
George A Nation, III
Contracting for Healthcare: Price Terms in Hospital Admission Agreements

George A. Nation III*

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

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

I. Introduction

The amount that hospitals claim to be owed for medical services varies dramatically based on the entity paying the bill.1 Speaking generally, there are three

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** G. K. Chesterton, “The Unmentionable Man” in “The Paradoxes of Mr. Pond” at 96 [http://gutenberg.net.au/ebooks05/0500421h.html].
1 See George A. Nation III, Determining the Fair and Reasonable Value of Medical Services: The Affordable Care Act, Government Insurers, Private Insurers and Uninsured Patients, (hereinafter “Fair and Reasonable”) 65 Baylor Law Rev. 425 (2013) at 446-449 (discussing price discrimination by hospitals based on the entity paying the hospital).
levels of payment. The first, and highest, is the chargemaster price, which is the hospital’s list price. These list prices are contained in a computer file called a Charge Description Master (CDM). Chargemaster price rates are excessive; on average they are about 500 percent higher than the amount that Medicare pays for the same care!

This disparity is due to the fact that CDM prices are set unilaterally by hospitals without any market constraint. CDM rates are used by hospitals primarily as a cudgel to threaten commercial health insurance companies with exorbitant prices unless they agree

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2 See George A. Nation III, Hospital Chargemaster Insanity: Heeling the Healers, (hereinafter “Chargemaster”) 43 Pepperdine L. Rev. 745, (2016) (today chargemaster prices are insanely high, often running 10 times the amount that hospitals routinely accept as full payment from insurers); id. at 748; George A. Nation III, Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured, (hereinafter “Obscene Contracts”) 94 Ky. Law Rev. 101 (2006) (arguing that the admission agreement between a hospital and a patient, in which the patient agrees to pay the hospital's “full charges” for necessary medical services, is unenforceable because it is unconscionable).; Id. at 105.

3 Id. at 746-747 (A chargemaster is a list of all goods and services provided by the hospital and the hospital’s list price, or charge, for each item).

4 See e.g., Steve I. Wasserman, Remedies For An Epidemic of Medical Provider Price Gouging, 90 Fla. Bar J. 22 (Feb. 2016) (noting that: ”Average charge master pricing at Florida hospitals is a minimum of 500 percent of Medicare allowable amounts . . .” and citing Center for Medicare and Medicaid Services data, revealing hospital list prices (i.e., charges) and Medicare actual payments for the 100 most common inpatient services by state averages and specific hospitals, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/.)

5 See Nation Chargemaster, supra note 2 at 760 (The single most important reason that chargemaster rates remain so high is that competitive forces in the healthcare market have broken down, and as a result, many hospitals may raise their chargemaster rates with impunity. Moreover, such rate increases are associated with increases, albeit much smaller ones, in revenues. Finally, hospitals currently have absolutely no reason to reduce their chargemaster rates. That is, hospitals suffer no competitive disadvantage by setting their rates ever higher because no market participants with any market power pay CDM rates) (notes omitted).
to the reimbursement rates demanded by the hospital.\textsuperscript{6} In other words, if the insurance company does not agree to pay the reimbursement prices that are acceptable to the hospital, then patients with that company’s insurance will be out-of-network with respect to that hospital, and the hospital will demand its excessive CDM prices from those patients by “balance billing” them.\textsuperscript{7} Obviously, this practice will upset those patients and

\textsuperscript{6} See George A. Nation III, Healthcare and the Balance-Billing Problem: The Solution Is the Common Law of Contracts and Strengthening the Free Market for Healthcare, 61 VILL. L. REV. 153, 154–55 (2016) [hereinafter Nation, Balance Billing] (noting that the hospital’s bargaining power is increased by the fact that if the insurance company fails to agree to the reimbursement rates desired by the hospital, then all of the insurance company’s customers will be balance billed at exorbitant chargemaster rates). Id. at 163; Nation Chargemaster \textit{supra} note 2 at 748 (the purpose of these fictitious list prices is to serve as a starting or anchoring point for negotiations with third-party payers regarding the amount that they will actually pay the hospital for goods and services). In addition, excessive CDM rates are beneficial to hospitals in other illegitimate ways. For example, they allow hospitals to overstate their charitable care. See Nation, Chargemaster \textit{supra} note 2 at 747-758. Exorbitant CDM rates also allow hospitals to increase their revenue from sources other than in-network insurance companies by enabling hospitals to price gouge self-pay patients, especially in third-party liability cases where the ability to use hospital lien statutes greatly increases the hospital’s ability to recover these insanely high prices. See George A. Nation III, Hospitals Use the Pernicious Chargemaster Pricing System to Take Advantage of Accident Victims: Stopping Abusive Hospital Billing, 66 Drake Law Rev. 645 (2018) [hereinafter “Accident”] (hospitals unilaterally set their charges at grossly excessive levels that the market rejects, and thus the vast majority of patients do not pay, which is why these exorbitant chargemaster-based rates are not a proper measure of the price anyone should pay for healthcare. But, because of the complexities involved in healthcare billing and payment systems and the confusion these complexities cause, hospitals are permitted to enforce excessive and market-rejected rates against self-pay patients, and even worse, in the TPL situation, hospitals force of a government-granted lien to enforce these unilaterally set excessive charges.) (note omitted) Id. at 699.

\textsuperscript{7} See Nation \textit{Balance Billing, supra} note 6 at 154-155 (describing balance billing and noting that because an out-of-network patient's insurer has no contract with the hospital, the hospital is not obligated to accept the payment from the insurance company as full payment, and therefore, the hospital bills the patient for the balance, that is, the difference between the exceedingly high hospital list price and the reasonable amount paid by the insurer). In addition, this means that exorbitant chargemaster based prices are really set to be discounted and not paid; however, if a hospital sees a chance to collect these enormous prices it usually pursues it
may cause them to buy insurance from a different insurance company that is in-network with that hospital. From the hospital’s perspective, however, there is every reason to set chargemaster prices ever higher as there is no penalty for doing so.

The second highest payment level is the price paid by in-network commercial health insurance companies pursuant to contracts formed between the insurance company, hospitals, and other providers. On average, these health insurance companies pay a little less than one third of the CDM list price and hospitals willingly aggressively and relentlessly causing a tremendous amount of financial hardship and pain in the process. The media has covered many cases of abusive conduct by hospitals trying to collect their excessive “full charges”. See e.g., Nation, Obscene Contracts supra note 2 at 101-05 (recounting examples of harsh conduct by hospitals against patients to collect bills); Nation, Chargemaster, supra note 2 at 761-66 (same); George A. Nation III, Non-Profit Charitable Tax-Exempt Hospitals – Wolves in Sheep's Clothing: To Increase Fairness and Enhance Competition in Health Care All Hospitals Should be For-Profit and Taxable, (hereinafter “Wolves”) 42 Rutgers Law Journal 4, at 174-180 (2010) (discussing harsh collection tactics used by many charitable hospitals).

See Gerard F. Anderson, From ‘Soak the Rich’ to ‘Soak the Poor’: Recent Trends in Hospital Pricing (hereinafter “Soak the Rich”), 26 HEALTH AFF. 780, 783 (2007) (noting that hospitals set high charges as a negotiating strategy with managed care plans; if a plan does not have a contract with the hospital then it pays full charges, the higher the charges the greater the incentive to sign a contract with hospital).

See Nation Balance Billing, supra note 6, at 160 (noting that as hospitals consolidate, more large healthcare systems are created, and these dominant systems do not feel any competitive pressure to contract with insurance companies at reasonable reimbursement rates); Nation Chargemaster, supra note 2, at 760 (noting that hospitals currently have absolutely no reason to reduce their chargemaster rates—that is, hospitals suffer no competitive disadvantage by setting their rates ever higher).

Importantly these are the only prices that can be said to be market derived. See Nation Determining, supra note 1, at 460-465 (noting that these rates reflect most strongly and effectively operating free-market).
agree to accept this amount as full payment. In other words, the chargemaster-based price is more than three times higher than the price hospitals agree to accept as full payment from commercial insurance companies. The prices paid by in-network commercial insurers are on average about 160 percent of the Medicare reimbursement rate. Another very important aspect of the contracts executed between commercial health insurers and hospitals, pursuant to which hospitals become “in network,” is that these contracts require the hospital to accept the agreed-upon reimbursement amount as full payment. Accordingly, the hospital is prohibited from billing the patient for any

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11 Today, on average, hospital chargemaster prices exceed payments by more than a factor of three. Michael Batty & Benedic Ippolito, Mystery of the Chargemaster: Examining the Role of Hospital List Prices in What Patients Actually Pay, 36 HEALTHAFF. 689, 689 (2017). For example, if Medicare reimbursed for a particular procedure at $100, then the average commercial insurance payment, agreed to by the hospital, would be $160. But the CDM based rate would be 3 times the commercial insurance rate, totaling $480.00. Moreover, since hospitals willingly agree to accept this amount from commercial insurance, it is reasonable to conclude that it represents not only coverage of their costs but also a reasonable profit as well. See Michael K. Beard & Dylan H. Marsh, Arbitrary Healthcare Pricing and the Misuse of Hospital Lien Statutes by Healthcare Providers, 38 AM. J. TRIAL ADVOC. 255, 257–58 (2014).

12 See, Nation III, Accident supra note 6 (noting that on average, hospitals receive only 33% of their chargemaster prices from all payers). However, in many instances, chargemaster rates can be even higher. For example, California Pacific Medical Center, owned by Sutter Health, has a chargemaster rate of $96,642 to treat a stroke, while Medicare reimbursement for this treatment is $9,583. See Nation, Chargemaster, supra note 2, at 762 (discussing this and other examples of egregious chargemaster rates). In other words, Medicare reimbursed less than 10 percent of the billed chargemaster rate. Id.

13 On average, nationwide, commercial insurance companies pay hospitals approximately 160 percent (i.e., 1.6 times) allowable Medicare reimbursement rates, which is equivalent to approximately 150 percent of hospital costs. See, MedPAC Report to Congress: Medicare Payment Policy Ch. 3, Hospital Inpatient and Outpatient Services 67 (Mar. 2015), available at http://www.medpac.gov/documents/reports/chapter-3-hospital-inpatient-and-outpatient-services-%28march-2015-report%29.pdf?sfvrsn=0.
amount in excess of the agreed-upon reimbursement with the exception of co-payments, deductibles, and coinsurance amounts.  

Finally, the lowest payment amounts are those set by government insurers Medicare and Medicaid.  

As noted, Chargemaster-based rates are, on average, about 500 percent of Medicare reimbursement levels. Medicare rates are set by the Center for Medicare Services (CMS) to provide hospitals with a reasonable reimbursement. Although some have argued that Medicare reimbursements represent only about 90 percent of hospital costs, others have argued that efficiently run hospitals do make a profit on Medicare reimbursements. Hospitals agree to accept the Medicare

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14 See Nation Balance Billing, supra note 6 at 154-155 (discussing balance billing).
15 See Nation Fair & Reasonable supra note 1 at 459-460 (in fact, some have argued that the government insurers reimburse below cost, however not all Medicare reimbursement rates are unprofitable for hospitals) Id.; Matthew Yglesias, Do Health Care Providers Lose Money on Medicare Patients?, SLATE: MONEYBOX (Feb. 22 2013, 3:10 PM), http://www.slate.com/blogs/moneybox/2013/02/22/medicine_providerPayments_do_hospitals_lose_money_treating_medicare_patients.html (suggesting such claims are dubious and noting that even though Medicare reimbursement rates may be below fully allocated costs for some hospitals, the rates are in excess of marginal costs and therefore, add significant profits once fixed costs are covered).
16 See supra note 4 and accompanying text.
17 See, Nation, Chargemaster supra note 2 at 767 (discussing Medicare and Medicaid reimbursement procedures); Mercy Catholic Med. Ctr. v. Thompson, 380 F.3d 142 at 144-45 (3d Cir. 2004) (the court summarizes developments in setting reimbursements in the Medicare program).
18 Virgil Dickson, Slumping Medicare Margins Put Hospitals on Precarious Cliff, MOD. HEALTHCARE (Nov. 28, 2017), http://www.modernhealthcare.com/article/20171125/NEWS/171129969?template=print (“In 2015, the aggregate margin hit a negative 7.1% across hospitals, according to the Medicare Payment Advisory Commission; margins are expected sink to a negative 10% this year.”). Cf. Yglesias supra note 12.
reimbursement amounts when they sign a Provider Agreement with CMS. Hospitals are not required to sign a Provider Agreement with CMS. However, if the hospital does not sign a Provider Agreement, the hospital cannot receive Medicare payments. Medicaid reimbursements are usually lower than Medicare reimbursements.

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

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20 CMS develops Conditions of Participation (COPs) and Conditions for Coverage (CFCs) that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs. See, https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCOPs/index.html?redirect=/CFCsAndCOPs/. Also, a hospital may terminate its participation at any time. See, https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/ge101c05.pdf 10.6.1 - Voluntary Termination. A provider may terminate its agreement its... by filing with the Secretary a written notice of its intention to terminate the agreement.

21 See Mary Lou Weden, Why Do Hospitals Get Accredited by The Joint Commission? September 15, 2016, at https://www.intermedix.com/blog/why-do-hospitals-get-accredited-by-the-joint-commission (Quite simply, hospitals pursue accreditation because it is required in order for their organizations to receive payment from federally funded Medicare and Medicaid programs.)

22 See, Nation Fair & Reasonable supra note 1 at 459 nt. 268 (on average in the US Medicaid payments to hospitals fall well short of fully allocated costs).

