victims of sharp dealing) \textit{Id.} at 560.

\textsuperscript{21} See, \textit{e.g.}, Ellsworth Dobbs, Inc. \textit{v.} Johnson 236 A. 2d 843 (N.J. Sup.Ct. 1967). The case involves a real estate broker that found a buyer for the seller. The seller and buyer entered into a contract for sale but the contract was never performed due to breach by the buyer. The real estate broker brought suit against the seller, alleging that based on the express terms of the listing agreement the commission was earned upon execution of the contract between buyer and seller. The court ruled that any contractual provision in the listing agreement that required the seller to pay the commission even though the buyer of the land was unable to arrange financing and therefore breached the contract of sale, was "...so contrary to the common understanding of men, and also so contrary to common fairness, as to require a court to condemn it as unconscionable." \textit{Id.} at 857. In so ruling the court applies the following reasoning that is equally applicable to the hospital admission contracts discussed here:

Courts and legislatures have grown increasingly sensitive to imposition, conscious or otherwise, on members of the public by persons with whom they deal, who through experience, specialization, licensure, economic strength or position, or membership in associations created for their mutual benefit and education, have acquired such expertise
The case, *Earl of Chesterfield v. Janssen* (1697) is cited as the source of the doctrine in English law. In the United States, the Supreme Court stated in *Hepburn v. Dunlay & Co.*, (1816) that “a contract should be set aside if in conscience it should not be enforced.” In *Hume v. United States* the Supreme Court quoted *Earl of Chesterfield* noting that a bargain is unconscionable if it is “such as no man in his senses and not under delusion would make on the one hand, and as no honest and fair man would accept on the other.”

The doctrine of unconscionability is recognized in Article 2 of the Uniform Commercial Code. Article 2 states:

or monopolistic or practical control in the business transaction involved as to give them an undue advantage. [citations omitted] Grossly unfair contractual obligations resulting from the use of such expertise or control by the one possessing it, which result in assumption by the other contracting party of a burden which is at odds with the common understanding of the ordinary and untrained member of the public, are considered unconscionable and therefore unenforceable. *Id.* at 856.

The perimeter of public policy is an ever increasing one. Although courts continue to recognize that persons should not be unnecessarily restricted in their freedom to contract, there is an increasing willingness to invalidate unconscionable contractual provisions which clearly tend to injure the public in some way. *Id.* at 857.

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23 2 Ves. Sr. 125, 155; 28 Eng. Rep. 82, 100 (ch. 1750).

24 See Brown supra note 22 (“As early as 1697, English law already had an equitable rule against the enforcement of unconscionable contracts.”) *Id.* at 288.

25 14 U.S. (197 Wheat) 179 (1816).

26 *Id.* at _____.

27 132 U.S. 406, 415 (1889). *See also* Eyre v. Potter, 56 U.S. (60 How.) 42 (1953) (behavior sufficiently outrageous to shock the conscience of the court).

28 See supra note 23.

29 See U.C.C. § 2-301 (this section, perhaps more than any other in Article 2, has been the subject of controversy see supra note 22).
If the court as a matter of law finds the contract or any clause of the contract to have been unconscionable at the time it was made the court may refuse to enforce the contract, or it may enforce the remainder of the contract without the unconscionable clause, or it may so limit the application of any unconscionable clause as to avoid any unconscionable result.  

Article 2 does not define unconscionability either in 2-302 or in the Official Comments. The Comments attempt to offer some guidance stating: “the basic test is whether in light of the general commercial background and the commercial needs of the particular trade or case, the clauses involved are so one-sided as to be unconscionable under the circumstances existing at the time of the making of the contract.” Obviously it does not help to state that a contract is unconscionable if it contains unconscionable terms. Notwithstanding the lack of a definition, 2-302 is the law in 49 states and has been widely applied by the courts to consumer sales contracts.

The Restatement (Second) of Contracts also includes the doctrine of unconscionability. While Restatements do not have the force of law they are considered to be authoritative. Moreover, while the Article 2 provision is limited to contracts involving the sale of goods, the Restatement’s unconscionability provision is applicable to all types of contracts. The Restatement provides the following:

If a contract or term thereof is unconscionable at the time the contract is made a court may refuse to enforce the contract, or may enforce the

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30 See U.C.C. § 2-301 (1); See, Brown supra note 22 (noting that it took a decade before the courts began using 2-302; by 1968 fewer than 20 cases were decided on the basis of 2-302.) Id. at 289.
31 See U.C.C. § 2-301 cmt. 1.
32 1 JAMES J. WHITE AND ROBERT S. SUMMERS, UNIFORM COMMERCIAL CODE 206 (4th ed. 1995) (noting that the section is "enshrined in the statutory law of forty-nine states"). Id. at 208. California omitted 2-302 when it adopted the Code but unconscionability is part of California law by statute. See, e.g., Cal. Civ. Code § 1670. 5 (Deering 2004).
33 See Brown Supra note 22 ("...and is widely applied by courts to consumer sales contracts and in certain circumstances to sales contracts between merchants as well.") Id. at 289.
36 See U.C.C. § 2-102 ("...this Article applies to transactions in goods...").
remainder of the contract without the unconscionable term, or may so limit the application of any unconscionable term as to avoid any unconscionable result.\(^{38}\)

The Comments to Section 208 are similar to the Official Comments to UCC 2-302 in that they indicate that the doctrine of unconscionability allows a court to refuse to enforce part or all of an agreement because it is so unfair as to be unconscionable rather then resort to “adverse construction of the language”\(^{39}\) of the contract or clause.\(^{40}\) Also similar to the Code’s 2-302, no definition of unconscionability is provided.\(^{41}\)

There are at least two reasons for the doctrine’s checkered history. First, the idea of invalidating a contract, otherwise enforceable, because it is deemed by a court to be unfair seems to violate a basic principal of contract law; freedom of contract.\(^{42}\) That is, a competent person has the freedom (within the boundaries set by the established policing, formation and disclosure doctrines such as fraud, duress, etc.) to enter into any agreement

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\(^{38}\) Id.

\(^{39}\) See U.C.C. 2-302 Official Comment 1.

\(^{40}\) See RESTATEMENT (SECOND) OF CONTRACTS § 208 (1981) Comment 1 ("…permits the court to pass directly on the unconscionability of the contract or clause rather than to avoid unconscionable results by interpretation.")

\(^{41}\) Id.

\(^{42}\) See Klock supra note 12 ("…there is fundamental tension between the doctrine and basic contract law, which holds that the level of consideration is irrelevant to contract formation.") Id. at 333. Klock goes on to state:

> Unconscionability, for which no redundant defenses exist, is indeed inconsistent with fundamental contract theory. Basic contract theory requires only competent parties making an agreement with bilateral consideration to make an enforceable contract. 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. Unconscionability is an inherently paternalistic doctrine that is intended to protect individuals from the consequences of their own decisions and allows them to avoid detrimental terms. [notes omitted] Id. at 343-44.
he/she sees fit, profitable or unprofitable, fair or unfair.\textsuperscript{43} Thus, the doctrine of unconscionability seems to violate the principal of freedom of contract.\textsuperscript{44} It has however been argued that, in fact, the doctrine strengthens the principal of freedom of contract by preventing its abuse.\textsuperscript{45} Under the framework discussed below, the doctrine applies only when the element of free choice is compromised (albeit not sufficiently to allow application of any of the more established doctrines such as fraud or duress).\textsuperscript{46}

The second difficulty with the doctrine is its lack of definition.\textsuperscript{47} Neither the Code, the Restatement, nor the courts have developed a consistent specific definition of an unconscionable contract.\textsuperscript{48} Many definitions are tautologies: a contract is unconscionable because it contains unconscionable terms.\textsuperscript{49} This lack of definition has given rise too much of the criticism leveled at the doctrine.\textsuperscript{50} The most serious being that the doctrine is inconsistently applied because it encourages courts to simply substitute their own ex-post judgment regarding fairness for the ex-ante judgment of the parties.\textsuperscript{51}

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\textsuperscript{43}See CALAMARI AND PERILLO supra note 10 at §§ 31-3; 1-4.
\textsuperscript{44}See supra notes 42-43 and accompanying text.
\textsuperscript{45}See, e.g., Williams v. Walker-Thomas Furniture Co. 350 F. 2d 445 (D.C. Cir. 1965) ("Whether a meaningful choice is present in a particular case can only be determined by consideration of all the circumstances surrounding the transaction. In many cases the meaningfulness of the choice is negated by gross inequality of bargaining power.") \textit{Id.} at 449.
\textsuperscript{46}See Leff \textit{supra} note 22 at 487-89.
\textsuperscript{47}See Klock \textit{supra} note 12 at 1830 ("The lack of definition or pretense of structure in section 2-302 of the Code has led to unending criticism from legal academics.") \textit{Id.}; Brown \textit{supra} note 22 at 289 ("Common law definitions of unconscionability are likewise so unclear and inconsistent that they provide little, if any, guidance…American Law Institutes Restatement …also fail to provide any guidance whatsoever"). \textit{Id.} at 289.
\textsuperscript{48}See \textit{supra} note 47.
\textsuperscript{49}See U.C.C. § 2-302 cmt. 1 (1990) ("The basic test whether in the light of the general commercial background…the clauses are so one-sided as to be unconscionable under the circumstances existing at the time of the making of the contract.")
\textsuperscript{50}See note 47. \textit{Cf.} Frank P. Darr, \textit{Unconscionability and Price Fairness} 30 HOUS. L. REV 1819 ("Despite the large amount of ink spilled in criticism of the use of unconscionability, the courts nonetheless resort to the doctrine to reject or modify contractual arrangements. The courts have found some utility in the concept.") \textit{Id.} 1832; Brown \textit{supra} note 22 at 306 ("The greatest advantage of U.C.C. § 2-302, its flexibility, is without doubt also its greatest drawback.").
\textsuperscript{51}See Alan Schwartz, \textit{A Reexamination of Nonsubstantive Unconscionability}, 63 VA. L. REV. 1053 (1977) (noting that if courts modify certain contracts ex-post they will cease to be available ex-ante.). \textit{Id.} 1062-63.
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However, as discussed infra an analytical framework for unconscionability involving both procedural and substantive elements suggested by Arthur Allen Leff has been widely accepted by courts and commentators. Professor Leff’s framework comes the closest to a generally accepted definition of unconscionability. The doctrine’s problems notwithstanding, unconscionability seems to be flourishing. The doctrine is frequently raised in cases, written into legislation, and written about by legal scholars.