23 See, Batty & Ippolito supra note 11.

24 See Nation Chargemaster, supra note 2 at 746-747 (noting that each hospital maintains its own unique charge master, which it updates annually or more frequently as it sees fit, and extreme variation in list prices among hospitals even those in the same geographic area, is common). Cf., Banner Health v. Medical Savings Insurance Co., 163 P.3d 1096 (2007). (Banner Health sued patients for breach of contract for failing to pay for the services they received and basing its claim on the "Conditions of Admission" ("COA") signed by the patients upon entering a Banner hospital and which provided either: I will pay the hospitals usual and customary charges, which are those rates filed annually with the Arizona Department of Health
company or government insurer pays CDM rates, there is no market constraint on the
level of these rates.\textsuperscript{25} CDM rates are exorbitant.\textsuperscript{26}

\begin{quote}
\textit{Services... or "pay the account of the patient."} It is important to note that the
majority found that Arizona had a regulatory regime requiring hospitals to file their
CDM rates with state regulators who had to approve them before they became
effective. \textit{Id.} at 1100. This was a point of contention for the Dissent who said that it
was an informational requirement only and there was no substantive review of the
rates by the state. \textit{Id.} at 1104. However, the majority's opinion must be seen in light
of its assumption that the CDM rates were required to be filed with and approved by
the state and further that they had to be published and posted and available to the
public in the lobby of each hospital. \textit{Id} at 1100. As a result, there was a significant
issue regarding whether the COAs that did not specifically mention that the rates
referred to were the rates filed with the Arizona Department of Health Services
sufficiently referred to those rates. The Majority ultimately held that both types of
COAs were sufficient in light of Arizona's unique regulatory regime, and
distinguished this case from \textit{Doe} on that basis. (But \textit{Doe} involved very different facts.
There was no statutory scheme governing the setting, filing, and publishing of hospital
rates and charges; the hospital's "Charge Master" rates were in fact confidential and not
ascertainable by a patient; and the contract with the patient contained no reference to the
"Charge Master" rates. \textit{46 S.W.3d at 193-94.} The \textit{Doe} court concluded that the contract
was "indefinite" and unenforceable because it did "not refer to a document or extrinsic
facts by which the price will be determined." \textit{Id. at 197.} \textit{Id.} at 1101. Further, the
Majority felt it inappropriate to consider whether the rates set by the hospital were
excessive because the state had, in the Majority's view, approved those rates. \textit{Id at
1103}.)
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\textsuperscript{25} No market participants with any market power pay CDM based prices. \textit{See} Nation
\textit{Chargemaster, supra} note 2 at 764 (noting that no one – not hospital administrators, not
government insurers, and not private insurers– expect the chargemaster rates to be paid).
As a result, hospitals suffer no competitive disadvantage by increasing their CDM rates.
Moreover, in the case of self-pay patients, the only market participants expected to pay
these rates, hospitals until recently treated their CDM prices as proprietary and kept them
secret. A new rule took effect on Jan. 1, 2019 requiring hospitals that accept Medicare
patients to make their CDM available to the public. \textit{See, Fiscal Year (FY) 2019 Medicare
Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Acute Care
Hospital (LTCH) Prospective Payment System Final Rule (CMS-1694-F)
(https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPPS/FY2019-IPPS-Final-Rule-Home-Page.html).} Unfortunately,
published CDMs will not allow self-pay patients to determine the price they will actually
have to pay for the healthcare they are going to receive, and as a result, the new rule will
not create meaningful price transparency. \textit{See, Julie Appleby and Barbara Feder Ostrov,
Hospitals must post prices online, but they may be more confusing than helpful,} (Kaiser
Health News)
Contract law determines the financial relationship between hospital and patient.\(^{27}\)

Depending on the facts and circumstances surrounding a patient’s admission, the rights and obligations between the patient and hospital are determined either by an express contract, an implied-in-fact contract, or a quasi contract. If a patient signs an admission agreement, and it is deemed enforceable then an express contract is created. When a patient does not sign an admission agreement, or if a signed admission agreement is found to be unenforceable, the parties may have created an implied-in-fact contract based on their conduct. Finally, if no express contract or implied-in-fact contract has been created then a quasi contract, sometimes called an implied-in-law contract, will define the rights and obligations of the patient and the hospital. For example, a quasi contract would exist in cases where the patient was unable to consent because of the circumstances surrounding his or her admission, as in the case of admission for an emergency medical

[https://www.abc57.com/news/hospitals-must-post-prices-online-but-they-may-be-more-confusing-than-helpful](https://www.abc57.com/news/hospitals-must-post-prices-online-but-they-may-be-more-confusing-than-helpful). A CDM contains between 20 and 30,000 separate line items. Even with access to the CDM it is virtually impossible for the consumer to use it to calculate the amount that the patient will owe for a specific procedure. For example, a patient is in no position to determine the specific goods and services the hospital will use in performing a knee replacement. Nor do patients typically understand medical coding which is the key to deciphering the CDM. Interestingly however, government insurance as well as most commercial insurance companies reimburse hospitals based on procedures and not based on a la cart pricing. As I have argued elsewhere, if procedure based pricing was made readily available to consumers (e.g. the total amount the hospital was reimbursed on average for a knee replacement, an MRI or a CAT scan, etc.) this would be useful transparency, which in turn would lead to price competition among hospitals. See Nation Chargemaster supra note 2 at 773-780 (proposing procedure based reimbursement transparency).

\(^{26}\) See generally, Nation Chargemaster supra note 2.

\(^{27}\) See Nation, Accident supra note 12 at 687 (noting that fundamentally, hospitals claim to payment from a patient is based on contract law); See Nation Balance Billing supra note 6 at 175-181 (discussing contract principles and contracting in the context of healthcare).
However, for patients who are covered by in-network health insurance the hospital chooses to accept, the exact nature of the contractual obligation created with the hospital is usually not relevant to the financial obligation incurred by the patient; the terms of the patient’s contract with the hospital (whether express, implied-in-fact, or quasi) are usually superseded by the agreement between the patient’s health insurer and the hospital.

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33 See e.g., infra notes 44-45 and accompanying text discussing the case of Mr. Dennis an emergency patient.

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

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

36 See Nation Fair & Reasonable, supra note 1 at 443-446 (noting that hospitals agree to accept the rates negotiated with in-network insurers as full payment and not to bill the patients/insureds for any additional amounts beyond the co-pays, co-insurance and deductible amounts the patients are responsible pursuant to their health insurance policy).
For the increasing number of patients who are self-pay,\textsuperscript{37} however, the exact nature of the contract entered into with the hospital is of critical importance because it will determine the rights and obligations between the patient and the hospital, including the amount that the patient is obligated to pay for the care received.\textsuperscript{38} Self-pay patients include patients who are uninsured, patients who are insured but receive care out-of-network (“OON patients”), or patients who have their in-network insurance rejected by the hospital because the injuries being treated were the result of a third-party’s negligence, such as a patient who was the victim of a motor vehicle accident.\textsuperscript{39} In these cases, there is either no superseding contract between the hospital and the patient's health insurer, or the hospital chooses to ignore the superseding contract and treat an insured in-network patient as uninsured.\textsuperscript{40}

Practically speaking, this means that the price that self-pay patients owe the hospital can vary significantly depending on the type and interpretation of the contract the self-pay patient entered into with the hospital.\textsuperscript{41} Hospitals typically claim that self-pay patients owe the exorbitant CDM-based price, but, depending on the application of contract law, the patient may be responsible to pay only the reasonable market value of the medical care received, which is much lower than the excessive CDM price.\textsuperscript{42}

\textsuperscript{37} See infra at note 38 and accompanying text (defining self-pay patients).
\textsuperscript{38} See infra notes 225-249 and accompanying text.
\textsuperscript{39} See Nation Fair & Reasonable, supra note 1 at 430 (defining self-pay patients).
\textsuperscript{40} See supra note 34.
\textsuperscript{41} See infra notes 29-52 and accompanying text.
\textsuperscript{42} See infra note 52-54 and accompanying text.
As noted, in the case of self-pay patients, hospitals claim that they have a right to be paid their exorbitant CDM prices. This claim is often based on the patient’s signature on the admission agreement. Consider, for example, the following facts taken from a recent Virginia case:

[Glenn] Dennis arrived at Carter Bank and Trust, his place of employment, on May 29, 2014. Karen Pratt, Misty Powell, and Kathy Gravely, Dennis’s coworkers, stated that Mr. Dennis was not functioning normally on that day. Ms. Pratt testified that Dennis was “not focusing, not concentrating… [and] fidgety.” She believed Dennis to be distracted from his work, upset and scared. Ms. Powell similarly stated that Dennis appeared “very upset. His face was kind of flushed. His eyes were kind of watery. He seemed very fidgety. Couldn’t seem to concentrate.” Ms. Gravely’s testimony was consistent with the other witnesses, as she stated Dennis “was very agitated. I could see in his demeanor, his expression, there was some pain in his face. He acknowledged that he was having chest pain’s that were like he had had before [during a previous heart attack].” Ms. Gravely did not trust Dennis to be in the bank that day, and Ms. Pratt drove him to Urgent Care because she did not think Dennis capable of driving himself.

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

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43 See infra notes 29-54 and accompanying text.
44 PHC-Martinsville, Inc., d/b/a Memorial Hospital of Martinsville and Henry County v. Glenn Michael Dennis (as contained in the letter opinion of Judge David V. Williams of the Twenty First Judicial Circuit of Virginia, dated March 31, 2016, a copy of which is on file with the author). The Supreme Court of Virginia concluded that the circuit court erred in ruling that the hospital failed to prove mutual assent to the contract and as a result reversed the judgment of the Circuit Court and remanded the case to the Circuit Court for findings related to the patient’s affirmative defenses. The Supreme Court’s unpublished decision in the case can be found at: http://www.courts.state.va.us/courts/scv/orders_unpublished/161019.pdf.
Dennis was agitated, tearful, illogical, less-than-normally coherent, and fearful.

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

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

Dennis testified that, though he does not specifically recall Ms. Ramsey, he knew the hospital wanted him to sign something, and he wanted to “move on so I could get treated.” Ms. Ramsey was in the room for an estimated two minutes. Dennis signed the documents that she had brought.

An important question addressed by this article is what impact, if any, circumstances like those surrounding Glenn Dennis’s signing of the hospital’s admission agreement should have on the enforceability of hospital/patient contracts. Specifically, 45

45 See e.g., St. John’s Episcopal Hosp. v. McAdoo, 405 N.Y.S.2d 935,936 (N.Y. Civ. Ct. 1978) (The court recognized the trauma and anxiety experienced by those confronted with an emergency medical crisis and concluded that a hospital emergency room is certainly not a place where a reasonable person could be expected to exercise "calm and dispassionate judgment... A reasonable person, according to the court, would give a hospital admission contract at most "cursory attention". The court concluded that a hospital "should not be permitted to enforce a contractual obligation entered into under such tension-laden circumstances.”) Id. at 937; See infra notes 79-140 and accompanying text.
when an admission agreement is signed by a patient in the emergency department should the court blindly apply the doctrine of objective intent and enforce the writing simply because it was signed? Or, should the court refuse to enforce the admission agreement because a patient like Mr. Dennis is in no position to give free and knowing assent to the agreement’s terms? Or, should the court find some middle ground, such as reviewing the agreement with special scrutiny to make sure that the terms are fair?

In addition, in the context of both emergency and non-emergency admissions, the admission agreement presented to patients is a contract of adhesion. That is, patients

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46 See e.g., PHC-Martinsville, Inc., d/b/a Memorial Hospital of Martinsville and Henry County v. Glenn Michael Dennis supra note 44. The Supreme Court of Virginia engaged in just such a blind application of the doctrine to reverse the Circuit Court’s holding that no mutual assent existed stating: contrary to the circuit court’s ruling, the evidence established the Dennis assented to the terms of the contract. Whatever Dennis’s unexpressed intentions may have been, his signature on the contract was clearly a manifestation of his intent to agree to its terms.) (The Supreme Court of Virginia Unpublished letter opinion at pg. 3 available at http://www.courts.state.va.us/courts/scv/orders_unpublished/161019.pdf. ; See infra notes 79-140 and accompanying text.

47 See e.g., PHC-Martinsville, Inc., d/b/a Memorial Hospital of Martinsville and Henry County v. Glenn Michael Dennis supra note 44 (where the Circuit Court held that under the circumstances the parties held that no mutual assent and thus no contract existed); See infra notes 79-140 and accompanying text.

48 See e.g., Phoenix Baptist Hosp. & Med. Ctr., Inc. v. Aiken, 877 P.2d 1345 (Ariz. Ct. App. 1994) (in the case of a contract of adhesion only provisions within the reasonable expectations of the parties under the circumstances should be enforced); St. John’s supra note 45 (same); See infra notes 79-140 and accompanying text.

49 See e.g., Banner Health v. Medical Savings Insurance Co., 163 P.3d 1096, 1104 (2007) Presiding Judge Kessler, concurring in part and dissenting in part: (Stating that: The contracts [Conditions of Admission (COAs)] signed by the patients were clearly contracts of adhesion. Contracts of adhesion are generally fully enforceable according to their terms. Courts will not, however, enforce a contract or a term of a contract if the contract or term exceeds a party's reasonable expectations. Additionally, as a matter of equity, the courts will not enforce a contract or a term thereof if it is unconscionable. According to the "reasonable expectation" rule, while a party is typically bound by the terms of an adhesion contract even when they do not know the details of the terms of the
have no ability to negotiate the terms of the admission agreement. Rather, patients are presented with a “take it or leave it” situation where they must either sign the admission agreement presented to them by the hospital or, in the non-emergency context, seek care elsewhere.  