**B. ANALYTICAL FRAMEWORK FOR UNCONSCIONABILITY**

The generally accepted analytical framework of unconscionability provided by Professor Leff suggests that unconscionability is different from the defenses of fraud, duress, mistake, impossibility, or illegality because these traditional defenses look at either the “process of contracting” or the “resulting contract”, but not both. Unconscionability, according to Professor Leff looks at both the process and the result. Thus, there are two prongs to the unconscionability analysis: the process prong or procedural unconscionability, and the “results prong” or substantive unconscionability.

While some courts are willing to find a contract unconscionable based on substantive

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52 See Brown supra note 22 at 291 (Professor Leff’s article...probably comes closest to defining unconscionability”). Id. While most courts accept Professor Leff’s analysis, a number of commentators have offered alternatives. See, e.g., Klock supra note 12 (incorporating the idea of discrimination into the definition of unconscionability) Id. at 376. Darr supra note 50 (suggesting that unconscionability analysis should address three factors; the perceived fairness of the contract price compared to a reference price the perceived fairness of the transaction process, and the ability of the market to enforce the perceived fair price.) Id. at 1840.

53 Id.

54 See Klock supra note 12 at 333 (“...evidence that indicate that the doctrine contrives to survive, if not flourish.”) Id.; see Darr supra note 50 at 1832 (despite the large amount of ink spilled in criticism of the use of unconscionability, the courts nonetheless resort to the doctrine to reject or modify contractual arrangements. The courts have found some utility in the concept. They appear to be attempting to enforce some norms of community justice in these cases. [citing cases]) Id.

55 See Klock supra note 12 at 333-34, (Klock cites examples of each); Brown supra note 22 at 289 (noting that U.C.C. 2-302 is "widely applied by courts...”). Id.

56 See Leff supra note 22 at 487.

57 Id.

58 Id.
unconscionability alone (this has most commonly occurred in excessive price cases). Analysis of court decisions suggests that a majority of courts generally accept Professor Leff’s framework and require both procedural and substantive unconscionability. However, there is case law support for the application of a sliding scale, so that the existence of an extreme in one component would allow a contract to be found unconscionable even though the other component was present to a much lesser degree.

1. PROCEDURAL UNCONSCIONABILITY

A contract is procedurally unconscionable if there is some defect in the contracting process such that one party has not entered into the agreement knowingly and freely. Important factors in this analysis are the relative bargaining power of the parties, whether the weaker party was free to negotiate for alteration of the terms offered (usually in a standardized preprinted form) by the stronger party, and whether the weaker party had the realistic opportunity to seek the goods or service elsewhere. The concept of

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59 See Brown supra note 22 at 294.
60 See, e.g., American Home Improvement, Inc. v. MacIver 201 A. 2d 886 (N.H. 1964) (contract unconscionable where homeowner agreed to pay excessive price and financing costs.) Id. 886-89; Toker v. Westerman 274 A. 2d 78 (N.J. Dist. Ct. 1970) (contract unconscionable due to price more than 2 1/2 times reasonable retail value, no evidence of procedural unconscionability) Id. 78-81; Darr supra note 50 at 1820 (reviewing price based unconscionability cases).
61 See Darr supra note 50. (Generally courts require...both substantive and procedural unconscionability.” [note omitted]) Id. 1820; WHITE AND SUMMERS supra note 32 at 231 (suggesting that both procedural and substantive unconscionability are required). Id.
62 See Brown supra note 22 at nt. 175, citing Tacoma Boatbuilding Inc. v. Delta Fishing Co. (“[t]he substantive/procedural analysis is more of a sliding scale than a true dichotomy”) 1980 WL 98503 n. 20 (W.D. Wash 1980). Brown notes that this case is cited in WHITE AND SUMMERS supra note 32 at 321; WHITE AND SUMMERS supra note 32 (“a contract that is ninety-eight parts substantively unconscionable may require only two parts of procedural unconscionability to render it unenforceable and vice versa.”) Id. at 231.
63 See Brown supra note 22 at 291 (noting that procedural unconscionability involves surprise which usually results where there are hidden contract terms, terms in unreadable fine print, or unusually complex technical terms that a reasonable consumer cannot understand.) Id.
64 See, e.g., Williams v. Walker Thomas Furniture 350 F. 2d 445 (D.C. Cir. 1965) (“[U]nconscionability has generally been recognized to include an absence of meaningful choice on the part of one of the parties together with contract terms which are unreasonably favorable to the other party”) Id. at 449. The court went on to discuss the importance of the relative bargaining power of the parties: ”[I]nquiry into the
adhesion contracts is very similar to procedural unconscionability. Most courts find that an adhesion contract is procedurally unconscionable.

A procedurally unconscionable contract results in the surprise or oppression or both of the weaker party. That is, the weaker party is surprised to learn of the terms of the agreement because they were hidden in fine print or obtuse language or the weaker party agreed to the terms because he/she had no realistic opportunity to acquire the goods or services without agreeing to the offered terms, or both. A contract is procedurally unconscionable when the weaker party is forced to agree to terms written by the stronger party either without fully understanding the terms or because the only way for the weaker party to acquire the goods or services is to agree to the terms dictated by the stronger party. Hospital admission contracts are written in a way that prevents the patient from knowing how much money they are agreeing to pay the hospital. In addition, the

relative bargaining power of the two parties is not an inquiry wholly divorced from the general question of unconscionability, since a one-sided bargain is itself evidence of the inequality of the bargaining parties.” Id. 449; Tunkl v. Regents of University of California 383 P. 2d 441 (1963) (concerning an exculpatory clause in a hospital admission contract the court noted that: “…the hospital certainly exercises a decisive advantage in bargaining. The would-be patient is in no position to reject the proffered agreement, to bargain with the hospital, or in lieu of agreement to find another hospital”) Id. at 447. (Tunkl is discussed infra at notes 171-174 and accompanying text).

65 See Wheeler v. St. Joseph Hospital et al., 133 Cal. Rptr. 775 (1976). The case involves an agreement to arbitrate in a hospital admission contract. Regarding the definition of adhesion contract the court stated: 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 [citations omitted]. The distinctive feature of a contract of adhesion is that the weaker party has no realistic choice as to its terms [citations omitted]. Id. at 783. (Wheeler is discussed in more detail infra at notes 175-196 and accompanying text.

66 See, e.g., Ting v. AT&T 319 F. 3d 1133 (9th Cir. 2003) (“a contract is procedurally unconscionable if it is a contract of adhesion) Id. 1148.

67 See, e.g., Phoenix Baptist Hospital v. Aiken 877 P. 2d 1345 (Ariz. 1994) (hereinafter "Aiken") (concerning hospital admission contract signed by husband for medical services provided to his wife and purporting to make husband personally liable for such services; noting that the trier of fact could conclude that the husband either did not understand the implications of the agreement, or that he felt he had no choice but to immediately sign the preprinted form) Id. 1350.

68 Id.

69 Id.

70 See infra notes 108-170 and accompanying text.
admission contract does not make clear that uninsured patients are, by agreeing to pay the hospital’s “full charges,” agreeing to pay many times the amount insured patients pay for the same medical services.71 Moreover, these agreements are entered into in circumstances where the patient has very little opportunity to understand the terms offered72 and no choice but to agree to what ever terms the hospital dictates.73 The lack of a commercial setting, a bargaining table, and time to read and negotiate, all contribute substantially to the procedural unconscionable of hospital admission contracts.74 The overriding factor however in finding hospital admission contracts procedurally unconscionable is that necessary medical services are necessities and time is virtually always important.75 Thus, even if a patient understood the terms in the hospital admission contract, as noted supra they usually do not,76 and decided he did not want to agree to them the patient is in no position to shop for an alternative supplier of necessary medical

71 As noted above the fact that hospital admission agreements do not contain a specific price for the medical services to be provided is not the fault of the hospital. In contrast, the fact that hospitals refer to "regular rates" or "full charges" is the fault of the hospital and is deceptive. These phrases "regular rates," "full charges" or "list prices" imply that these are the amounts that all or at least most patients pay. In fact, less then 4% of patients pay this amount. See supra notes 11-16 and accompanying text. Thus, the agreement to pay "regular rates" results in unfair surprise and oppression to uninsured patients.

72 See St. John's Episcopal Hospital v. McAdoo, 405 N.Y.S. 2d 935 (N.Y. Civ. Ct. 1978) (hereinafter "McAdoo") (It is reasonable in this situation for defendant to have seen himself as powerless to do anything other than sign the form. A hospital emergency room is certainly not a place in which any but the strongest can be expected to exercise calm and dispassionate judgment. Plaintiff hospital is surely no stranger to the trauma and anxiety experienced by those confronted with emergency medical crises. Armed with this knowledge it should have prepared the form it uses to impose liability so that the person being asked to sign it can readily grasp its meaning, even through a quick reading. Moreover, plaintiff should not be permitted to enforce a contractual obligation entered into under such tension-laden circumstances, as those defendant described.) Id. 937. (McAdoo is discussed infra at notes 205-211 and accompanying text.)

73 Id.

74 See Tunkl 383 P. 2d 441 (1963) at 447 (The would-be patient is in no position to reject the proffered agreement, to bargain with the hospital, or in lieu of agreement to find another hospital. The admission room of a hospital contains no bargaining table where, as in a private business transaction, the parties can debate the terms of their contract) Id.

75 A valid distinction may be drawn between necessary medical services, whether rendered on an emergency basis or on a planned basis, and elective medical services such as elective cosmetic surgery. See infra notes 212-222 and accompanying text.

76 See supra notes 70-74 and accompanying text.
services. The patient must agree to whatever terms the hospital offers because the patient needs the services. In the case of emergency medical services there is no time to shop. In the case of planned necessary medical services, the patient feels he/she must go to the hospital they have been directed to by their doctor. This of course is not the fault of the hospital, nor does it alone make hospital admission contracts unconscionable and thus unenforceable. The fact that patients are forced by circumstances to agree to whatever terms the hospital offers does make hospital admission contracts procedurally unconscionable. However, the hospital admission contract will be unenforceable only if in addition to being procedurally unconscionable, it is also substantively unconscionable or grossly unfair.