50 What impact should the adhesive nature of hospital admission agreements contract, they are not bound by the unknown terms of the contract that are beyond the range of reasonable expectation. A term may be deemed to exceed the party's reasonable expectation when the party enforcing the term has reason to believe the party against whom the agreement is enforced would not have accepted the agreement had he or she known the agreement contained that term. In determining whether a party enforcing an agreement had reason to believe the term exceeded the other party's reasonable expectations, courts may examine factors including: whether the term is bizarre or oppressive, whether the term eviscerates non-standard terms specifically agreed to, whether the term eliminates the dominant purpose of the contract, whether the other party had an opportunity to read the term, and whether the term is illegible or otherwise hidden from view. But even if the provision in question does not exceed the parties' reasonable expectations this does not end the inquiry. Courts may refuse to enforce a term within a party's reasonable expectations if that term is unconscionable. A contract or term therein may be procedurally unconscionable — wrong in the bargaining process—or substantively unconscionable — wrong in the contract terms per se. A contract may be deemed procedurally unconscionable when it is entered into hastily and/or in an emergency situation, when its terms are not explained at the time it is signed, and when the document does not call attention to terms to be enforced against the signing party. Indications of substantive unconscionability include gross disparity in the values exchanged, unduly oppressive terms, and overall imbalance in the rights and protections of the parties. In opposition to Banner's motion for summary judgment … the patients argued the price terms of the COAs were unconscionable. In support of this argument, the patients… stat[ed] that they signed the COAs in emergency situations, while they were under stress caused by their medical conditions… . Several of the patients stated in their affidavits that the COAs were not explained to them by the hospital personnel when they signed them, and that they believed that signing the COAs was a prerequisite to treatment. Furthermore, Banner's Vice President of Finance, indicated that the cost-to-charge ratio for some medical treatments at Banner hospitals was as low as 19.77% [this means that the lowest mark-up with respect to CDM prices was about 500%]. These facts raise at least the specter of unconscionability as to the price terms in the COAs. (citations omitted). Id. at 1108-1109; Nation, Obscene Contracts supra note 2 at 127-28 (discussing “planned” as opposed to “emergency” medical services and concluding that admissions agreements signed in both cases are adhesive contracts that are procedurally unconscionable); See infra notes 225-249 and accompanying text.  

50 Emergency patients cannot be turned away by the hospital regardless of their ability to pay or their refusal to sign the hospital’s admission agreement, however many emergency patients do not realize that this regulation exists and often believe
have on their enforceability? Of particular interest in this article is the enforceability of the price term contained in these agreements.

Consider these additional facts from the Dennis case:

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

The financial responsibility agreement is a form document, prepared by the hospital, and presented by a hospital employee to all patients (or, for those not capable of signing, their representatives), to be

that they must sign the forms presented to them in order to receive treatment. See, the Emergency Medical Treatment and Active Labor Act (EMTALA) Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (42 U.S.C. §1395dd); American College of Emergency Physicians (EMTALA is a federal law that requires hospital emergency departments to medically screen every patient who seeks emergency care and to stabilize or transfer those with medical emergencies, regardless of health insurance status or ability to pay) Id. at http://newsroom.acep.org/2009-01-04-emtala-fact-sheet; infra notes 225-237 and accompanying text.

See supra note 49 and infra notes 79-189 and accompanying text.

See e.g., Doe v. HCA Health Services of Tennessee, 46 S.W. 3d 191 (Tenn. 2001) (admission agreement required patient to be “financially responsible to the hospital for charges” not covered by insurance). The Tennessee Supreme Court held that, by failing to refer to the chargemaster rates in the agreement, the price term was left open. Id. at 197. The court then held that, given that indefiniteness, a court would have to determine the price term by the quasi-contractual remedy of quantum meruit, that is, the reasonable value of the services provided. Id. at 198-99. But see, Allen v. Clarian Health Partners, 980 N.E. 2d 306 (Ind. 2012) (finding that the phrase the undersigned guarantees payment of the account, was a clear and definite reference to chargemaster rates and therefore the admissions agreement was not missing a price term so no need to impute a reasonable price); Holland v. Trinity Health Care, 791 N.W. 2d 724, (Mich. App. 2010) (concluding the phrase "usual and customary charges" in hospital's contract with a patient "unambiguously refers to the 'Charge Master'); Shelton v. Duke Univ. Health Sys. Inc., 633 S.E. 2d 113,114 (N.C. App. 2006) (finding the language "regular rates and terms of the Hospital" not to be an open price term where the prices were set forth in the hospital's chargemaster), review denied.
signed before treatment is rendered. According to counsel for the hospital, “[t]he terms of the FRA [Financial responsibility agreement] signed by Mr. Dennis are the same as those of every other patient agreement in the same timeframe—whether elective or emergency, whether inpatient or outpatient.”

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

For example, in the *Dennis* case the court notes that the hospital charged Mr. Dennis $111,115.37 based on its CDM. By contrast, an in-network commercial insurer like Anthem would have paid a mere $23,389, pursuant to the rates negotiated between

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53 See supra note 44.
54 See e.g., Di Carlo v. St. Mary Hosp., 530 F.3d 255, 264 (3d Cir. 2008) (omitting a specific dollar figure is the only practical way in which the obligations of the patient to pay can be set forth, given the fact that nobody yet knows just what condition the patient has, and what treatments will be necessary to remedy what ails him or her).
56 See infra notes 56-60 and accompanying text.
57 See, PHC-Martinsville, Inc., d/b/a Memorial Hospital of Martinsville and Henry County v. Glenn Michael Dennis (as contained in the letter opinion of Circuit Court Judge David V. Williams, dated March 31, 2016, a copy of which is on file with the author).
the insurer and the hospital, for the exact treatment that Mr. Dennis received.\textsuperscript{58} Similarly, had Mr. Dennis been covered by Medicare, the government would have reimbursed approximately $20,000.\textsuperscript{59} In other words, Mr. Dennis was charged, based on his signature on the FRA, at least 4.75 times the amount that insured patients would have paid! It is important to note that even though commercial insurance companies may provide some benefits to hospitals that self-pay patients do not provide such as access to an increased volume of patients and quick and assured bill payment, the expense to the hospital of treating a patient is exactly the same regardless of whether the patient has private insurance, commercial insurance, or no insurance.

Mr. Dennis was in fact covered by commercial insurance, but his insurance was out-of-network—his insurance company had not entered into a contract with the hospital where Mr. Dennis was treated.\textsuperscript{60} However, Mr. Dennis’s insurance company did pay the hospital $27,254.95, but because there was no contract between the hospital and his insurance company the hospital claimed it was not required to accept the insurance company’s payment as payment in full, and therefore billed Mr. Dennis for the difference of $83,860.42 between the hospital’s CDM based rate and the amount received from Mr. Dennis’s insurer.\textsuperscript{61}

\textsuperscript{58}Id.
\textsuperscript{59} Id.
\textsuperscript{60} Id.
\textsuperscript{61} This is commonly referred to as balance billing. \textit{See infra} notes 6-14 and accompanying text. \textit{See}, Tara Bannow, Hospitals’ Solution to Surprise Out-of-Network Bills: Make Physicians Go In-Network, Modern Healthcare, Jan. 12, 2019 (discussing hospitals adopting a policy of requiring in-hospital physician groups to contract with the same insurance carriers as the hospital in response to patient complaints about receiving surprise balance bills)
The focus of this article is on the application of contract law principles to the relationship between hospitals and self-pay patients to determine how much self-pay patients owe the hospital for the health care they have received. For example, in the case of Mr. Dennis, should his signature on the FRA legally bind him to pay the hospital’s chargemaster rates? This article argues, based on the proper application of contract law principles, that Mr. Dennis must pay only the reasonable market-based value of the health care that he received (about $27,000). Moreover, the determination of


62 See, Christopher N. Osher, A Denver-area hospital sued a patient for nearly $230,000 over her surgery bill. A jury said not so fast. The Denver Post June 29, 2018 https://www.denverpost.com/2018/06/29/denver-hospital-bill-lawsuit/ (discussing the case of Lisa French who underwent spinal-fusion surgery in 2014 and was sued by the hospital 3 years later for $229,112.13, but an Adams County jury this month sided with French and found the hospital’s bills weren’t reasonable). According to the jury’s special verdict form, a copy of which is on file with the author, the jury found that Lisa French had entered into a contract with the hospital to pay “all charges of the hospital not otherwise paid by my health insurance or other payor”. The jury decided that the phrase “all charges of the hospital” did not refer to the predetermined charges for goods and services contained in the hospital’s chargemaster, but instead referred to the reasonable value of the goods and services provided to Ms. French. The jury found specifically that the hospital’s CDM rates were not reasonable. The hospital’s bill based on CDM rates was $303,709.49 and Ms. French’s out-of-network insurer paid $74,597.35. The jury found that Ms. French owed the hospital and additional $766.74 more than half of which was the unpaid portion of her deductible.

63 Id. See infra notes 79-189 and accompanying text.

64 This amount is derived as follows: assuming the Anthem rate is about equal to the average commercial insurer reimbursement rate then this would be increased by 10 to 15% to account for the benefits that commercial insurers provide to providers that self-pay patients do not. Thus, $23,389 X 1.10 = $25,728 and $23,389 x 1.15 = $26,897. See infra notes 225-249 and accompanying text.
reasonable value must be based on the market value—the actual reimbursements that the hospital receives—and not on the hospitals unilaterally set CDM prices.\textsuperscript{65}

In the case of self-pay patients who enter the hospital through the emergency department, they, like Mr. Dennis, usually simply lack capacity to contract due to rushed, stressful, and tension-laden emergency circumstances.\textsuperscript{66} As a result, most contracts signed by patients in the emergency department are not enforceable and the obligation of these patients to pay for the medical care they have received is based on quasi contract.\textsuperscript{67}

With respect to patients who enter the hospital other than through the emergency department, the admission agreements they sign, like those signed by emergency patients, are adhesion contracts (a/k/a, leonine, standard or form contracts) presented to patients on a take-it or leave-it basis.\textsuperscript{68} As a result, even if in the non-emergency context the patient is capable of giving assent, true assent by the patient is lacking, and the courts must closely scrutinize such contracts to ensure that the weaker party, the patient, is not taken advantage of by the stronger party, the hospital.\textsuperscript{69} A hospital’s exercise its prodigious bargaining power to extract a promise from a self-pay patient to pay more than three hundred percent of the price the hospital usually receives and accepts for the same

\begin{itemize}
\item \textsuperscript{65} The U. S. Congress has taken notice that CDM prices do not reflect market forces and thus, as part of the ACA, requires tax-exempt hospitals to collect from low income uninsured patients not more than the amount generally billed to individuals with insurance. See, Section 9007 of the ACA at Section 501(r)(5)(A) (West 2011) (discussed in Nation Fair & Reasonable, supra note 1 at 467-470. See infra notes 190-224 and accompanying text.
\item \textsuperscript{66} See infra notes 225-237 and accompanying text.
\item \textsuperscript{67} See infra notes 225-237 and accompanying text. Also, there may be no consideration and thus no contract when a hospital provides stabilizing treatment to a patient in an emergency. See infra notes 235-237 and accompanying text.
\item \textsuperscript{68} See supra note 49 and infra notes 79-140 and accompanying text.
\item \textsuperscript{69} See supra note 49 and infra notes 79-140 and accompanying text.
\end{itemize}
services from the majority of its patients is a prime example of a grossly unfair term that courts should refuse to enforce.\textsuperscript{70}

This article concludes that the misapplication of contract law principles in cases involving hospitals and self-pay patients has effectively resulted in hospitals price-gouging self-pay patients.\textsuperscript{71} Under the application of contract law principles argued for here, self-pay patients should rarely be obligated to pay more than a reasonable market-based value for the healthcare they receive.\textsuperscript{72} Finally, if courts apply contract law as suggested here to cases involving hospitals and self-pay patients, it will help to ameliorate excessive health care prices which are one of the most significant causes of exorbitant healthcare costs in the United States.\textsuperscript{73}

\textsuperscript{70} See supra note 49 and infra notes 79-140 and accompanying text.

\textsuperscript{71} See supra note 52 and infra notes 225-249 and accompanying text.

\textsuperscript{72} See infra notes 225-249 and accompanying text.

\textsuperscript{73} See, Gerard F. Anderson, Peter Hussey, and Varduhi Petrosyan, It’s Still the Prices, Stupid: Why the US Spends So Much on Health Care, And A Tribute to Uwe Reinhardt, Health Affairs Vol. 38, No.1, 87-95 (January 2019) (the sizable differences in health spending between the US and other countries were explained mainly by health care prices). https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05144; Zack Cooper, Stuart V. Craig, Martin Gaynor, and John Van Reenen, The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured, 134 The Quarterly Journal of Economics 51, (Vol.134, Issue 1, 51-107) (Sept. 4, 2018) (found that the commercial prices among US health care providers varied within regions, across regions, and within hospitals, and that variation in providers’ prices explained a large-share of the three-fold variation in commercial health spending across the US, and also found that hospital mergers raised prices and that hospitals in concentrated markets had higher prices and were able to negotiate more favorable payment terms with insurers). https://doi.org/10.1093/qje/qjv020; See, Michael Batty and Benedic Ippolito, Mystry of the Chargemaster: Examining the Role of Hospital List Prices in What Patients Actually Pay, Health Aff. Vol.36, No.4 (April 2017) (even though most patients do not pay hospital chargemaster prices, these excessive prices still can drive up health spending and increase hospital revenue).
This article begins with a discussion of the basic contract law principles relevant to the hospital/patient contracting situation. Next, the article discusses why admission agreements and their common price-formula terms are usually unenforceable. This discussion is followed by a analysis of why self-pay patients are obligated, pursuant to either an implied-in-fact contract or a quasi contract, to pay the hospital a reasonable market-based price for the healthcare they receive. The next section includes a brief summary of other work by the author outlining the process courts should use to calculate the fair and reasonable price for healthcare received by self-pay patients. Finally, the article concludes that the proper application of contract law principles by courts can help to solve the pressing problem of hospitals’ demanding exorbitant prices from self-pay patients.