2. Substantive Unconscionability

Substantive unconscionability is concerned with the terms of the agreement between the parties not the process from which it resulted. Specifically, a contract is substantively unconscionable if it is grossly unfair, or contains terms that are so one-sided

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77 Id.
78 Id.
79 Id.
80 See 133 Cal. Rptr. 755 at 789 (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") Id. Wheeler is discussed infra at notes 175-196 and accompanying text.
81 See supra note 84-107 and accompanying text. Notwithstanding the fact that patients are in no position to properly negotiate or even focus on the terms of the admission agreement when they seek necessary medical services, there is nothing unreasonable in requiring patients to pay the reasonable value of the medical services they receive. Cf. supra note 10 (recovery in quasi contract for medical services rendered to a patient incapable of entry into a contract).
82 See supra notes 70-74 and accompanying text.
83 See infra notes 84-107 and accompanying text.
84 See Leff supra note 22 at 487-88 (substantive unconscionability refers to the "fairness of the terms of the resulting bargain") Id.
or unfair as to shock the conscience of the court.\textsuperscript{85} A contract or a provision of a contract may be found substantively unconscionable if it provides for the allocation of risks between the parties in an unreasonable or unexpected manner.\textsuperscript{86} Oppression or overreaching by the stronger party are hallmarks of substantive unconscionability.\textsuperscript{87} One court noted that a contract is substantively unconscionable if it results in the assumption by the weaker party of a burden which is at odds with the common understanding of the ordinary and untrained member of the public or if the terms are contrary to common fairness.\textsuperscript{88}

An excessive price may support a finding of substantive unconscionability;\textsuperscript{89} excessive prices also provide an indication or corroboration of defects in the bargaining process.\textsuperscript{90} One commentator has concluded that “price unconscionability is part of the basic foundation of contract law.”\textsuperscript{91} Courts however, have not been consistent in setting a standard for when a price becomes unconscionably excessive.\textsuperscript{92} Some courts have found that an excessive mark up results in substantive unconscionability.\textsuperscript{93} Other courts

\textsuperscript{85} See Brown \textit{supra} note 22 at 292 (discussing substantive unconscionability in terms such as unfair, harsh, one-sided, oppressive or the unjustified reallocation of the risks of the bargain in an unreasonable or unexpected manner) [citations omitted]. \textit{Id.}

\textsuperscript{86} \textit{Id.} See, e.g., Ellsworth Dobbs Inc. v. Johnson 236 A. 2d 843 (N.J. Sup. Ct. 1967) (assumption of burden by weaker party that is at odds with consumer understanding is unconscionable) (discussed \textit{supra} in note 21) \textit{Id.} at 856.

\textsuperscript{87} See, e.g., U.C.C. § 2-302 Cmt. 1 ("The principal is one of the prevention of oppression and unfair surprise..."\textsuperscript{\textit{)}}. \textit{Id.}


\textsuperscript{89} See Brown \textit{supra} note 22 at 292 (noting that excessive price cases are a common type of substantive unconscionability case). \textit{Id.}

\textsuperscript{90} See RESTATEMENT (SECOND) OF CONTRACTS § 2-302 Cmt. C ("...gross disparity is the values exchanged may be an important factor in a determination that a contract is unconscionable...").

\textsuperscript{91} See Dart \textit{supra} note 50 at 1872 ("...price unconscionability is part of the basic foundation of contract law. [citation omitted"]\textsuperscript{\textit{)}}. \textit{Id.}

\textsuperscript{92} See Brown \textit{supra} note 22 at 292 (noting that the price cases "lack a consistent standard for determining whether or not a price is excessive"). \textit{Id.}

\textsuperscript{93} See, e.g. Frostifresh Corp. v. Reynoso 274 N.Y.S. 2d 757 (Dist. Ct. 1966) reversed on other grounds, 281 N.Y.S. 2d 964 (Sup. Ct. 1967) (Sellers cost was $348 and the installment sale price was $1,145.80) \textit{Id.}; American Home Improvement, Inc. v. MacIver 201 A. 2d 886 (N.H. 1964) (goods priced at $950 sold for $2,568) \textit{Id.}
find a price to be substantively unconscionable if it is "higher than those charged by other merchants for the same or similar goods." 94 Other courts focus on whether the price returns too great a profit to the seller. 95 In addition a price might be considered exorbitant in part because of the economic status of the purchaser. 96

Commentators also have not been consistent in setting a standard for an unconscionable price. 97 Some commentators have suggested that a substantively unconscionable price results when the seller is engaged in price discrimination. 98 An argument may be made that price discrimination, that is, charging a different price based solely on the identity of the buyer with no cost justification is always unconscionable. 99 Other commentators suggest that an unconscionably excessive price can only be determined by comparing the contract price to some reference price. 100 One commentator suggested that it is necessary to find "a sufficient disparity (possibly two to one) between the price charged by the seller and the average of all retail prices charged for like goods in the community in which the consumer resides." 101 Commentators have suggested that an excessive price is one "two or three times greater than at least one other available price

95 See Brown supra note 22 ("Courts might consider a price excessive because it returns too great a profit to the seller or because it represents a substantially higher price than similarly situated merchants charge for like items.") Id. 293.
96 See Williams v. Walker Thomas Furniture Co., 350 F. 2d 445 (D.C. Cir. 1965) (the district court described one of the appellants, Ora Lee Williams, as being "a person of limited education separated from her husband" and "maintaining herself and her seven children by means of public assistance.") Id. at 915.
97 Cf. Darr supra note 50 (three requirements for excessive price to be unconscionable: high price based on a standard such as cost, fair market value, or historic cost; process problems; and market failure in sense of no private enforcement of price norms) Id. at 1841; Klock supra note 12 (excessive price is unconscionable only in context of market failure) Id. at 373.
98 See Klock supra note 12 at 367.
99 See Klock supra note 12 at 353.
101 Id.
in the low income neighborhood or elsewhere."\textsuperscript{102} Still another commentator suggests a three prong test consisting of a price significantly in excess of a reference price (substantive prong) contracting process problems, resulting in over reaching (procedural prong) and the inability of the market to enforce a fair price (a third requirement, market failure).\textsuperscript{103}

Whether a specific price is unconscionable also depends on the amount of procedural unconscionability present.\textsuperscript{104} With significant procedural unconscionability, courts are likely to require less excessiveness in order to find a high price unconscionable.\textsuperscript{105} The cases and commentary suggest that an unconscionable price is one which is significantly greater than; either the price at which the same seller sells to other customers (unless there is a cost justification for the different prices), or the price charged by other sellers in the area for the same good or service, or the cost of the good to the seller.\textsuperscript{106} Regardless of which of the above standards is used the "full charges" reflected on hospital Charge Masters are unconscionable.\textsuperscript{107}

\textbf{PART III: HOSPITAL BILLING PRACTICES}

\textsuperscript{102} See White and Summers \textit{supra} note 32 at 222.
\textsuperscript{103} See Darr \textit{supra} note 50 discussed at note 97 \textit{supra}.
\textsuperscript{104} See \textit{supra} notes 61-62 and accompanying text.
\textsuperscript{105} Id.
\textsuperscript{106} See \textit{supra} notes 89-105 and accompanying text.
\textsuperscript{107} See \textit{infra} notes 255-310 and accompanying text.
Problems with pricing are inherent in contracting for medical services. With the exception of purely elective medical procedures, medical services are necessary and thus there is much less change in the demand for medical services as a result of rising prices than for other types of goods or services. Moreover, patients usually do not know with any degree of certainty what medical services or goods they are buying nor the specific price they are agreeing to pay for such goods or services at the time of contracting. Patients are simply following their doctor’s advice when seeking medical care at a hospital. In many cases a patient literally trusts his life to his doctor’s judgment.

Specifically, neither the hospital nor the patient knows at the time the contract is entered

108 See Darr supra note 50 discussing the distinction between auction and price tag markets and market failure regarding pricing. Id. 1834. The conditions that lead to the inability of the market to enforce a fair price according to Darr include "limited likelihood of future sale, difficult informational problems in determining either the need for the product or its quality relative to price, high relational effects between the parties that prevent the erosion of good will, or situations in which the future credibility of the seller is not relevant to the buyer." Id. at 1840. All of these conditions exist with regard to the uninsured patient purchase of medical services. See infra notes 109-113 and accompanying text. Indeed, with respect to price the markets for medical services is not an auction nor a price tag market; it is a blind market because neither party knows the price at the time of contracting. Thus, courts must intervene under the doctrine of unconscionability to set a fair price.

109 The fact that necessary medical services are a necessity prevents markets from operating normally and necessitates the courts involvement to set a fair price. See Darr supra note 50 ("Except in the rare case of necessities, it is difficult to imagine that a party could not walk away from a transaction or that a party could be surprised a price term…") Id. 1832.

110 Hospital admission agreements provide that the patient agrees to pay for all medical services provided by the hospital at its "regular rates." There is typically no mention made of a specific dollar amount, thus, the patient has no idea how much he is agreeing to pay the hospital. This however, is not the hospitals fault nor the result of any deception on the part of the hospital. The reason for the lack of a specific amount is endemic in the nature of medical service. That it, at the time of admission neither the hospital nor the patient knows the extent of medical services that will be required.

111 See Wheeler 133 Cal. Rptr. 775 (1976) at 786 ("Unless advised by his doctor to the contrary, the patient normally feels he has no choice but to seek admission to the designated hospital and accede to all of the terms and conditions for admission…") Id. (…nor did Mr. Wheeler have a choice among hospitals…. 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…) Id. 789.

112 See e.g., Canterbury v. Spence, 464 F. 2d 772, 782 (D.C. Cir. 1972) in which the court stated: “The patient's reliance upon the physician is a trust of the kind, which traditionally has exacted obligations beyond those associated with arms-length transactions. His dependence upon the physician for information affecting his well being, in terms of contemplated treatment, is well nigh abject. …[L]ong before the instant litigation arose, courts had recognized that the physician had the responsibility of satisfying the vital informational needs of the patient. More recently, we ourselves have found in the ‘fiducial qualities of [the physician-patient] relationship the physician's duty to reveal to the patient that which in his best interests it is important that he should know’. ” Id.
into, the extent and thus the price of the medical services the patient will require.\footnote{See Lagnado supra note 11 (“For years, details on hospital charges were kept secret. Hospitals deemed their prices proprietary, to be kept off limits from institutional rivals, insurers and even consumers. Patients often had no idea what costs they were racking up until they got their bill.”) Id. at col. 5. \textit{See, e.g., Aiken 887 P. 2d 1345 (Ariz. 1994)} (agreement signed by patient provided \textit{inter alia} “…is hereby obligated to pay the account of the hospital in accordance with the regular rates and terms of the hospital…” \textit{Id.}; Wheeler v. St. Joseph Hospital et al., 133 Cal. Rptr. 775 (1976) (agreement signed by patients provided “…he hereby individually obligates himself to pay the account of the hospital in accordance with the regular rates and terms of the hospital.”) \textit{Id.})} As a result the patient often has no idea at the time of contracting how much he is agreeing to pay.\footnote{See supra note 113.} The actual amount is not known until long after the creation of the contract.\footnote{Id.} Typically patients agree to a very open-ended obligation by agreeing to pay the hospital’s “full charges” (or some similar language) for all services and goods provided.\footnote{Id.} Finally, the hospital pricing policy is the result of a perverted maize of confusing and contradictory regulations resulting from the third party reimbursement system.\footnote{See, e.g., \textit{Mercy Catholic Medical Center v. Tommy G. Thompson, Secretary of Health and Human Services 380 F. 3d 142 summarizing some of the more recent developments in the federal Medicare program: [footnotes are omitted]}}

\textbf{A. Statutory Background}

The federal Medicare program, administered by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services, is the largest public program financing health care services for the aged and disabled. Hospitals that provide services to Medicare patients are reimbursed for their expenses under Title XVII of the Social Security Act (the "Medicare Act"), 42 U.S.C. § 1395 et seq. Part A of the Medicare Act authorizes payment to participating hospitals ("providers") for their direct and indirect costs of providing inpatient care to beneficiaries. 42 C.F.R. § 413.9(a), (b). Medicare also reimburses teaching hospitals for the costs of graduate medical education, including physician time for instructing and supervising interns and residents. 42 U.S.C. § 1395ww (h).

Medicare services are furnished by "providers of services" that have entered into provider agreements with the Secretary of the United States Department of Health and Human Services. 42 U.S.C. §§ 1395x (u), 1395cc. To receive payment from the Secretary, providers are required to comply with the provider agreement, as well as all Medicare statutes and regulations. 42 U.S.C. § 1395cc(b) (2).

From its inception, Medicare reimbursed hospitals for all reasonable incurred costs related to providing medical care to patients. The Medicare Act defines "reasonable cost" as "the cost actually incurred," less any costs "unnecessary in the efficient delivery of needed health services." 42 U.S.C. § 1395x (v) (1) (A). Under the historical system of reasonable cost reimbursement, no reimbursement distinction turned on whether costs were reported as operating costs (the day-to-day expenses incurred in running a business) or graduate medical education costs. Medicare paid its full pro rata share of all allowable graduate medical education costs and operating costs actually incurred, consistent with
Hospitals devote significant time and effort to establishing and updating their Charge Master which is a detailed list of full charges for each good and service provided.\(^{118}\) However, hospitals establish these charges with the clear expectation that they will receive only a portion of these so-called “full charges”.\(^{119}\) For example, in one case the court noted that the hospital’s “full” or “published” charges for 1997 were about 300\% of the hospital’s costs.\(^{120}\) The same case notes that hospitals actually recover their full charges only one to three percent of the time.\(^{121}\) More recently the national average full charge rate was about 345\% of costs.\(^{122}\) Private payors such as insurance companies and HMO’s pay a negotiated rate which is contractually discounted.\(^{123}\) The

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The statutory requirement preventing shifting the costs of services incurred on behalf of Medicare beneficiaries to other patients or third party payers. 42 U.S.C. § 1395x (v) (1) (A).

In 1982, Congress modified the Medicare program to require hospitals to render services more economically. In the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), Pub. L. No. 97-248, Congress amended the Medicare Act by imposing a ceiling on the rate-of-increase of inpatient operating costs recoverable by a hospital. Under TEFRA, costs were still reimbursed on a reasonable cost basis, but subject to rate-of-increase limits. The rate-of-increase limit was computed according to a "target amount," which, in turn, was calculated according to a hospital's allowable net Medicare operating costs in the hospital's base year. See 42 U.S.C. § 1395ww(b); 42 C.F.R. § 413.40(c) (2002).

In 1983, Congress amended the Medicare Act again, establishing a prospective payment system for reimbursing inpatient operating costs of acute care hospitals. See 42 U.S.C. § 1395ww(d). Hospitals now are reimbursed on the basis of prospectively determined national and regional rates for each discharge, rather than on the basis of retrospectively determined reasonable costs incurred. Under this system, payment is made at a predetermined rate for each hospital discharge, according to the patient's diagnosis.

See Lagnado supra note 11 at A-6 col. 3 (quoting William McGowan, chief financial officer of the University of California, Davis, Health System with 30 years of experience in hospital finances. With regard to pricing and billing Mr. McGowan says "There is no method to the madness." The current reimbursement system for hospitals is in need of drastic reform. Mr. McGowan says "We have…allowed the industry to develop a system we all know is broken"). Id.\(^{118}\) See supra notes 11-19 and accompanying text.

Id.\(^{119}\)

See Temple University Hospital, Inc., v. Healthcare Management Alternatives, Inc. 832 A.2d 501 (Pa. 2003) at 509.\(^{120}\) Id. at 508.\(^{121}\) See Love or Corruption supra note 11 at 3 (discussed supra at note 15).\(^{122}\) See supra notes 11-19 and accompanying text.
reimbursement on average is about 40% of a hospital’s “full” or “published” charge. It is estimated that HMO’s pay about 55%-60% of list price, while government payors such as Medicare and Medicaid generally pay less. Each contract insurer and health maintenance organization negotiates its own reimbursement rate and information regarding reimbursement rates is kept confidential. Technically every patient is billed the “full charges” because this allows the hospital to establish that these very inflated prices are really its "usual charges". This is important because Medicare regulations prohibit providers from charging Medicare “substantially in excess” of the hospital’s “usual charges”.

However while all patients and payors are billed the “full charges”, the only ones actually expected to pay these charges are those patients without medical insurance. Hospitals feel financial pressure to set their “full charges” or charges reflected on their Charge Master as high as possible because the higher the “full charge” the greater the reimbursement amount the hospital receives because reimbursement rates are often set as a percentage of the hospital’s “full charge.” Another factor that causes the “full

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124 See Temple University Hospital, Inc. v. Healthcare Management Alternatives, Inc. 832 A.2d 501 (Pa. 2003) at 509 (“In addition, Dr. Dobson testified that private payors typically paid 121% of the cost of hospital services in 1994, 119% in 1995, and 112% in 1996. Government payors generally pay less.”) Id.

125 Id. (thus, list prices are set at 300% of cost while reimbursement is 112% of cost – e.g., if cost is $5.00, list price is 15 and reimbursement by private payors is 112% of cost or $5.60 or 5.60/15.00 = 37% of list price).

126 Id.

127 See Lagnado supra note 11 at A6 col. 6 (“…high list prices have been a negotiating tool for hospitals in dealing with HMO's that demand big discounts.”) Id.; Jones supra note 11 at 29 (“Unfortunately, the exact predetermined fixed rates paid by managed care plans are carefully guarded secrets. Our research disclosed that every private managed care contract contains a confidentially provision.”). Id.

128 See Medicare Provider Reimbursement Manual (PRM) § 2203; 42 U.S.C. 1320 a-7(b)(6).

129 See Lagnado, supra note 11 A6 at col. 4 (noting that only uninsured patients are expected to pay full charges). Id.

130 See Love or Corruption supra note 11 at 4 (listing annual budgeting, consequential reductions from insurance contracts, consequential reduction of governmental "stop loss" reimbursement and consequential loss of Medicare outliers as reasons charges are so high and hospitals reluctant to lower them.) Id. Interestingly it is not a violation of federal regulations for hospitals to set high full charge rates that do not relate closely to costs. Id. at 9.
The "full charge" amount must be set very high to make the hospital's budget balance. In addition, federal “stop loss and outlier” reimbursement provisions also encourage hospitals to set very high charges and raise them often.

While all uninsured patients are expected to pay the hospital’s “full charges” it appears that in fact less than five percent actually pay the full charge. Even though most uninsured patients do not actually pay the full charge, the burden created by this debt and the often harsh collection tactics used on behalf of many hospitals by their debt collectors can devastate uninsured patients. Moreover, hospitals have generally refused to discount their “full charges” because this could dramatically lower the payments they receive under existing contracts with private insurers, HMO’s, and the government.

There are a number of federal rules and statutes that discourage hospitals from discounting charges and/or waiving co-insurance payments. Essentially, by reducing

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131 Id.
132 Id.
133 Id at 5-8 (explaining why the rules for outlier reimbursement encouraged hospitals to raise their list prices and noting that while the rules are influx its not clear the problem has not been solved.) Id.
134 See Temple University Hospital, Inc. v. Healthcare Management Alternatives, Inc. 832 A.2d 501 (Pa. 2003) at 506 (“...ninety-four percent of the time hospitals receive less than eighty percent of the hospitals published rates.”) Id.
135 See, e.g., Lagnado supra note 1, 5 and 11; Lucette Lagnado, Twenty Years and Still Paying Wall St. J., March 13, 2003 B1 col. 2 (discussing Quinton White, 77 years old. and his struggle to pay for his late wife’s ballooning hospital bill for the past 20 years); Lucette Lagnado, Hospitals Try Extreme Measures to Collect Their Overdue Debts Wall St. J., October 30, 2003, p. 1 col. 4 (discussing the harsh tactics used by hospitals including body attachment or civil arrest warrants to enforce the excessively high bills of the uninsured); Lucette Lagnado Taming Hospital Billing: Lawmakers Push Legislation to Curb Aggressive Collection Against Uninsured Patients Wall St. J., June 10, 2003 B1 col. 2 (discussing harsh collective tactics used on behalf of hospitals); Lucette Lagnado, Dunned for Old Bills, Poor Find Some Hospitals Never Forget Wall St. J., June 8, 2001 p. 1 col. 5 (discussing harsh collection tactics of hospitals and the devastating impact on uninsured patients).
136 See supra notes 130-133 and accompanying text.
137 See Love or Corruption supra note 11 at 12 (“A panoply of federal rules and statutes also have discouraged hospitals from discounting and waiving co-insurance payments.”) Id. There has been some discussion of these issues but whether progress has been made is hard to tell. See, e.g., Lucette Lagnado,
its full charges or by waiving co-payments a hospital may be jeopardizing its Medicare and Medicaid reimbursement, and perhaps its reimbursement from HMO’s and contract insurers as well. This is something no hospital can afford to do. As noted, all of these payors negotiate contractual discounts that are often expressed as a percentage of the hospital’s “usual charges.” The problem for the hospital is that if they reduce their “full charge” for uninsured patients then they are vulnerable to the argument that their real “usual charge” is not that contained on the hospital’s “Charge Master” but is in fact the reduced rate at which it bills the uninsured. There is a narrow exception in the federal regulations that allows hospitals to waive or reduce its usual or full charges for the indigent but this is acceptable only after the hospital determines in good faith that the individual is in “financial need” or “fails to collect…after making good faith collection efforts.” The Provider Reimbursement Manual (PRM) does allow for write-offs (not waivers) based on financial or medical indigency but provides that indigency: “Must be determined by the provider,” not based merely on a signed patient declaration of inability to pay. Providers must consider cash and assets (other than those required for

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**Hospitals Will Give Price Breaks to Uninsured, if Medicare Agrees: They Concede Many Charges Aren’t Fair to the Needy But Blame Federal Rules** Wall St. J., December 17, 2003 p. 1 col. 5 (discussing the American Hospital Associations claim that Medicare regulations prevent hospitals from reducing prices for the uninsured); Lucette Lagnado, *HHS Chief Rebukes Hospitals for their Treatment of Uninsured*, Wall St. J., February 20, 2004 p. 1 col. 5 (discussing HHA’s claim that hospitals had mischaracterized government policy and were simply not correct in arguing that complex federal rules left them no choice but to bill the uninsured full price); Lucette Lagnado, *New York State Hospitals Agree to Cut Prices for Uninsured* Wall St. J., February 2, 2004 B-1 col. 2 (hospitals in New York State have agreed to a voluntary program to cut prices and provide charity care for their poorest patients.); Rhonda L. Rundle, *Activist for Uninsured Needles Hospitals – And Draws Blood*, Wall St. J., June 19, 2003, A-1 col. 1 (Tenet Healthcare Corp. announced a “Compact with Uninsured Patients” in which they pledge to start giving discounts to uninsured people similar to the discounts it offers managed-care companies).