II. Background: Contract Law in Hospital/Patient Contracting

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

Contract law is the law of voluntary agreement. No one may force another to enter into a contract; each party must knowingly and freely choose to enter into the contract. The law of contracts—its rules and doctrines—must always reflect this

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74 See infra notes 79-189 and accompanying text.
75 See infra notes 190-224 and accompanying text.
76 See infra notes 225-249 and accompanying text.
77 See infra notes 250-314 and accompanying text.
78 See infra note 314 and following text.
79 See, JOHN D. CALAMARI & JOSEPH M. PERILLO, THE LAW OF CONTRACTS §§ 1.3 -1.4 (2nd ed. 1977) (discussing freedom of contract and the philosophical foundation of contract law respectively)
fundamental fact. The doctrine of freedom of contract provides that contracting parties are free to mutually assent to any terms they desire, within the parameters established by the law. Thus, the primary role of the courts, when they are convinced that mutual assent has been given, is to enforce agreements voluntarily made by the parties.

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

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80 Id. (noting that most of contract law is premised upon the model consisting of two alert individuals, mindful of their self-interest, hammering out an agreement by a process of hard bargaining.).

81 Id.; See RESTATEMENT (SECOND) OF CONTRACTS § 17 (the formation of a contract requires a bargaining in which there is a manifestation of mutual assent).

82 See e.g., Mark Klock, Unconscionability and Price Discrimination, 69 Tenn. L. Rev. 317 (2002). The consideration can be as nominal as a peppercorn for the agreement to be legally enforceable. Courts do not inquire into the distribution of benefits between the parties. This legal fact is deeply rooted in a strong faith in the efficiency of free markets. Individuals do not voluntarily enter into agreements that they expect to make them worse off than before the agreement. If the agreement was made voluntarily, everyone is presumed to have been made better off by the agreement. This presumption can be justified by economic thought which, given a few simple axioms, demonstrates that markets will channel resources to their most valued use and maximize society’s wealth when all market participants are permitted to freely make their own decisions. Government intervention cannot improve the allocation of resources and can even impede it. Id. at 343-44 (citations omitted).


84 Id. § 24-94.
Generally, in order to have a valid contract, there must first be an offer. An offer exists when one party communicates to another the intent to contract by indicating a willingness to exchange one thing for another according to reasonably definite and certain terms. The requirement of reasonably definite and certain terms means that the parties must agree on all of the essential terms related to their contract so that the court can properly enforce the parties’ agreement. Acceptance requires that the person who received the offer communicate their intent/assent to enter into a contract on the exact terms offered to the offeror. The requirement of consideration, reflecting the importance of the economic function served by contracts, requires that the parties have agreed to a bargained-for-exchange for something of value. An individual has the capacity to enter into a contract if, at the time of contracting, the individual can understand in a reasonable manner the nature and consequences of the transaction.

While the foregoing requirements help to establish what the law means by mutual assent in the context of contracts, contract law also relies heavily on the concepts of agreement and intent. Thus, courts must determine the intent of the parties and

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85 Id. § 24-34.
86 Id. § 24, 33.
87 Id. § 33.
88 Id. § 50-70.
89 Id. § 71-94.
90 Id. § 15 ((1) A person incurs only voidable contractual duties by entering into a transaction if by reason of mental illness or defect (a) he is unable to understand in a reasonable manner the nature and consequences of the transaction, or (b) he is unable to act in a reasonable manner in relation to the transaction and the other party has reason to know of his condition). Id. Comment c. states... Age, bodily infirmity or disease, use of alcohol or drugs, and illiteracy may bolster other evidence of incompetency. (emphasis supplied).
91 See supra notes 82-89 and accompanying text.
whether they have agreed on the necessary terms of the contract.\textsuperscript{92} Contract law plays an important modern role in facilitating the operation of our economy based on free market capitalism. Consequently, in the interest of certainty and predictability, the law determines contractual intent by using the concept of \textit{objective} intent as a proxy for actual, \textit{subjective} intent.\textsuperscript{93}

Under the doctrine of objective intent, a party’s actual, subjective intent is deemed to be consistent with that party’s objective manifestations as interpreted by a reasonable person.\textsuperscript{94} The unexpressed, hidden, or secret intentions of a party are irrelevant to the determination of objective intent precisely because the other party is unaware of them.\textsuperscript{95}

When determining the objective intent, the law instead looks at a person’s conduct and

\textsuperscript{92} See supra note 80.
\textsuperscript{93} See \textit{e.g.}, Calamari and Perillo supra note 79 at § 2-2 (1977) (objective and subjective intention).

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

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

\textsuperscript{94} \textit{Id.}
\textsuperscript{95} \textit{Id.}
interprets its meaning from the perspective of a reasonable person dealing with that person. In other words, in the context of contracts, the law concludes that a patient’s intent is the same as the intent that a hypothetical reasonable person in the hospital’s position and endowed with the same knowledge as the hospital would ascribe to the patient. Under the objective theory of contracts, a person is bound by the impression he reasonably creates, even if he/she had an unexpressed intent that was different.

In the context of negotiated voluntary agreements, where two parties of relatively equal bargaining power and knowledge confer back-and-forth and finally come to an agreement, the justness of the objective intent doctrine is virtually unassailable. Contract law could not function effectively if it was necessary to be concerned with the possible unexpressed or secret intentions of the party with whom one was doing business.

However, in the context of contracts of adhesion, the validity of the conclusions drawn from the objective intent doctrine may be suspect and rote application of the

96 Id.
97 Id.
98 Id.
99 A negotiated contract is the type that courts have traditionally had in mind when developing the rules of contract law. As noted by John D. Calamari and Joseph M. Perillo in The Law of Contracts “most of contract law is premised upon the model consisting of two alert individuals, mindful of their self-interest, hammering out an agreement buy a process of hard bargaining”. See supra note 79. Those authors also note that there has been increasing recognition and legal literature that the bargaining process has become more limited modern society. See, Calamari and Perillo supra note 79 (1977) at § 1-3.
100 See, Calamari and Perillo supra note 79 at § 2-2 (1977) (noting that an objective test is believed to “protect the fundamental principle of the security of business transactions”). (notes omitted).
doctrine may fail to produce just results.\textsuperscript{101} The hallmarks of a contract of adhesion are unequal bargaining power between the contracting parties, an imbalance of knowledge that favors the party who drafted the agreement or otherwise dictated the terms of the agreement, and an inability of the weaker a party to meaningfully negotiate the terms of the agreement.\textsuperscript{102} The result of these characteristics is that the weaker party is faced with a take it or leave it situation;\textsuperscript{103} the weaker party must either agree to the terms demanded by the stronger party, or there is no agreement and the weaker party must find a different seller who is willing to negotiate, or must do without the goods or services in question.\textsuperscript{104} Theoretically, it would be possible for the weaker party to seek the goods or services from another seller more amenable to negotiation. Practically, however, locating alternative services is not possible because the same considerations that gave rise to the

\textsuperscript{101} Calamari and Perillo supra note 79 (1977) at § 9-44 (discussing the modern view of contracts of adhesion and noting the tendency to treat contracts of adhesion or standard form contracts differently from other contracts). (notes omitted); \textit{See} the dissent in \textit{Banner supra} note 49.

\textsuperscript{102} \textit{See}, Friedrich Kessler, Contracts of Adhesion-Some Thoughts About Freedom of Contract, 43 Colum. L. Rev. 629 (1943) (the weaker party, in need of the goods or services, is frequently not in the position to shop around for better terms either because the author of the standard contract has a monopoly (either natural or artificial) or because all competitors use the same clauses... contractual intention is but a subjection more or less voluntary to terms dictated by the stronger party, terms whose consequences are often understood only in a vague way, if at all.) \textit{Id.} at 632; Wheeler v. St. Joseph Hosp., 63App.33d 345, 356 133 Cal. Rpt.775. 783 (1976) (An adhesion contract is typically a standardized form offered to consumers of goods and services on essentially a take it or leave it basis without affording the consumer a realistic opportunity to bargain and under such conditions that the consumer cannot obtain the desired product or services except by acquiescing in the form contract). Id.

\textsuperscript{103} \textit{See supra} note 102.

\textsuperscript{104} \textit{See supra} note 102.
contract of adhesion in the first instance usually result in all sellers of such goods or services presenting customers with very similar contracts of adhesion.\(^{105}\)

In the case of hospitals and patients, hospitals argue that the offer is contained in the admission agreement presented to the patient. Thus, when the patient signs the agreement, hospitals contend that the patient has assented to the terms of the agreement. Consideration is argued to be the hospital’s agreement to give health care in exchange for the patients promise to pay for the care pursuant to the terms outlined in the admission agreement. However, the question becomes what to make of the hospital’s claim that the patient—the weaker party—has objectively agreed to the terms dictated by the hospital—the stronger party?\(^{106}\) Is this claimed objective agreement indicative of real assent by the patient?\(^{107}\)

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\(^{105}\) See supra note 102.

\(^{106}\) See e.g., Broemmer v. Abortion Services of Phoenix, Ltd., 840 P.2d 1013 (1992) (concerning an agreement to arbitrate included in the admissions documents provided to a patient at a clinic; the court cites with approval the Restatement (Second) of Contracts section 211 (Standardized Agreements),”Although customers typically adhere to standardized agreements and are bound by them without even appearing to know the standard terms in detail, they are not bound to unknown terms which are beyond the range of reasonable expectation”). Id. at 1017. Further the court concluded that “contracts of adhesion will not be enforced unless they are conscionable and within the reasonable expectations of the parties and stated that “[t]his is a well-established principle of contract law”; today we merely apply it to the undisputed facts of the case before us.) Id. at 1018. But see, Rory v. Continental Insurance Co. 703 N. W. 2d 23 (2005) (Sup. Ct. Mich.) (an adhesion contract is simply that: a contract. It must be enforced according to its plain terms unless one of the traditional contract defenses applies.) Id. at 35 (notes omitted). Rory was a 4-3 decision and Justice Kelly in dissent, joined by two other dissenting Justices states: “...the majority of the courts in this country has disavowed the strict construction policy in construing contracts of adhesion.”) Id. at 52. (notes omitted).

\(^{107}\) Regarding contracts of adhesion, that is contracts that are not negotiated but instead prepared by the stronger party and presented the weaker party on take it or leave it basis as a condition of treatment, at best the weaker party has assented only to conscionable terms that are within the reasonable expectations of the parties. See
When the weaker party signs a written contract of adhesion, some courts have used—really misused—objective intent and a related concept, the duty to read,\(^{108}\) as excuses to enforce all of the terms of the writing against the weaker party without first closely examining those terms to ensure that the weaker party is not being taken advantage of by the stronger party.\(^{109}\) Essentially, the duty to read stands for the proposition that a party who signs a written contract is bound by the party’s signature whether the party chose to read the document or not.\(^{110}\) That is, a signature creates the impression that the signer has agreed to all the terms contained in the writing and,

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\(^{108}\) *Broemmer supra* note 106. The Restatement notes that: “standardized agreements are enforceable except where a party [stronger party] has reason to believe that the other party [weaker party] would not manifest assent if he knew that the writing contained a particular term”. The Comment goes on to state that: “such a belief or assumption may be shown by prior negotiations or inferred from the circumstances. Reason to believe may be inferred from the fact that the term is bizarre or oppressive....” *See* Restatement (Second) Contracts *supra* note 81 Section 211 (3). In the context of hospital admissions agreements, those signed in the Emergency Department are signed under *circumstances* which would prevent a reasonable person from interpreting the patients signature as a manifestation of assent. *See infra* notes 108-140 and accompanying text. Moreover, the price term contained in these agreements, whether signed in the emergency department or otherwise, is *oppressive*, requiring the patient pay many times the market value of the care received. As a result, no properly informed patient who had a choice would ever agree to sign it. *See infra* notes 190-203 and accompanying text.


\(^{110}\) *See e.g., Allen, Holland and Shelton supra* note 52.
therefore, the signer is bound by that impression. 111 The idea behind the duty to read rule is that without it, one could not rely on a signed document because the party who signed it could avoid the transaction by saying that he had not read it, did not understand the writing, or secretly disagreed with its terms. 112

Like the objective intent doctrine, the duty to read concept makes good sense in the context of negotiated contracts but may produce pernicious consequences in the context of adhesion contracts. 113 This article and others argue that applying objective intent and the duty to read in the context of contracts of adhesion is a fundamental misapplication of the doctrine of freedom of contract. 114 As one court noted, "failure to read an instrument is not negligence per se but must be considered in light of all surrounding facts and circumstances." 115 The adhesive nature of the contract and the context in which it is signed are very important facts and circumstances indeed. 116

For example, in the Dennis case discussed above, Mr. Dennis signed the admission agreement and the other papers presented to him by the hospital’s

111 Id.
112 Id.
113 Id. § 9-44.
114 See e.g., Kessler supra note 102 (the law will not protect the public against any abusive contract as long as we fail to realize the freedom of contract must mean different things for different types of contracts. Its meaning must change with the social importance of the type of contract and the degree of monopoly enjoyed by the author of the standardized contract.) Id. at 642.
116 See e.g., St. John’s supra note 45 (there are circumstances [the court was discussing an emergency hospital admission and a signature on an admission agreement] under which a reasonable person might sign a contract, without reading it or understanding it, so that requiring adherence to its terms would be grossly unfair). Id. at 936; See note 113 supra.
representative when he clearly was in no position to read, understand, or negotiate the terms contained in those writings. Moreover, even if he had attempted to negotiate the terms of the agreement, the hospital’s representative who presented the forms to Mr. Dennis did not have the authority to agree to change the terms. To force Mr. Dennis to pay more than three times the market value of the care received based solely on his signature on the admission agreement is a pernicious consequence indeed. If a court finds that the rules associated with objective intent and the duty to read dictate such result then the court is misapplying the rules.