138 See * supra* notes 134-137 and accompanying text.

139 *Id.*

140 *Id.*

141 *Id.*


143 See Provider Reimbursement Manual *Supra* note 128 at 312.

144 *Id.*
daily living) which are “convertible to cash” and verify the absence of any other legally
responsible payment source.145 The file “should contain documentation of the method by
which indigence was determined in addition to all backup information” used to
“substantiate the [indigency] determination.”146 The Office of the Inspector General
(“OIG”), which has the power to terminate Medicare participation, also requires vigorous
collection efforts and has denied bad debt reimbursements for write-offs based on patient
provided financial information.147

Moreover, Medicare provides hospitals a dollar for dollar credit for Medicare bad
debt (i.e. unpaid deductibles or co-insurance) but only if the provider undertook
reasonable collective efforts.148 This requires that collection efforts for Medicare and
non-Medicare patients be similar.149 For example, in Mt. Sinai Hospital v. Shalala150 the
government refused to reimburse the Hospital for bad debt because the collection efforts
used for Medicare and non-Medicare accounts were different.151 The hospital’s attempts
to collect both Medicare and non-Medicare accounts were identical during the first 120
days the debts were outstanding.152 During this time the collection effort was handled
directly by the hospital.153 After 120 days non-Medicare debts over $50.00 were turned

145 Id.
146 Id.
147 See Shalala v. St. Paul-Ramsey Medical Center, 50 F. 3d 522 (8th Cir. 1995)(denials of bad debt
reimbursement due to reliance on patient provided financial information).
148 See 42 C.F. R. § 413.80e (requires provider to undertake reasonable collection efforts).
149 See Provider Reimbursement Manual supra note 128 at 310 (noting that “where a provider expends less
effort to collect from some patients than from others” its policy is deemed contrary to Medicare Policy
because it is inconsistent). Id. In a February 2004 letter the Centers for Medicare and Medicaid Services
noted that hospitals may waive self-payments for indigent or medically indigent patients uniformly, but
may not claim bad debt for such voluntarily reduced collections from indigent Medicare patients.
Otherwise collections policies against all non-indigent patients should be uniform. See Love or Corruption
supra note 11 at 15.
150 196 F.3d 703 (7th Cir. 1999).
151 Id. 705.
152 Id.
153 Id.
over to various collection agencies for further effort at settling the accounts.\textsuperscript{154} The Medicare debt however was submitted to Medicare for reimbursement as bad debt.\textsuperscript{155} The hospital argued that, given the low rate of return expected on its Medicare accounts, (the hospital was located on the west side of Chicago and served an impoverished area; 82 percent of the hospitals revenue came from Medicare) referral of these accounts to a collection agency would not be cost effective.\textsuperscript{156} In addition, the hospital argued that referral of Medicare accounts to collection agencies might prevent needy patients from seeking treatment.\textsuperscript{157} The hospital lost, and was denied reimbursement of its Medicare bad debts for the years involved.\textsuperscript{158} In February 2004 the Centers for Medicare and Medicaid Services (CMS) noted that hospitals may waive self payments for indigent or medically indigent patients including Medicare patients, uniformly, but the hospital may not claim bad debt reimbursement for such voluntarily reduced collections from indigent Medicare patients.\textsuperscript{159}

As a result of these rules and regulations hospitals are engaged in an odd type of price discrimination.\textsuperscript{160} That is, the amount the hospital requires a patient to pay changes depending on who, if anyone, provides the patients insurance.\textsuperscript{161} The type of price discrimination practiced by hospitals is odd because they are not segmenting the market by demand and charging more to high demand/high net worth patients.\textsuperscript{162} Rather, the price discrimination practiced by hospitals is a consequence of the third party

\begin{footnotes}
\footnote{154}{\textit{Id.}}
\footnote{155}{\textit{Id.} at 705-706.}
\footnote{156}{\textit{Id.} at 709.}
\footnote{157}{\textit{Id.}}
\footnote{158}{\textit{Id.} at 711.}
\footnote{159}{See supra note 148.}
\footnote{160}{See supra notes 11-13 and accompanying text.}
\footnote{161}{\textit{Id.}}
\footnote{162}{See Klock \textit{supra} note 12 at 327-33 (discussing price discrimination).}
\end{footnotes}
reimbursement system and the ill conceived and inconsistently applied rules that govern the reimbursement system.\textsuperscript{163} Notwithstanding the odd nature of hospitals’ price discrimination, it is nevertheless grossly unfair to uninsured patients.\textsuperscript{164} The result is that charges to the uninsured are outrageously high, but hospitals are very reluctant to write-off or forgive the debt of uninsured patients who do not pay in full and hospitals feel forced to use tough and often harsh collection tactics in order to qualify for bad debt reimbursement under federal regulations.\textsuperscript{165}

The basic unfairness is patent; there is no good reason why one patient should be expected to pay two or more times the amount paid by other patients for the same exact services and goods provided by the same hospital.\textsuperscript{166} The uninsured should not be forced to compensate hospitals for losses incurred as a result of federal requirements and contracts with insurers.\textsuperscript{167} Nor should the uninsured be burdened with the obligation to pay exorbitant charges that are the result of the hospitals desire to maximize reimbursement from third party payors.\textsuperscript{168} The contention that the principal of freedom of contract gives a hospital the right to unilaterally set a price for its services that bears no relationship to either the cost of the goods or services or to the amount customarily paid for such goods or services is untenable.\textsuperscript{169} The fact that an uninsured patient has signed a

\textsuperscript{163} See supra notes 108-160 and accompanying text.
\textsuperscript{164} Id.; see Temple 832 A.2d at 509 (hospitals list prices were "designed to offset the shortfall caused by its federal mandate to treat indigent patients.") Id.
\textsuperscript{165} See supra notes 108-162 and accompanying text.
\textsuperscript{166} This of course is true of all price discrimination and has caused one commentator to state ".\ldots if price discrimination is not unconscionable, then what is?" See Klock supra note 12 at 353.
\textsuperscript{167} See supra note 162; Lagnado, supra note 11 at A6 col. 4 (With regard to the excessive list prices or full charges the author notes: "Buffeted by managed care, squeezed by federal and state governments and overrun with patients who either couldn't pay or lacked coverage, hospitals felt they had no choice but to develop aggressive survival strategies.") Id.
\textsuperscript{168} See supra note 137.
\textsuperscript{169} See St. John's Episcopal Hospital v. McAdoo 405 N.Y.S. 2d 935 (N.Y. Civ. Ct. 1978) ("This is exactly the type of situation in which a flexible application of the doctrine of inviolability of contract is warranted to permit appropriate judicial compassion and understanding") Id.; Temple 832 A.2d at 510 ("The
hospital admission form that says he agrees to pay the hospital’s ”full charges” does not change the unfairness of hospital pricing.\textsuperscript{170} Given the circumstances of hospital admissions, the nature of medical services, and the inflated level of “full charges”, the argument that the patient’s express agreement to pay the hospital’s “full charges” should be enforced, is grossly unfair and places form over substance.\textsuperscript{171} It is just this sort of grossly unfair result that the doctrine of unconscionability prevents and in so doing strengthens the principal of freedom of contract.\textsuperscript{172}

**PART IV: CASE LAW**

**A. CASE LAW: PROCEDURAL UNCONSCIONABILITY**

Many courts have found that hospital admission contracts are procedurally unconscionable. In *Tunkl v. Regents of University of California*\textsuperscript{173} the defendant hospital presented all incoming patients with a document titled “Conditions of Admission” which included an exculpatory clause pursuant to which the patient released the hospital from liability for negligent or wrongful acts.\textsuperscript{174} In refusing to enforce the agreement the court noted that “the would-be patient is in no position to reject the proffered agreement, to bargain with the hospital, or in lieu of agreement to find another hospital”.\textsuperscript{175} The court in *Tunkl* concluded therefore that the patient had no realistic choice but to assent to the

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\textsuperscript{170} See supra notes 108-165 and accompanying text.

\textsuperscript{171} Id.

\textsuperscript{172} Id.

\textsuperscript{173} 383 P.2d 441 (1963).

\textsuperscript{174} Id. at 442.

\textsuperscript{175} Id. at 447.
standardized agreement under which he waived his right to recover for negligently inflicted injuries.\textsuperscript{176}

In \textit{Wheeler v. St. Joseph Hospital}\textsuperscript{177} Mr. Wheeler was admitted to the hospital for an angiogram and catheterization studies in connection with a coronary insufficiency.\textsuperscript{178} The following morning, shortly after the tests were performed, Mr. Wheeler suffered a brain stem infarction rendering him a total quadriplegic with inability to speak or communicate except with his eyes.\textsuperscript{179} At issue was an arbitration provision that was included in an agreement titled “Conditions of Admission” that Mr. Wheeler signed when he was admitted to the hospital.\textsuperscript{180} The agreement included a paragraph titled “Arbitration Option” which provided:

If patient, or undersigned, does not agree to the “Arbitration Option” then he will initial here \(\underline{____} \). The undersigned certifies that he has read the foregoing, receiving a copy thereof, and is the patient, or is duly authorized by the patient as patient’s general representative to execute the above and accept its terms.\textsuperscript{181}

The agreement provided that the patient could opt out of arbitration either by placing his initials in the space provided or in the alternative, by notifying the hospital in writing within 30 days of his discharge.\textsuperscript{182} Mrs. Wheeler stated that her husband signed the admission agreement without reading it; no one at the hospital called their attention to the arbitration option, either before or after her husband signed the agreement; that neither

\textsuperscript{176} Id.
\textsuperscript{177} Id. at 779.
\textsuperscript{178} 133 Cal. Rptr. 775 (1976).
\textsuperscript{179} Id. at 778.
\textsuperscript{180} Id. at 779.
\textsuperscript{181} Id. at 780.
\textsuperscript{182} Id.
The court focused on the question of whether there was an enforceable agreement to arbitrate. The court noted that there was nothing in the record to show, and the plaintiffs did not contend that the hospital would have denied Mr. Wheeler admission if he had declined to agree to the arbitration provision. The court also noted that California has a public policy in favor of arbitration but only if it is voluntarily agreed to by all of the parties. Thus, the issue as the court saw it was whether under the circumstances, Mr. Wheeler had voluntarily agreed to arbitrate.