The correct (not rote) application of objective intent and the duty to read would result in Mr. Dennis being liable to pay fair market value for the care received and no more. For example, the hypothetical reasonable person who is the focus of the objective intent analysis is deemed to be aware to the same extent as the actual contracting party, the hospital, of the circumstances surrounding Mr. Dennis’s signing of the admissions agreement. This is because the objective intent doctrine places the hypothetical reasonable person in the position of the other party—here, the hospital—and assumes that the hypothetical reasonable person has the same specific knowledge as the

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117 See supra notes 44-45 and accompanying text.
118 See supra notes 44-45 and accompanying text.
119 See supra notes 1-26 and accompanying text.
120 See Kessler supra note 102 (in referring to the traditional application of freedom of contract doctrine to contracts that are NOT negotiated contracts (e.g., contracts of adhesion) Kessler states: Freedom of contract enables enterprisers to legislate by contract and, what is even more important, to legislate in a substantially authoritarian manner without using the appearance of authoritarian forms. Standard contracts in particular could thus become effective instruments in the hands of powerful industrial and commercial overlords enabling them to impose a new feudal order of their own making up on a vast host of vassals.)
121 See infra notes 122-124 and accompanying text.
actual contracting party. In Mr. Dennis’s case, the hospital was clearly aware that the documents were signed in the emergency department by a patient who believed that he was having a heart attack and could die if treatment was not provided quickly.\textsuperscript{122} As a result, it is likely that the hypothetical reasonable person would conclude that Mr. Dennis’s signature indicates a desire to receive treatment rather than agreement with any unusual or oppressive terms contained in the document.\textsuperscript{123} Specifically, Mr. Dennis’s signature would not be interpreted as his assent to the payment formula that required him to pay an unreasonable and excessive amount for his treatment.\textsuperscript{124}

Under the correct application of the objective intent doctrine, a hospital has a somewhat limited ability to contract with emergency patients.\textsuperscript{125} This analysis suggests, that emergency patients lack the ability to enter into a valid contract, or, at the very least, that emergency patients lack the ability to agree to any unusual or oppressive terms.\textsuperscript{126} Essentially, patients in the emergency department lack, at least temporarily, the full capacity to contract due to the emergency circumstances surrounding their admission to the hospital.\textsuperscript{127}

\textsuperscript{122}See, Calamari and Perillo supra note 79 (1977) at §2-2 (By testing the meaning to be given to a party’s words from the point of view of the reasonable man in the second party’s position, the subjective element of this party’s particular knowledge is incorporated into the objective test. In other words, the test considers what the second party knows or should know about the intention of the first party).

\textsuperscript{123}Id.

\textsuperscript{124}Id.

\textsuperscript{125}See supra notes 121-124 and accompanying text.

\textsuperscript{126}See supra notes 121-124 and accompanying text.

\textsuperscript{127}See, Calamari and Perillo supra note 79 (1977) at § 8-10 (noting other forms of mental infirmity resulting in a loss of capacity such as temporary delirium deriving from physical injuries sustained in accidents.) (notes omitted); Murray v. Ready 292 P.2d 87 (Colo. Supreme Court 1930) (noting that a person being in great pain
This patient incapacity creates some limitations for the hospital that the hospital may consider problematic, but the solution is not to misapply the doctrine of objective intent and in so doing treat patients like Mr. Dennis unfairly.\textsuperscript{128} Moreover, the problem is not one unique to the hospital setting but in fact is very common due to the abundance of adhesion contracts in use today.\textsuperscript{129} For example, when using the Internet it is common to encounter websites that require the user to agree to the site’s terms and conditions before proceeding.\textsuperscript{130} Typically, the user indicates their agreement by placing a check in the box provided and hitting the enter key.\textsuperscript{131} However, these are clearly and/or being under the influence of drugs can help reach a conclusion that the person is not confident to contract) \textit{Id.} 88; \textit{supra} note quoting the Restatement (Second) of Contracts. It seems quite likely that a patient in the emergency department, like Mr. Dennis, would have a difficult time understanding in a reasonable manner the nature and consequences of the transaction. Moreover, the hospital would certainly have reason to know the patient’s condition and that it would renders a patient like Mr. Dennis unable to act in a reasonable manner in relation to the transaction.

\textsuperscript{128} That is, by leaving patients like Mr. Dennis at the mercy of the hospital’s demand for an exorbitant fee. Something that Mr. Dennis and every patient like him would refuse to agree to if they had the knowledge and ability to do so.


\textsuperscript{130} See \textit{e.g.}, TermsFeed, 5 Reasons Why You Need Terms and Conditions at https://termsfeed.com/blog/5-reasons-need-terms-conditions/ (last visited Jan. 27, 2019) (noting that a Terms and Conditions agreement is a set of regulations which users must agree to follow in order to use a service. Terms of Use is often named Terms of Service, Terms and Conditions, or Disclaimer when addressing website usage, and that it is recommended to have a Terms and Conditions agreement for your website in order to, prevent abuses, own your content, terminate accounts, limit liability, and set the law that will govern any disputes).

\textsuperscript{131} See \textit{e.g.}, TermsFeed, Add “I agree to terms” Checkbox at https://termsfeed.com/blog/add-i-agree-terms-checkbox/ (last visited Jan. 27, 2019) (It’s pretty clear that including a Privacy Policy or a Terms and Conditions section on your website is important. However, it’s just as important to be able to enforce these legal agreements, as they will do you no good if they’re found to be
adhesion contracts because the users only choice is to agree or disagree; there is no ability to negotiate terms. Moreover, while the voluminous terms and conditions are only a few clicks away, I suspect that many users simply do not bother to read the terms and conditions, but simply check the box so they can proceed. But, what are the owners of the website to do in order to secure the user’s agreement to its desired terms and conditions? Notwithstanding the websites’ dilemma, it seems unlikely that a reasonable person would believe nor would it be good policy to treat the checked box as an indication that the user has agreed to any unusual, unexpected, unfair and/or

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unenforceable. However, the most recommended method to make these legal agreements enforceable is called the clickwrap method. This method requires users to read and agree to the presented legal agreement by making it mandatory to check a checkbox with the text "I Agree to The Terms" or "I Agree To The Privacy Policy").

132 See e.g., Schnabel v. Trilegiant Corp., 697 F.3d 110 (2012) (2d Court of Appeals) (The court refused to enforce an arbitration provision alleged to have been included in the terms and conditions of the website and in the course of the opinion stated: To be sure, the “duty to read” rule combined with the “standardized form” contract makes it unlikely in many contexts that a consumer will actually read such an agreement beyond a quick scan, if that. See Charles L. Knapp, Taking Contracts Private: The Quiet Revolution in Contract Law, 71 Fordham L. Rev. 761, 770 (2002). “A party who makes regular use of a standardized form of agreement does not ordinarily expect his customers to understand or even read the standard terms. One of the purposes of standardization is to eliminate bargaining over details of individual transactions, and that purpose would not be served if a substantial number of customers retained counsel and reviewed the standard terms.” Restatement (Second) of Contracts § 211 cmt. b (1981). But inasmuch as consumers are regularly and frequently confronted with non-negotiable contract terms, particularly when entering into transactions using the Internet, the presentation of these terms at a place and time that the consumer will associate with the initial purchase or enrollment, or the use of, the goods or services from which the recipient benefits at least indicates to the consumer that he or she is taking such goods or employing such services subject to additional terms and conditions that may one day affect him or her.) Id. at 127.

133 Id.
134 Id.
oppressive provisions or even that the checked box indicates the user’s willingness to take the risk that any such provisions may be included in the terms and conditions.\textsuperscript{135}

When dealing with contracts of adhesion, modern courts have applied the doctrine of objective intent so that it indicates assent to reasonable, conscionable, expected, or usual terms only.\textsuperscript{136} Mr. Dennis’s signing of the agreement should, at most, be interpreted as agreement only to terms and conditions that a hospital patient would expect and that are fair, reasonable, and conscionable, rather than agreement to any unexpected, unusual, unfair, or oppressive terms.\textsuperscript{137} That is, those terms and conditions that typical hospital patients would expect, rather than agreement to any unexpected, unusual, unfair or oppressive terms.\textsuperscript{138} A full discussion of this matter is not necessary here and is beyond the scope of this article. The author has discussed in other work the issues involved in determining whether CDM based prices are conscionable or unconscionable.\textsuperscript{139} With regard to emergency health care, legal recognition of the full or

\textsuperscript{135} Id.
\textsuperscript{136} See, Calamari and Perillo supra note 79 (1977) at §9-46 (Thus, some of the more modern cases search not only for apparent objective assessment but also for a true assent. Under this view true accent does not exist unless there is a genuine opportunity to read the clause in question and its impact is explained by the dominant party and understood by the other party who has a reasonable choice under the circumstances, of accepting or rejecting the clause. ... The Restatement Second goes one step further when it indicates that what is important, at least in contracts of adhesion, is whether a reasonable man would have expected to find such a clause in the contract. ... The Restatement Second seems to be suggesting a new kind of objective approach to standardized agreements. Rather than seeking out true assent on a case-by-case basis it places the duty upon the courts to consider the essential fairness of the printed terms, both from the viewpoint of surprise and inherent one-sidedness.); The Dissent in Banner supra note 49.
\textsuperscript{137} See e.g., Broemmer supra note 106.
\textsuperscript{138} Id.
\textsuperscript{139} See generally, Nation Obscene Contracts supra note 2.
partial inability of a patient seeking emergency care to contract does not leave hospitals at a tremendous disadvantage. As discussed below, even when the hospital has no real contract with the patient, the hospital will have the right under quasi contract to recover the fair market value of the goods and services provided to the patient.  

**B. Types of Contracts: Quasi Contracts**  

Contracts may be entered into based on the parties’ words—either written or oral—or actions. The law also recognizes a cause of action for unjust enrichment under the doctrine of quasi contract. In a quasi contract, or an implied-in-law (as

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140 See *e.g.*, *In re Estate of Boyd* 8 P. 3d 664 (Ct, App. Idaho 2000) (concerning medical services rendered to decedent who never signed the admissions agreement, where the lower court found that the medical services provided to the decedent were necessary and voluntarily accepted, and that the decedent was not admitted to the hospital against his will and finding an implied-in-law contract obligating the decedent’s estate to pay the reasonable value of the care provided and noting: where necessary and reasonable medical services are rendered by a hospital and received by a patient, a contract implied in law is formed to mandate remuneration ... and citing Landmark Medical Center v. Gauthier, 635 A.2d 1145 (R.I. 1994) for the holding that an implied-in-law contract is formed when medically necessary services are rendered even without mutual assent.); *PHC-Martinsville, Inc., d/b/a Memorial Hospital of Martinsville and Henry County v. Glenn Michael Dennis* (as contained in the letter opinion of Judge David V. Williams, dated March 31, 2016, a copy of which is on file with the author) (noting that: *even if the court finds – as it has–no express contract existing, Dennis is still obligated mine implied contract to pay the reasonable value of the services rendered*) *Id.* at p.9. See infra notes 225-237 and accompanying text.  

141 See CALAMARI & PERILLO, supra note 79, § 1.12, at 19-20 (2nd ed. 1977) (discussing express, implied, and quasi contracts).
opposed to an implied-in-fact contract, the law imposes a contract-like duty to prevent one party from being unjustly enriched at the expense of another.

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

\[142\] Id.; See e.g., In re Estate of Boyd supra note 138; River Park Hospital Inc. v. Bluecross Blueshield of Tennessee, Inc. No. M2001-00288-COA-R3-CV, (Tn. Ct. App. 2002) (discussing the fact that contracts can be either express, implied in fact or implied in law and finding that when parties are forced to deal with each other and could not come to an agreement an implied-in-law contract exists); Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alternatives, Inc. 832 A.2d 501, 508 (Pa. Super. Ct. 2003) (similar and noting that how much a hospital typically receives for its services is more probative of reasonable value than its published rates).

\[143\] See e.g., In re Estate of Boyd supra note 138 (noting that such implied-in-law contracts formed in order that a person needing help in an emergency and not able to ask for it should obtain it, the attainment of such result being created by assuring compensation to the person rendering aid and citing Estate of Crisan, 107 N.W.2d 907 (Mich. 1961).

\[144\] See CALAMARI & PERILLO, supra note 79, § 1.12, at 19-20 (2nd ed. 1977) (discussing express, implied, and quasi contracts).

\[145\] Id.

\[146\] Id.; See, Landmark Medical Center v. Gauthier, 635 A.2d 1145, [pincite needed] (R.I. 1994) (holding that an implied-in-law contract is formed when medically necessary services are rendered even without mutual assent.)

\[147\]See CALAMARI & PERILLO, supra note 78, § 1.12, at 19-20 (2nd ed. 1977) (discussing express, implied, and quasi contracts).

\[148\] Id.

\[149\] Id.
of contracts (express, implied-in-fact, and quasi) are relevant to healthcare contracting.  