The court recognized that the hospital admission agreement possess all of the characteristics of a contract of adhesion. The court described adhesion contracts as standardized contract forms offered to consumers on essentially a take it or leave it basis; without a realistic opportunity to bargain; under conditions that result in the consumer being unable to obtain the goods or services except by acquiescing to the form contract. The court cited the following language from the Tunkl case:

The would-be patient is in no position to reject the proffered agreement, to bargain with the hospital, or in lieu of agreement to find another hospital. The admission room of a hospital contains no bargaining table where, as in a private business transaction, the parties can debate the terms of their contract. As a result, we cannot but conclude that the instant agreement manifested the characteristics of the so-called adhesion contract.

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183 Id.
184 Id. at 781.
185 Id.
186 Id. at 782.
187 Id.
188 Id. at 783.
189 Id.
190 Id.
191 Id.
The court then stated: "To the ordinary person, admission to a hospital is an anxious, stressful, and frequently a traumatic experience." As a result, the patient cannot reasonably be expected to read the printed agreement in detail much less to fully comprehend its terms. A patient is usually directed by his treating physician to be admitted to the hospital where the doctor enjoys staff privileges. The court notes that unless the patient is advised by his doctor to the contrary, he normally feels he has no choice but to seek admission to the designated hospital and to accede to all of the terms and conditions for admission, including the signing of all forms presented to him.

The court concluded that 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. To believe otherwise would, according to the court, "require us to ignore the stress, anxiety, and urgency which ordinarily beset a patient seeking hospital admission". The court found that Mr. Wheeler was not bound to the arbitration provision.

In *Phoenix Baptist Hospital v. Aiken*, Thomas Aiken took his wife Patricia Aiken to the hospital for emergency medical care. At the time of his wife's admission Thomas signed a "Financial Agreement" which provided in part as follows:

The undersigned agrees (whether signing as agent, representative, or as patient, and whether or not insured or a member of a 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

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192 Id. at 786.
193 Id.
194 Id.
195 Id.
196 Id. at 790.
197 Id.
198 Id.
200 Id. at 1348.
hospital in accordance with the regular rates and terms of the hospital
unless otherwise agreed in writing by the hospital corporation. Should the
hospital account be referred for collection, the undersigned agrees to pay
reasonable collection expenses, counsel fees, and court costs…

The issue in the case was whether the agreement was enforceable so that Thomas was
liable from his personal assets for the medical services provided to his wife. He
claimed the agreement was unconscionable and therefore unenforceable. The court, in
discussing the procedural unconscionability of the agreement, noted that Thomas
hurriedly signed the agreement under extremely stressful circumstances without having
the terms of the agreement explained to him. The court concluded that the trier of fact
could have concluded that Thomas did not understand the implications of the agreement,
or that he felt he had no choice but to immediately sign the printed form. In denying
the hospitals request for summary judgment, the court concluded that there was a material
issue of fact as to the unconscionability of the procedure used to obtain the agreement.

Finally, in St. John's Episcopal Hospital v. McAdoo the issue concerned
whether Charles McAdoo's signature on a standard form contract prepared by the hospital
bound him to pay his estranged wife's medical fees. The court noted the basic contract
law principal that a literate, competent adult is ordinarily held legally responsible for his
contractual obligations once he signs a contract. The court went on to note that "there
are circumstances under which a reasonable person might sign a contract, without reading

201 Id. at 1347.
202 Id. at 1348.
203 Id. at 1349.
204 Id.
205 Id. at 1350.
206 Id.
208 Id. at 936.
209 Id.
or understanding it, so that requiring adherence to its terms would be grossly unfair.\textsuperscript{210} The court then recognized the trauma and anxiety experienced by those confronted with an emergency medical crises 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.\textsuperscript{211} A reasonable person according to the court would give a hospital admission contract at most cursory attention.\textsuperscript{212} The court concluded that a hospital "should not be permitted to enforce a contractual obligation entered into under such tension-laden circumstances….\textsuperscript{213}

Hospital admission contracts relating to necessary medical services are procedurally unconscionable even if the medical services are not sought on an emergency basis. In a case where a patient's doctor has determined that hospitalization will be necessary for the treatment of the patient's medical condition but the treatment is not on an emergency basis, the patient may visit the hospital days or even a week or two before admission.\textsuperscript{214} At this initial visit the patient may sign his admission forms and be provided with copies of them.\textsuperscript{215} In addition, in this somewhat more relaxed setting of admissions (rather that the emergency room) the hospital staff may take more time to explain, and the patient may be better able to understand, the terms of the admission contract.\textsuperscript{216} Theoretically, at least, it may be possible, though practically unlikely, for the patient to have the admission contract reviewed by counsel after the initial visit to

\begin{itemize}
\item \textsuperscript{210} Id.
\item \textsuperscript{211} Id. at 937.
\item \textsuperscript{212} Id.
\item \textsuperscript{213} Id.
\item \textsuperscript{214} Cf. McAdoo 405 N.Y.S. 2d 935 at 937 (discussing the stress a lack of time to read closely or discuss medical admission forms.)
\item \textsuperscript{215} Cf. Wheeler 133 Cal. Rptr. 775 at 786 (discussing the fact that the arbitration option contained in the admission forms was not explained nor was the patient provided with a copy of the form.)
\item \textsuperscript{216} Id.
\end{itemize}
admissions but prior to the patient's actual admission to the hospital.\textsuperscript{217} Thus, it is possible, though still unlikely, that the patient in this non-emergency context may be fully aware that he is obligating himself to pay the hospital’s "full charge" and even aware that because he is uninsured this is many times the amount an insured patient would be expected to pay for the same medical care.\textsuperscript{218} Even if the patient is "fully aware" of the provisions and their meaning in the admission contract before signing it, the admission contract is still procedurally unconscionable. The reasons for this are several, but they all spring from the nature of necessary medical services.\textsuperscript{219} Necessary medical services are necessary so that even if the patient has some choice as to timing he has no real choice concerning his need for the service.\textsuperscript{220} A patient's hospital choice is determined largely by his doctor.\textsuperscript{221} That is, the patient goes to the hospital he is directed to go to by his doctor because this is the hospital where his doctor is on the staff.\textsuperscript{222} Moreover, regardless of which hospital the patient is directed to, virtually all will require his agreement to pay "full charges" because as discussed this stems from the Medicare and Medicaid requirements to which virtually all hospitals are subject.\textsuperscript{223} Thus, even in the case of "planned" as opposed to "emergency" necessary medical services, hospital admission agreements are procedurally unconscionable.\textsuperscript{224}

\textsuperscript{217} See Richard M. Alderman, The Business of Medicine – Health Care Providers, Physicians, and the Deceptive Trade Practices Act 26 HOUS. L. REV. 109 (1989) (The author notes that the health care consumer views the industry as a profession separate from the average business, and often placed unqualified trust in the physician, is reluctant to question any aspect of treatment, including billing and collection and is much, much more focused on results then costs, especially at the time of seeking treatment) \textit{Id.} at 112 and 139.
\textsuperscript{218} See generally Lagnado supra note 11 (discussing a California law requiring disclosure by hospitals in the state of their Charge Masters.)
\textsuperscript{219} See generally Lagnado supra note 11 (discussing a California law requiring disclosure by hospitals in the state of their Charge Masters.)
\textsuperscript{220} \textit{Id.}
\textsuperscript{221} \textit{Id.}
\textsuperscript{222} \textit{Id.}
\textsuperscript{223} See supra notes 108-170 and accompanying text.
\textsuperscript{224} See supra notes 212-220 and accompanying text.
B. CASE LAW: SUBSTANTIVE UNCONSCIONABILITY

Substantive unconscionability is often defined in terms of oppression, overreaching and unfair surprise.\textsuperscript{225} A hospital admission contract is likely to be found unfair if it contains harsh terms contrary to common expectation and common fairness that have been effectively forced on the patient.\textsuperscript{226} For example, in \textit{Wheeler}\textsuperscript{227} the hospital admission contract included a term requiring the patient to arbitrate any claims against the hospital.\textsuperscript{228} In refusing to enforce the provision, the court concluded that it represented an unfair surprise.\textsuperscript{229} The court states:

The manifest objective of a medical entity in including an arbitration clause is to avoid a jury trial and thereby hopefully minimize losses for any medical malpractice and correspondingly to hold down the amount of any recovery by the patient. The law ought not to decree a forfeiture of such a valuable right where the patient has not been made aware of the existence of an arbitration provision or its implications. Absent notification and at least some explanation, the patient cannot be said to have exercised a "real choice" in selecting arbitration over litigation. We conclude that in order to be binding, an arbitration clause incorporated in a hospital's "Conditions of Admission" form should be called to the patient's attention and he should be given a reasonable explanation of its meaning and effect, including an explanation of any options available to the patient.\textsuperscript{230}

In \textit{Wheeler} the courts concern with the patients awareness of the terms of the admission contract makes sense because the agreement allowed the patient to opt out of arbitration by initialing the form or objecting to arbitration within 30 days of discharge.\textsuperscript{231} However, hospital admission contracts do not allow patients to opt out of agreeing to pay

\textsuperscript{225} See supra notes 84-107 and accompanying text.  
\textsuperscript{226} Id.  
\textsuperscript{227} Id. at 780.  
\textsuperscript{228} Id. at 786.  
\textsuperscript{229} Id.  
\textsuperscript{230} Id. at 780.  
\textsuperscript{231} Id. at 780.
full charges. Moreover, the *Wheeler* court recognized that the context of hospital admission is such that unexpected or harsh terms in hospital admission contracts may be unfair even if the patient is aware of them because the patient has no choice but to agree. The *Wheeler* court states:

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. To posit otherwise would require us to ignore the stress, anxiety, and urgency, which ordinarily beset a patient seeking hospital admission.