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

If there is an actual contract between the parties, the doctrine of quasi contract cannot be applied. In addition, the law usually does not look favorably on one party

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150 See infra notes 225-250 and accompanying text.
151 See In re Estate of Boyd supra note 138.

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

Id. at 1025; Van Zanen v. Qwest wireless, LLC 522 F.3d 1127 (10th Cir. 2008) (to establish a claim of unjust enrichment a plaintiff must show that “(1) at plaintiff’s expense (2) defendant received a benefit (3) under circumstances that would make it unjust for defendant to retain the benefit without paying.”). Id. at 1130.

152 See supra note 150.

153 See supra note 150.

154 See supra note 150.

155 See CALAMARI & PERILLO, supra note 79, §1.12 (2nd ed. 1977) (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). Id. note omitted).

156 See e.g., In re Estate of Boyd supra note 140 (where an express contract exists, an implied contract between the same parties for the same contractual purpose is precluded.
foisting their goods or services upon another.\textsuperscript{157} For example, if I were stopped at a red traffic light and someone came out and cleaned my windshield without my consent or request, quasi contract could not be used to require payment for the service.\textsuperscript{158}

However, there is a well-settled exception for emergency medical care.\textsuperscript{159} That is, if a doctor happens upon an injured party and provides medical care, the doctor may recover under quasi contract for his or her services even if the patient was unconscious from enforcement.\textsuperscript{.)} Id. at 668; Industrial Lift Truck Serv. Corp. v. Mitsubishi Int'l Corp. 432 N.E.2d 999, 231 (Ill. Ct. App. 1982) (The general rule is that no quasi-contractual claim can arise when a contract exists between the parties concerning the same subject matter on which the quasi-contractual claim rests) Id. at 231.\textsuperscript{157} See e.g., In re Estate of Boyd supra note 140 (the services must be rendered under such circumstances as to indicate the person rendering an expected to be paid, and that the recipient expected, or should have expected to pay for them.) Id. at 668.\textsuperscript{158} Id.; Cf. \url{https://www.consumer.ftc.gov/articles/0181-unordered-merchandise} (If you receive merchandise that you didn't order, you have a legal right to keep it as a free gift.).\textsuperscript{159} See e.g., In re Estate of Boyd supra note 140; Landmark Medical Center v. Gauthier supra note 146. The exception is an old one. See, e.g., Frederic Campbell Woodward, The Law of Quasi Contracts, § 201 (1913 ed.)

It seems to be taken for granted that at the common law there is no legal obligation, independent of contract, to pay for non-professional services rendered, in an emergency, in the preservation of life. The intervention may be dutiful; the conduct of the intervener may be heroic. But… There is an irrefutable presumption, based either upon considerations of policy or upon knowledge of normal human conduct, that the service is intended to be gratuitous. The considerations which underlie the irrefutable presumption just referred to have no application in the case of professional services, as of a physician or nurse. For while such services are usually prompted in greater or less measure by motives of humanity, they are generally rendered with the expectation of compensation. Moreover, in the case of a physician or nurse there is nothing unworthy in such an exception. It follows that for professional services, unless there is evidence either that credit was extended to the third-party or that there was no intention to charge, the beneficiary should be required to pay reasonable value.

\textsuperscript{.)} Id. (available at \url{https://chestofbooks.com/business/law/Quasi-Contracts/Sec-200-IV-Sundry-Instances-Of-The-Obligation.html}).

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during the treatment.\textsuperscript{160} In other words, the law takes the position that an injured party would have consented to emergency medical care had they been able to consent to the care offered.\textsuperscript{161} As a result, both public policy and fairness require that the doctor receive reasonable compensation for the services provided.\textsuperscript{162} The doctor will be able to recover the fair or reasonable market value of the medical care provided.\textsuperscript{163}

\section*{C. Types of Contracts: Express and Implied-In-Fact Contracts}

As noted, express contracts are based upon the words, either oral or written, that the parties have exchanged.\textsuperscript{164} In a hospital admission contract, these words are written; therefore, the hospital attempts to enforce an express contract with the patient.\textsuperscript{165}

Establishing an express contract requires mutual assent between the parties.\textsuperscript{166} As discussed above, in an emergency admission situation like that involving Mr. Dennis,

\begin{footnotesize}
\textsuperscript{160} See Landmark Medical Center v. Gauthier, supra note 146 (holding that an implied-in-law contract is formed when medically necessary services are rendered even without mutual assent.)
\textsuperscript{161} See, e.g., Estate of Crisan, 107 N.W.2d 907, 914 (Mich. 1961) (noting that such implied-in-law contracts are formed in order that a person needing help in an emergency and not able to ask for it should obtain it, the attainment of such result being created by assuring compensation to the person rendering aid).
\textsuperscript{162} Id.
\textsuperscript{163} See, e.g., In re Estate of Boyd supra note 140 (the measure of damages claim for unjust enrichment is the value the benefits bestowed upon the defendant which, in equity, will be in just for him or her pain without compensating the plaintiff) Id. at 669. It is important to note that in, In re Boyd the court awarded the Hospital an amount equal to its chargemaster price, but the court noted specifically that this was due to the fact that the amount of the charge was not challenged, rather only liability on the account was challenged. Id.
\textsuperscript{164} See supra note 141.
\textsuperscript{165} Id.
\textsuperscript{166} See supra notes 79-140 and accompanying text.
\end{footnotesize}
there is usually no real mutual assent.\textsuperscript{167} As a result, courts should either reject the written contract notwithstanding the fact that the patient signed it (in which case the hospital would have the right to recover the fair market value of its services under a quasi contract theory),\textsuperscript{168} or closely scrutinize the written contract to identify and prevent enforcement of any unexpected, unusual, unfair, or oppressive terms such as a payment formula tied to the hospital’s CDM rates.\textsuperscript{169}

In non-emergency admissions, including voluntary inpatient and outpatient admissions, patients are often capable of giving real assent. However, for the reasons discussed below, this rarely occurs with respect to price.\textsuperscript{170} In the non-emergency context, hospital admission agreements are still contracts of adhesion; they are written solely by the hospital, the dominant party that possesses much more bargaining power and knowledge regarding the contract and its meaning than the patient. Even if a patient understood the price formula, which is very unlikely, the patient has no meaningful ability to negotiate with the hospital.\textsuperscript{171} Finally, the price terms included in these contracts (e.g. the patient is obligated to pay the hospital in accordance with the hospital’s “regular rates,” “charges,” “billed charges,” or “charge description master”), as discussed in more detail below, are indefinite, confusing, and misleading to patients; most importantly, they provide for a price that is grossly excessive.\textsuperscript{172} As a result, when courts scrutinize these contracts looking for unexpected, unusual, unfair, or oppressive

\begin{itemize}
\item \textsuperscript{167} See supra notes 79-140 and accompanying text.
\item \textsuperscript{168} See supra notes 79-140 and accompanying text.
\item \textsuperscript{169} See supra notes 79-140 and accompanying text.
\item \textsuperscript{170} See infra notes 79-140 and accompanying text.
\item \textsuperscript{171} See supra notes 79-140 and accompanying text.
\item \textsuperscript{172} See infra notes 204-224 and accompanying text.
\end{itemize}
terms, they should pay particular attention to the price term.\textsuperscript{173} In the alternative, a court may decide that no contract has been entered into based on the written agreement, because true mutual assent to the writing is lacking due to either its adhesive nature, or its indefinite, confusing, and unfair terms, or both.\textsuperscript{174}

If a court decides, in the non-emergency context, that no contract exists based on the written admission agreement, then in all likelihood the court will find that an implied-in-fact contract exists based on the actions of the hospital and the patient.\textsuperscript{175} That is,

\textsuperscript{173} Recall that the patient's agreement to pay the hospital's charges is really an agreement to pay an exorbitant amount, on average more than three times the price the hospital has agreed to accept in full payment from the majority of its patients. See supra notes 1-26 and accompanying text.

\textsuperscript{174} See supra notes 204-224 and accompanying text.

\textsuperscript{175} See Portercare Adventist Health System v. Lego, 312 p.3d 201, 203 (Colo. App. 2010), rev'd on other grounds, 286 P.3d 525. The case involved a breach of an implied-in-law contract to pay for medical services provided to defendant's wife, and the issue in the case (due to different statute of limitation periods) concerned whether the hospital's claim concerned a contract in which the damages were liquidated or unliquidated but determinable (if either of these conditions were met the longer limitations period would apply). Approximately one month after the patient was admitted to the hospital the patient’s insurer informed the patient and the hospital that it thought that the patient no longer required the level of care provided at the hospital and that after a specified date it would no longer cover the patient’s expenses and the patient would be liable personally to pay for any expenses incurred. Both patient and her husband refused to accept financial responsibility for the patient’s expenses and also refused to leave the hospital. Ultimately, the patient did leave the hospital and the hospital submitted a bill. The patient’s insurance company paid its portion of the bill up to and including the date set by the insurer for the patient to leave the hospital. The balance left owing by the patient was about $144,000. The hospital claimed the right to recover based on an implied-in-fact contract. The hospital pointed to the actions of the patient and her husband of “specifically, (1) Ms. Lego’s decision to remain at the hospital after her insurance coverage ceased, knowing that the hospital would charge her for services provided after October 1, and (2) the hospital's provision of services after that date — created a contract implied in fact.” Id. at 203. The patient and her husband argued that that recovery under a claim for breach of a contract implied-in-fact is the reasonable value of the services provided, and no document evidencing any contract purported to show either what that reasonable amount was or how it could be readily calculated. The court held that a sum is liquidated or determinable only where the
medical care is provided by the hospital and accepted by the patient; the hospital
reasonably expects payment; and the patient reasonably expects to pay for the care
received. As a result, the court is likely to recognize that the parties have entered into
a contract based on their actions even though there was no mutual assent to the written
admission agreement.

If the court recognizes that an implied-in-fact contract exists, then the court must
provide the price that the patient is required to pay since there would have been no
express agreement on a price formula. The court will likely decide that the price that
should be provided is that which a prudent buyer and seller would agree to if they had the
time and knowledge to properly negotiate: the fair market value of the medical care
received. As discussed below, the court can easily and readily determine the

agreement sets forth an amount owed or a formula for calculating an amount owed. The
court noted that in this case, no provision of any alleged agreement sets forth an amount
owed or formula for determining the amount owed. “The hospital did not allege a
contractor rising from a document. Rather, as noted, it alleged a contractor rising from
the parties’ conduct.” Id. at 205. The Court stated further that “the hospital’s position
that the amount owed is readily determinable is based chiefly on the bill it sent to [the
patient]. But that bill was not the parties’ agreement; it was merely a statement of
charges— the hospitals assessment of what [the patient] owed under the alleged
agreement.” Id. at 206. The court noted that the amount owed under the implied in fact
contract is the reasonable market value of the services or goods. Id.; CALAMARI &
PERILLO, supra note 79, §1.12 at 19-20 (2nd ed. 1977) (discussing implied-in-fact
contracts).

176 See Portercare supra note 175 (“Several courts have found the contract implied-
in-fact where a patient accepts medical services understanding that those services
must be paid for by the patient, and have held that the measure of recovery is the
reasonable value of those services.” (citations omitted)).

177 Id.
178 Id.
179 Id.
reasonable market value of medical care by consulting the average amount the hospital has agreed to accept as full payment from in-network private health insurers.\textsuperscript{180}

In summary, courts should recognize that providers of emergency health care have a right to recover fair market value under the doctrine of quasi contract.\textsuperscript{181} For non-emergency care, if the patient has signed an admission agreement, the court must determine whether to enforce it or reject it as lacking real mutual assent.\textsuperscript{182} Courts deciding to enforce the admission agreement in this context should recognize that it is a contract of adhesion and scrutinize it for any unusual, unexpected, oppressive, or unfair terms, such as price terms that require the patient to pay exorbitant CDM-based list prices.\textsuperscript{183} These terms should be struck from the contract and—for CDM-based price formulas—replaced with a reasonable price equal to the fair market value of the healthcare received by the patient.\textsuperscript{184} Courts refusing to enforce the admissions agreement after medical care has been provided and accepted will likely find that an implied-fact-contract exists and will find, as in the quasi contract situation, that the patient owes the fair market value of the health care provided.\textsuperscript{185}

This article focuses next on price terms in hospital admissions contracts and specifically on how they should be interpreted.\textsuperscript{186} As discussed below, it is argued here that the patient has agreed to pay only the market-based fair value of the care

\textsuperscript{180} See infra notes 250-314 and accompanying text.
\textsuperscript{181} See supra notes 79-140 and accompanying text. In addition, it is very important to note that CDM-based prices are not a reflection of reasonable value.
\textsuperscript{182} See supra notes 79-140 and accompanying text.
\textsuperscript{183} See supra notes 79-140 and accompanying text.
\textsuperscript{184} See supra notes 141-163 and accompanying text.
\textsuperscript{185} See supra notes 141-163 and accompanying text.
\textsuperscript{186} See infra notes 190-224 and accompanying text.
Market-based fair value is the amount that the hospital actually receives in payment from the majority of its patients for the same care that has been provided to the patient in question. A hospital’s argument that, pursuant to the terms of the admissions agreement, a patient has agreed to a CDM-based price formula that requires the patient to pay the hospital’s list price—which, as noted, is on average three and a half times the market value—should be rejected.