Both the *Aiken*'s and *McAdoo* courts apply similar reasoning to conclude that provisions of hospital admission contracts may be unenforceable. Both cases involve provisions that impose personal liability on the signer even though the party signing the agreement was *not* the patient. In *Aiken*, Thomas Aiken took his wife to the hospital after she suffered a heart attack and signed the admission form without reading it. Likewise in *McAdoo*, Mr. McAdoo took his estranged wife to hospital fearing she was near death and did not read carefully or question the admission forms he signed. In addressing the enforceability of the provisions imposing personal liability both courts focused on the reasonable expectations of the party signing the agreement. Both courts noted that as a result of the circumstances surrounding hospital admissions the signer

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232 See *supra* note 113.
233 *Wheeler* 133 Cal. Rptr. at 789-790.
234 *Id.* at 789.
237 See *infra* notes 236-254 and accompanying text.
238 See *supra* notes 197-211 and accompanying text.
240 *Id.* at 1347-48.
242 *Id.* at 936.
243 *Aiken*, 877 P.2d at 1349-50; *McAdoo*, 405 N.Y.S. 2d at 937.
could not be expected to give the written agreement careful consideration.\textsuperscript{244} Thus, the courts focused on whether the provisions included in the admissions contract are the ones that a reasonable person would expect to find in such a contract.\textsuperscript{245} The \textit{Aiken}’s case involved an appeal from the grant of summary judgment in favor of the hospital; the court noted, "We must consider, then, whether it was beyond Thomas' reasonable expectations to have liability imposed upon his separate property."\textsuperscript{246} The court concluded that the "evidence creates a material issue of fact as to Thomas' reasonable expectations."\textsuperscript{247} In \textit{McAdoo}, the court discussed "whether a reasonable person should have expected to find such a clause in the particular instrument he was signing."\textsuperscript{248} The court concluded that the clause was beyond reasonable expectations and concluded that the hospital "should not be permitted to enforce a contractual obligation entered into under such tension-laden circumstances."\textsuperscript{249}

The agreement of a patient to pay a hospital’s "full charges" or "regular rates" sounds reasonable.\textsuperscript{250} However, closer examination reveals that in fact the patient is agreeing to a grossly exorbitant and unfair price that on average is 365 percent of the hospital’s cost,\textsuperscript{251} a price that is set with little, if any, reference to the value or cost of goods and services sold,\textsuperscript{252} a price that is set to be discounted and that is in fact heavily discounted 95 percent of the time.\textsuperscript{253} Moreover, most patients are expected to pay only a

\textsuperscript{244} \textit{Aiken} 877 P.2d at 1349-50; \textit{McAdoo} 405 N.Y.S. 2d at 937.
\textsuperscript{245} \textit{Aiken} 877 P.2d at 1349-50; \textit{McAdoo} 405 N.Y.S. 2d at 937.
\textsuperscript{246} \textit{Aiken} 877 P.2d at 1349.
\textsuperscript{247} \textit{Id.} 1350.
\textsuperscript{248} \textit{Id.} 405 N.Y.S. 2d at 937.
\textsuperscript{249} \textit{Id.}
\textsuperscript{250} \textit{See supra} notes 14-18 and accompanying text.
\textsuperscript{251} \textit{See supra} notes 108-178 and accompanying text.
\textsuperscript{252} \textit{Id.}
\textsuperscript{253} \textit{Id.}
fraction of this full price for the same exact goods and services. In effect, the uninsured
patient by agreeing to pay "full charges" is agreeing to pay a huge premium for all goods
and services received. Such an agreement is well beyond the reasonable expectations
of an ordinary person and is grossly and shockingly unfair.

V. ANALYSIS: UNCONSCIONABILITY AND HOSPITAL ADMISSION AGREEMENTS THAT
REQUIRE UNINSURED PATIENTS TO PAY FULL CHARGES

In all price unconscionability cases the same obvious and troubling questions
arise. First, why would anyone agree (assuming there has been no fraud, duress,
mistake, etc. which is a reasonable assumption or we would not need to use
unconscionability to invalidate the contract) to pay a price that is grossly unfair?
That is, if there is one term above all others of which the buyer is likely to be acutely

254 Id.
255 See Klock supra note 12 at 327-333 (discussing that calling a lower price for some consumers a
"discount" is simply marketing, the economic reality is that all other consumers are in fact paying a
premium). Id.
256 See Temple 832 A.2d at 508 (noting that the important question regarding a hospitals published rates is
not whether they are higher or lower than other hospitals published rates, but what the hospital actually
receives for its services, and since the hospital received its published rates rarely, those rates cannot be
considered the value of the benefit conferred.) Id.
257 See Darr supra note 50 at 1821 ("Of all the terms in a contract, the one most assuredly understood by the
buyer is the price term.") Id. Darr goes on to note that "Thus, neither traditional rules of contract nor the
classic economics on which they are based support the doctrine of price unconscionability." Id. at 1823.
However, the assumptions of classic economics do not always apply in the real world. Thus, in some
situations, like hospital admission, problems with the markets pricing mechanisms arise and remain
uncorrected by the market.
("Ideally, the unconscionability doctrine protects against fraud, duress and incompetence, without
demanding specific proof of any of them") Id. at 302, (also noting that the unconscionability doctrine can
be useful when proof required for fraud etc. is difficult) Id. at 295; Richard Craswell, Property Rules and
may be used to deal with situations of imperfect consent) Id. at 40-41; Klock supra note 12 at 341
(discussing the usefulness of unconscionability because "there is no such thing as…almost duress, or partial
capacity…our system does not contemplate varying degrees of valid consent.") Id.
259 See Darr supra note 50 at 1821.
aware it is the price.\textsuperscript{260} If the price is oppressive why didn't the buyer refuse to agree and walk away from the offered bargain?\textsuperscript{261} This is especially troublesome if the oppressive price is defined in terms of being higher than the price offered by other sellers in the same area.\textsuperscript{262} That is, why didn't the buyer choose to buy from a different seller?\textsuperscript{263}

The other troubling question in excessive price cases is how the court is to determine a "fair" price.\textsuperscript{264} In order to find that the contract price is excessive and to provide an appropriate remedy if it is, the court must determine a "fair" price for the contract.\textsuperscript{265} Even if the court can determine that the contract price is grossly unfair (for example, where there is price discrimination)\textsuperscript{266} and explain why a reasonable buyer would agree to pay a grossly unfair price in the first place, (for example, where the contract terms are complicated, obtuse and confusing)\textsuperscript{267} to resolve the case the court

\begin{flushleft}
\textsuperscript{260} Id.
\textsuperscript{261} Id. However, Darr does recognize an exception in the case of necessities or in cases where reference price information is not readily available. Id. at 1832-1841.
\textsuperscript{262} See supra note 97-103 (defining excessive price in terms of the price charged for like goods in the community).
\textsuperscript{263} Or more to the point why is the buyer worthy of judicial protection if he chose not to protect himself? Of course, in the hospital admission contract cases the buyer has no choice but to sign the forms presented. See supra notes 194-222 and accompanying text.
\textsuperscript{264} Determining the fair value of anything is difficult. See ARTHUR L. CORBIN, CORBIN ON CONTRACTS (1963) at 540-42 ("Very generally we speak of ‘value’ as if it were definite and exact, an easily ascertainable amount of money. In fact, it is always variable, always a matter on which opinions may differ, and frequently one that is very difficult to estimate.") Id. It is no wonder then that courts usually leave price determinations to the parties.
\textsuperscript{265} Id.
\textsuperscript{266} When the seller sells to other buyers at a lower price with no cost justification the higher price is clearly excessive. See Klock supra note 12 at 358-361.
\textsuperscript{267} See, e.g., Williams v. Walker Thomas Furniture 350 F.2d 445 (D.C. Cir. 1965) (confusing terms in contract).
\end{flushleft}
must somehow determine a "fair" price for the contract at issue.\textsuperscript{268} In general, having courts substitute their ex-post judgment for the parties' ex-ante agreement is a bad idea.\textsuperscript{269}

The law deals with the first question by, as discussed supra, requiring both procedural and substantive unconscionability.\textsuperscript{270} That is, in order to find an excessive price contract unenforceable due to unconscionability the price must be oppressively high and there must be some defect in the bargaining process.\textsuperscript{271} This defect will not meet all of the requirements of other policing, formation or disclosure common law doctrines designed to deal with contracting process problems, but there must be some process problem.\textsuperscript{272} For example, in many price cases the buyer’s behavior is explained by the fact that the buyer was unaware of the true price because it was hidden from him in the obtuse terms of the contract, complicated finance charges, hidden fees or all three.\textsuperscript{273}

Commentators have also suggested that buyers may lack appropriate information regarding a reference price at the time of contracting and thus may not be aware of the great disparity between the contract price and a fair price.\textsuperscript{274} Certainly, this reasoning can

\begin{footnotes}
\item[268] As discussed infra in the case of hospital admission contracts the fair price is determined by the hospital itself (i.e. the average charge the hospital receives from governmental agencies and insurance companies for the services rendered to the patient) and the court is not forced to set the price. See infra notes 298-303 and accompanying text.
\item[269] See, e.g., Melvin Aron Eisenberg, The Limits of Cognition and the Limits of Contract, 47 STAN. L. REV. 211 (1995) (noting that contract is based on the "…premise that in making a bargain a contracting party will act with full cognition to rationally maximize his subjective utility." Id. at 211. The author goes on to state: "Parties are normally the best judges of their own utility, and normally reveal their determinations of utility in their promises. Bargain promises are normally made in a deliberative manner for personal gain, and promises so made should normally be kept. Bargains normally create value, enable the parties to plan their future conduct reliably, allocate commodities to their highest-valued uses, and best distribute the factors of production…"). Id. at 211-212. Klock supra note 12 at 347 (listing the undesirable consequences of such action as; creating uncertainty as to the enforceability of contract generally, denying the protected class of people access to the contracted for goods or services; loss of incentive for people to protect themselves) Id.
\item[270] See supra notes 56-107 and accompanying text.
\item[271] Id.
\item[272] See supra note 270.
\item[273] See, e.g., Williams v. Walker Thomas Furniture Co. 350 F.2d 445 (D.C. Cir. 1965). For more cases see Darr supra note 50.
\item[274] See Darr supra note 50 at 1833-39.
\end{footnotes}
be applied to a patient's agreement to pay "full charges." That is, the patient does not know the actual amount in dollars that he is agreeing to pay. Moreover, the patient does not have the necessary information regarding a reference price, thus he does not know that he is agreeing to pay many times what other patients pay for the same goods and services.