III. The Price Formula in Patient/Hospital Contracts (Incomplete Contracts, Missing Price Term Contracts, and Illusory Contracts)

A. Missing Price Term Versus Price Formula

When a court decides to enforce the admission agreement, one issue that arises is whether the agreement is missing a price term. This is important because if the court finds that a contract based on the admission agreement exists, but also finds that the

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187 See infra notes 225-249 and accompanying text
188 See infra notes 278-294 and accompanying text
189 See supra notes 1-26 and accompanying text
190 See e.g., Allen supra note 52. The admissions agreement stated: “In consideration of services delivered by Clarian North Medical Center and/or the physicians, the undersigned guarantees payment of the account, and agrees to pay the same upon discharge if such account is not paid by a private or governmental insurance carrier.... If the amounts due Clarian North Medical Center for services rendered become delinquent and the debt is referred to an attorney for collection, it is understood and agreed that I shall be responsible for reasonable attorneys’ fees, court costs, and pre-judgment interest.” Id. at 309. Patients argued that the chargemaster rates imposed by Clarian were unreasonable and constituted a breach of contract. Id. The Court noted that the breach of contract claim depended on a critical underlying premise, namely, that the contract lacked the material term of price, and because no price term was present the court needed to impute a "reasonable price" to the contract. The court noted that a contract need not declare a specific dollar amount for goods or services in order to be enforceable. Id.
parties have not agreed on a clear, definite, and fixed price then the court must provide
the price. Courts typically do so by determining a reasonable price based on the market
value of the goods or services in question.\textsuperscript{191} As a result, if a court finds that the
admission agreement does not contain a reasonably definite, certain, and fixed price, then
the patient will be obligated to pay far less than the provider’s exorbitant CDM-based list
price.\textsuperscript{192}

Hospital admissions agreements refer to price in a variety of ways. In the case of
Mr. Dennis, the financial responsibility agreement stated, “[T]he patient is obligated to
pay the hospital in accordance with the hospital’s charge description master.”\textsuperscript{193} Other
common price term formulations contained in admissions agreements refer to the
patient’s obligation to pay the hospital its “regular rates,” “list charges,” “billed charges,”
“list prices,” or “all amounts billed by the provider.”\textsuperscript{194} What all of these various
formulations have in common is that they do not state a specific dollars-and-cents price

\textsuperscript{191}See, e.g., Ind. Bell Tel. Co. v. Ice Serv. Inc., 231 N.E. 2d 820,824 (1967) (“Where
there is an agreement that compensation is to be paid but the price is not fixed, the
party furnishing services and materials in performance of the contract is entitled to
the reasonable value thereof.”).

\textsuperscript{192}See e.g., Doe supra note 52 (holding that a patient’s agreement to be “financially
responsible to the hospital for charges not covered by” insurance was indefinite and
hospital was entitled to the reasonable value of the medical goods and services it
provided to patient). \textit{Id.}

\textsuperscript{193}See supra note 52 and accompanying text.

\textsuperscript{194}See e.g., Allen supra note 52 (guarantees payment of the account); Doe, supra note
52 (agreement to be "financially responsible to the hospital for charges not covered
by" insurance); Phoenix Baptist Hosp. supra note 48 at 1347 (obligated to pay the
account of the hospital in accordance with the regular rates and terms of the
hospital); St. John’s Episcopal Hosp. supra note 48 at 935 (charges not covered by
insurance).
and they all, regardless of whether they specifically mention the CDM, purport to require the patient to pay the hospital’s CDM-based list price for the medical care received.\textsuperscript{195} The law does not require that the parties always agree to a dollars-and-cents price. The parties may agree to a price formula.\textsuperscript{196} The agreed-upon formula can be used subsequently to determine the dollars-and-cents price.\textsuperscript{197} For example, in a requirements contract, the buyer may agree to pay $3.00 per gallon for all heating oil requested and delivered during a particular heating season.\textsuperscript{198} The actual dollars-and-cents amount that the customer will owe at the end of the season for heating oil under the contract is not stated, but once the customer requests and receives a delivery, the amount owed can be

\textsuperscript{195} See, e.g., Doe supra note 52 (hospital demanding its chargemaster based prices); Allen supra note 52 (same).
\textsuperscript{196} See, e.g., Allen supra note 52 (A contract need not declare a specific a dollar amount for goods or services in order to be enforceable.). \textit{Id.} at 310. ; However, the formula agreed to must be reasonably definite and certain. See, e.g., Doe supra note 52 (holding that admission agreement that referred “to the patient's being financially responsible to the hospital for charges not covered by insurance” was not clear that it intended the hospital's CDM to be used as the formula to set the price and therefore finding the contract contained no price term). \textit{Id.} at 197. Moreover, the formula used must be set at the time of the contract and not be illusory. See CALAMARI & PERILLO, supra note 79, §2.13 at 19-20 (2\textsuperscript{nd} ed. 1977) (discussing indefiniteness as it relates to mutual assent and providing the following illustration: B promised to work as a foreman of a plant for one year in exchange for a fair share of the profits, and the promise was held to be too vague and indefinite to be enforced, but if B performs under the agreement he may obtain a quasi-contractual recovery measured by the reasonable value of his services). As discussed \textit{infra}, CDM’s change frequently and many hospitals keep no record, at least ascertainable by patients as to what the historical prices contained in the CDM.
\textsuperscript{197} See \textit{infra} notes 198-199 and accompanying text.
\textsuperscript{198} See generally, Note, Requirements Contracts Under the Uniform Commercial Code 102 U. Penn. L. Rev. 654 (1954) https://www.jstor.org/stable/3310137?seq=14#metadata_info_tab_contents (“More recent authority, however, recognizes that in the bargained-for exchange of promises each party has limited his freedom to some extent and that the terms "requirements" or "needs" supply a sufficiently objective standard to be enforceable. Thus, today, the typical requirements contract is generally held valid.”). \textit{Id.} at 654-55.
determined by applying the formula contained in the contract ($3.00 multiplied by the number of gallons requested and delivered).

As noted, hospital admission agreements virtually never contain an actual dollars-and-cents price.\textsuperscript{199} A possible legitimate reason for this in the emergency admission context is that at the time of admission neither the hospital nor the patient knows with certainty the exact type and quantity of healthcare that will be needed by the patient.\textsuperscript{200} The question for the court is whether the admission agreement, notwithstanding the fact that does not contain a dollars-and-cents price, contains a price formula that is both fixed, reasonably definite, and certain enough to be used to determine the price.\textsuperscript{201} If it does

\textsuperscript{199} As noted, an exception would be non-medically necessary cosmetic procedures such as certain non-medically necessary face-lift, hair-plugs, breast augmentation, or liposuction.

\textsuperscript{200} See, e.g., DiCarlo supra note 54 (involving admissions to the emergency department the Court stated, “[T]he price term ‘all charges’ is certainly less precise than price term of the ordinary contract for goods or services in that it does not specify the exact amount to be paid. It is, however, the only practical way in which the obligations of the patient to pay can be set forth, given the fact that nobody yet knows just what condition the patient has, and what treatments will be necessary to remedy what ails him or her.”) Id. at 264. It must be noted, however, that in the non-emergency admissions context, it is likely very possible for hospitals to give a precise and accurate price quote for the medical care the patient is scheduled to receive. For example, the hospital agrees in advance with its in-network insurers the price it will accept for the medical procedures it provides. Further, for non-medically necessary procedures that are not covered by insurance, for example, non-medically necessary plastic surgery, an exact price is commonly set in advance. It seems possible, perhaps even likely, that hospitals could provide such a price quote but choose not to in order to preserve their pricing flexibility and maximize their revenue.

\textsuperscript{201} See, e.g., Doe supra note 52 (holding that a patient’s agreement to be “financially responsible to the hospital for charges not covered by” insurance was indefinite and hospital was entitled to the reasonable value of the medical goods and services it provided to patient). Id. But see, Allen supra note 52 (holding that the promise to pay "the account" for treatment is, while imprecise, not sufficiently indefinite to justify imposition of a reasonable price standard and noting further that in the
not, then the contract is missing an enforceable price term. Given the adhesive nature of admission agreements, even if the court finds a price formula sufficiently fixed and clear and definite, the court will still need to look closely at the resulting price to ensure its fairness. These issues are discussed next.

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

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

This article argues that a CDM-based price formula is very unlikely to be enforceable in an admission agreement. This is true for several reasons. First, especially in the emergency context, it is likely that no mutual assent exists with respect to the context of a contract for the provision of and payment for medical services, a hospital’s chargemaster rates serve as the basis for its pricing).

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202 See CALAMARI & PERILLO, supra note 79, §2.13 at 19-20 (2nd ed. 1977) (discussing indefiniteness as it relates to mutual assent and providing the following illustration: “[I]f A and B agree that A will perform a service for B and no mention is made of price, it will be implied that the parties intended that a reasonable price should be paid and received. The same is true if goods are involved. It will be assumed that the parties contracted in terms of a reasonable price which will ordinarily be the market price.” (notes omitted)). Id. 45-46.

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

204 See supra notes 31 and 32 and accompanying text.

205 Id.

206 Id.
admission agreement. Because there is no contract between the hospital and patient, the
hospital’s recovery will be based on quasi contract.\footnote{207} Second, many of the references in
admission agreements are too indefinite to be enforceable. For example, when an
admission agreement requires a patient to pay “the account of the hospital,” “regular
rates,” “all charges,” “billed charges,” or words of similar import, it may not contain a
clear and definite reference to the hospital’s CDM-based price formula.\footnote{208} Third, even
when the admission agreement clearly provides for a price based on the hospital’s CDM,
it is likely that the CDM is illusory: too indefinite to be used as a price formula.\footnote{209} This
is because the CDM is completely under the control of the hospital; the hospital may
unilaterally change its prices at any time.\footnote{210} Thus, at the time of contracting, the CDM

\footnote{207} See supra notes 79-140 and accompanying text discussing the proper application
of objective intent.

\footnote{208} See, e.g., Doe supra note 52.

\footnote{209} See, e.g., Cape Reg’l Med. Ctr. supra note 29 (noting that most patients upon
entering the hospital sign an “Authorization for Treatment,” a “statement of
Financial Responsibility,” and/or another similar open-ended agreement pursuant
to which the patient purports to agree to pay for all medical goods and services
provided by the hospital at the hospital’s list (chargemaster) prices, but in reality,
however, this type of agreement amounts to a blank check given by the patient to
the hospital with the amount to be unilaterally filled in by the hospital at a later
date). \textit{Id.} at 9.

\footnote{210} \textit{Id.} This problem has been ameliorated somewhat, at least in theory, by the
recent requirement (as of January 1, 2019) that hospitals publish their CDMs.
However, in practice these published CDMs provide very little useful information to
patients and certainly do not allow patients to have any awareness of the price that
they will be charged. Moreover, the issues related to price changes and keeping
records of previous prices to determine the prices that apply to a particular patient
(is it the prices in effect when the patient signs the admission agreement, those in
effect when the goods and services are provided to the patient, or those in effect
when the final bill is calculated; and once any of the 30 or 40 thousand prices
contained in the CDM changes, how is the patient to access the old prices to be sure
the charges were accurately calculated?) have not been addressed by the new
requirement that hospitals publish their CDMs.
prices are not fixed but in flux. Finally, even if the court finds that the parties gave mutual assent to an admission agreement; finds that the agreement contains a clear and definite price formula tied to the hospital’s CDM; determines that the CDM published at the time the patient signed the admission agreement is the one that is referenced in the formula (so that the CDM-based prices were fixed on that date); and further finds somehow that the CDM’s gibberish of codes and numbers is meaningful to a patient,\textsuperscript{211} even then the biggest problem with CDM-based prices remains: the price arrived at by application of the formula is likely to be so grossly excessive and unfair to patients as to be unconscionable.\textsuperscript{212} Because the admission agreement is an adhesion contract,\textsuperscript{213} the unconscionable price term will not be enforced.\textsuperscript{214}

As noted, price formulas tied to CDM-based prices are not fixed at the time of contracting. This presents a potentially fatal problem from the perspective of contract law. Unlike the requirements contract example above, a hospital using a CDM-based price formula is not agreeing to a price formula that is either fixed\textsuperscript{215} or discernable by


\textsuperscript{212}See supra notes 1-26 and accompanying text.

\textsuperscript{213}See supra notes 79-140 and accompanying text.

\textsuperscript{214}See supra notes 79-140 and accompanying text.

\textsuperscript{215}As noted, hospitals may change these prices at any time, and the admission agreement does not state the date on which prices contained in the CDM will be fixed. One could argue that the CDM published, assuming there is only one, on the date the admission agreement was signed contains the prices that must be used to determine the price under that admission agreement. However, if prices are subsequently changed in the CDM, which is essentially assured, and this were to occur prior to the goods and services being used for the patient, then one could
As a result, courts may decide that CDM-based price formulas are illusory and therefore unenforceable. CDM-based prices remain solely under the control of the hospital. Hospitals can change the prices contained in their CDMs at any time, and they frequently do. Moreover, there is no requirement that a hospital keep a record of prices previously contained in the CDM. Nor is it clear what date hospitals will use to determine the CDM to apply when billing the patient. That is, which CDM rates will be used to calculate the amount the patient owes? The CDM rates that were in effect at the time the patient was admitted to the hospital? Those in effect when the patient received treatment? Those in effect when the patient was released from the hospital? Or those in effect when

argue that those more recent prices should be used in calculating the price due under the admission agreement. Finally, a case could be made for using the CDM published at time the patient's bill is calculated. (I would guess that in fact this is the method actually used by most hospitals.) The very fact that there are a variety of options possible is what destroys the certainty required to make a price formula based on CDM prices enforceable.

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

See Nation, Chargemaster supra note 2 at 746-747 (“Each hospital maintains its own unique charge master, which it updates manually or more frequently as it sees fit, an extreme variation in list prices among hospitals, even those in the same geographic area is common. The list price is contained in the charge master are truly arbitrary and capricious the point of view pricing except in one respect– the higher the list price, the higher the hospitals revenue.”) (notes omitted).