However, the usefulness of this analysis in the hospital admissions context is limited because it implies that if only the buyer had known how grossly unfair the price was he never would have agreed to the contract. This conclusion is erroneous in the context of hospital admissions. Patients generally do not understand what they are agreeing to when they sign a hospital admission contract that includes their agreement to pay the hospital’s "full charges" but, even if they did they would still sign the admission contract because what they are purchasing is a necessity and they really do not have any practical ability to go elsewhere for this necessary service.

For example, in Tunkl the admission agreement provided that the patient "releases…the hospital from any and all liability for the negligent or wrongful acts or omissions of its employees…." Tunkl was not decided on the basis of unconscionability, but the courts reasoning and conclusions concerning hospital admission contracts are relevant to the unconscionability analysis. The court notes: "That the services of the hospital to those members of the public who are in special need of the particular skill of its staff and facilities constitute a practical and crucial necessity is

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275 See supra notes 56-83 and accompanying text.
276 Id.
277 Id.
278 Id.
279 Id.
280 Id.
282 Id. at 442.
hardly open to question.\textsuperscript{283} With regard to the terms of the hospital admission contract the court concludes: "...the hospital certainly exercises a decisive advantage in bargaining.\textsuperscript{284} The court goes on to state: "The would-be patient is in no position to reject the proffered agreement, to bargain with the hospital, or in lieu of agreement to find another hospital."\textsuperscript{285} The \textit{Tunkl} court recognizes the fact that even if the patient understands perfectly what he is signing and the legal implications thereof and even if he concludes in his own mind that the terms are grossly unfair, he still has no choice but to agree.\textsuperscript{286} Although, as discussed above, disclosure of the actual price to be paid and the reference price to compare it to is not available to the patient at the time of signing the hospital admission agreement, even if such information were available, the legal conclusion that the agreement to pay "full charges" is grossly unfair would not change.\textsuperscript{287} The problem here is not limited to a lack of disclosure. The problem is that the full charges are discriminatory and are simply too high, especially for something necessary such as medical services. These high prices occur and remain unchecked because the circumstances surrounding hospital admission and pricing result in a market failure such that the problem can't be solved by the market.\textsuperscript{288} Thus, the courts must employ the flexible tool of unconscionability to prevent the injustice and unfairness that the market, because of its failure, allows to occur.\textsuperscript{289}

\begin{itemize}
\item \textsuperscript{283} \textit{Id.} at 447
\item \textsuperscript{284} \textit{Id.}
\item \textsuperscript{285} \textit{Id.}
\item \textsuperscript{286} \textit{Id.}
\item \textsuperscript{287} \textit{See supra} notes 277-284 and accompanying text.
\item \textsuperscript{288} \textit{See supra} notes 108-170 and accompanying text.
\item \textsuperscript{289} \textit{See Darr supra} note 50 at 1841 ("Under these circumstances [market failure] the courts would intervene to protect consumers from unfair prices and practices") \textit{Id.}
\end{itemize}
As discussed above hospitals set their full charges at such a high level because they expect to have the charges discounted.\(^{290}\) Recall that only uninsured patients are expected to pay these full charges and that less than five percent of patients ever pay the "full charges."\(^{291}\) Moreover, the reason hospitals don't simply agree to discount their "full charges" and charge a reasonable price to the uninsured is because they fear that under the federal regulations governing Medicare and Medicaid (a hospital's primary source of funds) discounting for anyone, even for the uninsured, could drastically reduce their reimbursement from Medicare, Medicaid, contract insurers and HMO's.\(^{292}\) From a hospital's point of view, there is no compelling reason to take such an enormous risk.

The result is that the uninsured are victimized much more by circumstance than by intent. An uninsured patient like Mr. Shipman\(^ {293}\) or Ms. Nix\(^ {294}\) is charged such a high amount almost by mistake.\(^ {295}\) The hospital's charges were not set with any real consideration that an individual would actually pay the charge.\(^ {296}\) The full charges are set to be discounted.\(^ {297}\) They are set so high because they must allow the hospital to receive sufficient revenue to continue to operate after the full charges have been reduced by an

\(^{290}\) See supra notes 118-170 and accompanying text.

\(^{291}\) Id.

\(^{292}\) Id.

\(^{293}\) See supra notes 1-18 and accompanying text.

\(^{294}\) Id.

\(^{295}\) There is no intent on the part of hospitals to treat the uninsured unfairly. In fact, some hospitals claim to want to reduce the amount they charge to the uninsured, but feel they can't under existing federal rules. See Lucette Lagnado, *Hospitals Will Give Price Breaks to Uninsured, If Medicare Agrees* Wall St. J., December 17, 2003 p. 1 col. 5 (hospitals concede many charges aren't fair to the needy but blame federal rules). Id.; Cf. Lucette Lagnado, *HHS Chief Rebukes Hospitals for their Treatment of Uninsured* Wall St. J., February 20, 2004 p. 1 col. 5 (HHS Secretary claims hospitals may cut charges to uninsured without fear of government reprisals) Id.

\(^{296}\) See supra notes 108-170 and accompanying text.

\(^{297}\) Id.
average 60 percent. However, the fact that the uninsured are not intended victims does not mean that they are any less victimized by hospital billing.

The second problem in price unconscionability cases is that judicial price setting is certainly inconsistent with a free market and is usually to be avoided. This is because a court is usually ill equipped to determine a reasonable value or fair price. However, the unique circumstances of hospital billing allows for the complete avoidance of the judicial price setting problem. The court is not required to set the price because the hospitals have, in fact, already set a reasonable price. An uninsured patient should be required to pay the average amount the hospital actually receives (not the amount it bills and then discounts) and accepts as full payment from Medicare, Medicaid, contract insurers and HMO's for the diagnostic code that applies to the medical goods and services received by the patient. This amount can be easily and objectively determined and does not require court involvement in judicial price setting.

An uninsured patient's agreement to pay a hospital’s full charges is unconscionable regardless of whether the uninsured patient is rich or poor. The factors

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298 Id.
299 Id.
300 See supra note 262.
301 Id.
302 As courts have noted the reasonable value of a hospitals goods and services is the average amount the hospital actually collects for such goods and services. This amount may be readily ascertained by examination of the hospitals contracts with governmental agencies, HMO's and contract insurers. See, Temple 832 A.2d at 509-510 (hospital may not recover billed "full" charges but may recover average collection rate for years in question) Id.; River Park Hospital v. Bluecross Blueshield of Tennessee, Inc. 2002 WL 31302926 (Tenn. Ct. App.) (similar).
303 Id.
304 Id.
305 Id.
306 That is, necessary medical services are necessary whether the patient is rich or poor. A rich patient has no more knowledge than a poor patient regarding hospital billing practices. Thus, a rich patient is no more likely to know that by agreeing to pay full charges or list prices he is agreeing to pay a huge premium. See Klock supra note 12 at 382 (“Sometimes the people discriminated against are poorer and less educated, are affluent or educated, or are corporate entities. Does it make a difference? If so, is that not analogous to suggesting that it is acceptable to steal from insurance companies, but not from individuals?”) Id.
that result in the unconscionability of such provisions when applied to poor uninsured patients apply equally well to wealthy uninsured patients.\textsuperscript{307} The unconscionability springs from several factors.\textsuperscript{308} First, the medical services are necessary and thus the patient, rich or poor, has no choice but to sign the forms presented by the hospital.\textsuperscript{309} Second, the patient rich or poor has no idea from the agreement that he is agreeing to pay a huge premium over the amount paid for the same goods and services by insured patients.\textsuperscript{310} Finally, the price discrimination practiced by hospitals and their setting of "full charges" at excessively high levels unrelated to their costs or a reasonable profit (because the full charges are set to be discounted, not paid) is grossly unfair and shocking.\textsuperscript{311} All of these factors apply to wealthy and poor uninsured patients alike.\textsuperscript{312}

\section*{VI. Conclusion}

Provisions in hospital admission agreements that require uninsured patients to pay a hospital’s “full charges” are unconscionable and therefore unenforceable.\textsuperscript{313} Such provisions are procedurally unconscionable because with regard to necessary medical services the patient has no choice but to sign the forms required by the hospital for admission.\textsuperscript{314} Moreover, uninsured patients have no idea that by agreeing to pay the hospital’s “full charges” they are in fact agreeing to pay a huge premium over the amount required to be paid for the same exact goods and services rendered to insured patients.\textsuperscript{315}

\textsuperscript{307} \textit{See supra} notes 255-304 and accompanying text.
\textsuperscript{308} \textit{Id.}
\textsuperscript{309} \textit{Id.}
\textsuperscript{310} \textit{Id.}
\textsuperscript{311} \textit{Id.}
\textsuperscript{312} \textit{Id.}
\textsuperscript{313} \textit{See supra} notes 1-18 and 255-304 and accompanying text.
\textsuperscript{314} \textit{See supra} notes 63-83 and 171-222 and accompanying text.
\textsuperscript{315} \textit{See supra} notes 108-170 and accompanying text.
An uninsured patient's agreement to pay a hospital’s full charges is substantively unconscionable because the hospital is engaged in price discrimination.\textsuperscript{316} That is, hospitals are charging a huge premium to the uninsured with no justification.\textsuperscript{317} The premium is the result of the excessively high full charges reflected on the Charge Masters of hospitals which in turn are the result of the often perverse rules and regulations associated with the third party reimbursement system.\textsuperscript{318} In fact, the victimization of the uninsured seems to be unintentional.\textsuperscript{319} Nevertheless the uninsured are victims and need protection.\textsuperscript{320} While clearly the proper solution to the problem is an overhaul of the rules and regulations of the third party reimbursement system,\textsuperscript{321} in the mean time the flexible doctrine of unconscionability can provide significant protection to the uninsured.\textsuperscript{322} Courts should use the doctrine to ensure that the most the uninsured are required to pay for necessary medical services is the average amount that the hospital providing the service accepts from third party payors for the diagnostic code relating to the goods and services provided to the patient.\textsuperscript{323}

\textsuperscript{316} See supra notes 84-107 and 223-254 and accompanying text.
\textsuperscript{317} See supra notes 108-170 and accompanying text.
\textsuperscript{318} Id.
\textsuperscript{319} See supra notes 291-297 and accompanying text.
\textsuperscript{320} See supra note 135.
\textsuperscript{321} See supra note 117.
\textsuperscript{322} See supra notes 255-304 and accompanying text.
\textsuperscript{323} See supra notes 300-304 and accompanying text.