See supra notes 204-217 and accompanying text.
the patient’s bill was finally calculated and sent (a process that can take months)?

Thus, the amount a patient owes can vary significantly depending on which CDM prices a hospital chooses. The result is that the hospital is not limited in any way by this formula; it may charge the patient virtually any amount it wishes!

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

\[\text{219} \text{ The fact that there are a variety of options, each of which may have a valid claim to being the proper one to use, is what destroys the certainty necessary to making a price formula based on a CDM enforceable. See supra note 213.}\]

\[\text{220} See supra note 209.\]

\[\text{221} See supra notes 195-203 and accompanying text.\]

\[\text{222} See supra notes 195-203 and accompanying text.\]

\[\text{223} See supra notes 195-202 and accompanying text.\]

\[\text{224} See supra note 209.}\]
IV. Contracting for Health Care

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

When patients enter the hospital through the emergency department, most patients are not able to assent to the written admission agreement even if they are able to sign it, for the reasons discussed above.225 Whether the court finds an implied-in-fact contract or a quasi contract depends on the facts and circumstances of the specific case. All patients in the emergency department are experiencing extreme and distressing circumstances, but their levels of cognitive ability may vary. For example, a patient who arrives unconscious has no ability to assent. In this case, the only option is a quasi contract, pursuant to which, as discussed above, the patient is required to pay the hospital the reasonable market value of the medical care received.226 This is true notwithstanding the fact that many hospitals in this situation will require the family member or Good

225 See supra notes 121-124 and accompanying text.
226 Cf. Phoenix Baptist Hosp. & Medical Center, Inc. supra note 48 (denying the hospital’s request for summary judgment and concluding there was a material issue of fact concerning the conscionability of the procedure used to obtain the agreement where a patient was unable to sign the admissions agreement so patient’s husband signed the admission agreement, which provided, “[T]he undersigned agrees ([whether] signing as agents, representatives, or as patient, and whether or not insured or a member of the health maintenance organization) that, in consideration of the services to be rendered to the patient, he or she is hereby individually obligated to pay the account of the hospital in accordance with the regular rates and terms of the hospital...” and the hospital claimed that husband was liable from his personal assets to pay for the hospital care provided to the patient); St. John’s Episcopal Hosp. supra note 45 (finding similarly, noting the trauma and anxiety experienced by those confronted with an emergency medical crisis and concluding that the hospital emergency room is certainly not a place where a reasonable person could be expected exercise “calm and dispassionate judgment” and that a reasonable person would give a hospital admission contract at most “cursory attention.”) The court in St. John’s Episcopal Hospital concluded that a hospital should not be permitted to enforce a contractual obligation entered into under such tension-laden circumstances. Id.
Samaritan who brought the patient to the hospital to sign the admission agreement.\textsuperscript{227}

The signature of anyone other than the patient, with the exception of an authorized agent of the patient (and very few patients arrive at the emergency department with an agent authorized to enter into contracts on their behalf),\textsuperscript{228} cannot bind the patient to the contract.\textsuperscript{229}

\textsuperscript{227} See supra note 226.

\textsuperscript{228} See Nation, Accident supra note 6 at 647-650 (discussing the circumstances surrounding a patient’s signing of an admission agreement and some of the terms commonly included in such agreements and noting that:

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

Id. 648-49.

\textsuperscript{229} It is important to note that entering into a contract is different than providing informed consent to receive medical treatment, which hospitals are required to get and which may be, in certain cases, provided by appropriate family members. See Raphael J. Leo, M.D., Competency and the Capacity to Make Treatment Decisions: A Primer for Primary Care Physicians, Prim. Care Companion J. Clin. Psychiatry v.1(5); 1999 (Oct.) (“To ensure that individuals retain as much autonomy or self-determination as is legally possible, the court makes a determination of one’s competence in a task-specific manner. For example, one can be determined to be incompetent to execute a will, but may be deemed competent to make treatment decisions.”). Id. at nt.7. See also, https://www.cancer.org/treatment/finding-and-paying-for-treatment/understanding-financial-and-legal-matters/informed-consent/who-is-allowed-to-consent.html (”Many states have passed family agency acts that choose which family members (in a listed order of priority) may act on behalf of a person who cannot speak for her- or himself. This option may be used if you don’t have an advance directive or court-appointed proxy. Depending on your family situation and which state you are in, that person may be your legal guardian, spouse, parent, child, sibling, or other relative.”); https://www.ama-assn.org/delivering-care/ethics/informed-consent
Other patients may arrive at the emergency department legally capable of entering into an implied-in-fact contract.\textsuperscript{230} Few, if any, patients arrive at the emergency department capable of reading and negotiating an express contract due to the stressful and tension-laden circumstances surrounding admission through the emergency department. As discussed above, these circumstances prevent the patient from giving free and knowing assent to the admission agreement they are forced to sign.\textsuperscript{231} However, depending on the exact circumstances, a court may find that some of these patients are sufficiently conscious that they are entering the hospital and that the hospital expects payment, such that a patient’s cooperation with and acceptance of the medical care provided can reasonably be interpreted as accepting an obligation to pay (a fair and reasonable amount) for the care received.\textsuperscript{232}

If a court finds that an implied-in-fact contract exists based on the actions of the parties, the court must provide the price for the parties because there has been no agreement between the parties on a specific price.\textsuperscript{233} As a result, a patient in this

\textsuperscript{230}See CALAMARI & PERILLO, supra note 79, §8.10 at 250-51 (2nd ed. 1977) (discussing the test for contractual capacity as whether the party understands the nature and consequences of his act time of the transaction.)

\textsuperscript{231}See supra notes 121-124 and accompanying text.

\textsuperscript{232}See, e.g., Portercare supra note 175 (noting that, “Several courts have found the contract implied-in-fact where a patient accepts medical services understanding that those services must be paid for by the patient, and have held that the measure of recovery is the reasonable value of those services.” (citations omitted). In other words, the patient may be able to understand in a broad way that he is agreeing to pay, a reasonable amount to the hospital for the care he will receive.

\textsuperscript{233}See supra notes 164-189 and accompanying text. See also, CALAMARI & PERILLO, supra note 79, §8.15 at 255 (2nd ed. 1977) (discussing the exploitation of
circumstance, like the unconscious patient entering the emergency department, would be legally responsible to pay the reasonable market value of the medical care received, though in this case the obligation will be pursuant to an implied-in-fact contract rather than a quasi-contract.\textsuperscript{234}

Finally, an argument can be made that there is no consideration (another essential requirement to create a contract)\textsuperscript{235} to support a patient’s promise to pay for the care received in an emergency admission. This argument is based on the fact that, under the federal EMTALA statute (the Emergency Medical Treatment and Active Labor Act requires any emergency room to evaluate, stabilize and treat any patient that is presented there regardless of the patient’s ability to pay.),\textsuperscript{236} hospitals have a pre-existing duty to provide a certain amount of care (stabilizing treatment) to all patients who enter the emergency room. As a result of this pre-existing duty, the hospital is not suffering a legal detriment in exchange for a patient’s promise to pay. That is, the hospital is not doing

\begin{footnotes}
\item[234] See supra notes 164-189 and accompanying text.
\item[235] See supra notes 79-90 and accompanying text.
\item[236] See supra notes 50-51 and accompanying text.
\end{footnotes}
something (providing treatment) that it was not already legally obligated do (pursuant to the statute) in exchange for the patient’s promise to pay. This argument may prevent formation of a contract based on either the express promise made in the admission agreement, if for some reason the court found that the written agreement was otherwise enforceable, or on the implied-in-fact promise to pay based on the actions of the parties. However, it would not prevent recognition of a quasi contract, because a quasi contract is not a real contract.237

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

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

The legal situation of patients who arrive at the hospital other than through the emergency department is different. Some of these patients may have the time and presence of mind to read, understand, and, theoretically at least, negotiate an admission agreement with the hospital.238 The problem that many of these patients face is that they are presented with an adhesive contract that is confusing and provides for a grossly unfair

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237 See supra notes 141-163 and accompanying text.
238 See supra note 199 discussing patients receiving non-medically necessary treatment.
price. That is, even if the circumstances allow the patient a meaningful opportunity to read the admission agreement, the patient will still have no ability to negotiate its terms or to understand the meaning of the ambiguous price term that it contains. As noted above, the CDM-based price formula contained in admission agreements is illusory, and patients cannot possibly use it to determine how much they will owe the hospital (even if patients have access to CDMs). Moreover, admission agreements typically contain price formulas based on CDM prices; these prices are grossly excessive and shockingly unfair.

As a result, if a court finds that an admission agreement signed by either an emergency or non-emergency patient is enforceable, then due to the admission agreement’s adhesive nature, the court should scrutinize it closely and refuse to enforce any price formula tied to CDM-based prices. As a result, the patient should be obligated to pay no more than the reasonable market value of the healthcare received.

There are a number of reasons a court may refuse to enforce a CDM-based price formula even if the admission agreement in which it is contained is otherwise enforceable (that is, 

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

240 Also, seeking treatment at another hospital is not a viable alternative for patients because they feel constrained to go to the hospital where their doctor is on staff. See, e.g., Wheeler supra note 102 ("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.").

241 See supra notes 209-211and accompanying text.

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

243 See supra notes 1-26 and accompanying text.

244 See supra notes 204-224 and accompanying text.
the court finds that under the circumstances the patient had the capacity to assent to the admission agreement and did in fact assent to it). These reasons include:

- The price formula in the admission agreement may not contain a clear and definite reference to the CDM.\textsuperscript{245}

- Even a clearly-referenced CDM-based price formula is illusory, and the prices it calls for may not be fixed at the time of contracting, as the hospital retains the right to change the CDM prices used in the formula up to the point it sends the patient a bill.\textsuperscript{246}

- Even if the court finds that the CDM published by the hospital fixed the CDM prices at the time of a patient’s admission, patients cannot understand the CDM and therefore cannot use the CDM-based price formula to determine how much they are agreeing to pay even if the CDM is available to them. For this reason the patient may not have assented to the price calculated with the CDM.

- Even if all of these issues are overcome in a particular case, a CDM-based price formula will very likely yield a grossly excessive price that is substantively unconscionable. As a result, a court may find that the hospital’s attempt to enforce the price formula violates the hospital’s obligation to perform and enforce the contract in good faith.\textsuperscript{247}

\textsuperscript{245} See, e.g., Doe supra note 52.
\textsuperscript{246} See supra notes 204-224 and accompanying text.
\textsuperscript{247} See, e.g., Nygaard v. Sioux Valley Hosp. & Health Sys., 731 N.W. 2d 184, 194 (S.D. 2007). (Patients argue that the Hospitals breached the covenant of good faith and fair dealing by charging prices that did not relate to the cost of the services and were unreasonable and unexpected based on the Hospitals’ representations. The court
CDM-based price formulas are usually contained in adhesion contracts, which are procedurally unconscionable. As a result, if the CDM price formula produces an unconscionable price, then both requirements for finding a contract unconscionable have been met, and the contract is unenforceable.248

noted that South Dakota does not recognize an independent cause of action, a tort, based on good faith. However, the court cited with approval a provision of the Uniform Commercial Code (UCC 1-203) that provides that "Every contract or duty within this title imposes an obligation of good faith in its performance or enforcement." Id. at 194. The court denied that the covenant of good faith had been breached because the patient in the pleadings claimed that the admission agreement called for the hospital to charge its “pre-set charges” and that the hospital had indeed charged the patient its pre-set charges.

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

Id. 194.

Very important in this case was the fact that the patients were the plaintiffs seeking to recover damages from the hospital. It seems as though the results would likely have been different had the hospital been suing the patients trying to recover its CDM-based prices under the contract. For example, the Court stated: "Counsel acknowledged at oral argument that the nature of an adhesion claim does not give rise to an independent cause of action for damages. But even aside from this acknowledgement, and assuming that the contract was an unconscionable contract of adhesion, patients have no right to recover damages simply because they entered into an unconscionable contract." (notes omitted). Id. at 195.

248 Id. at 194-95 (Patients pleaded that the Hospitals did not provide an opportunity for negotiating the agreements and that there was greatly disparate and wholly unequal bargaining power. They further pleaded that such standardized contracts are contracts of adhesion that are unconscionable and contrary to public policy. In determining whether a contract is an unenforceable contract of adhesion, this Court looks not only at the bargaining power between the parties but also at the specific terms of the agreement. Thus, we focus on both "overly harsh or one-sided terms,"
As a result, courts should rarely, if ever, enforce CDM-based price formulas.249

C. Determining the Fair and Reasonable Value of Healthcare

There is no single method that is universally accepted for determining the fair and reasonable price to be paid for healthcare.250 However, two methods are most often

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249 See supra notes 204-224 and accompanying text.
250 Colomar v. Mercy Hosp. Inc., 461 F. Supp. 2d 1265, 1268 (S. D. Fla. 2006) (the patient came to the hospital suffering shortness of breath and received treatment, her stay at the hospital lasted 26 hours. The patient received a bill for $12,863. Prior to receiving any treatment or services from Mercy, patient signed an "Authorization and Guarantee" form (the "contract") in which she agreed to pay all bills not otherwise covered by insurance or other means; the services she would need and the prices she would pay were unspecified in the contract. In support of an unreasonable pricing claim the patient made the following factual allegations: patient was charged nearly $12,863 for medical services, while the actual costs of the services were only $2,098; the hospital generally charged uninsured patients prices set at 450% of Medicare reimbursement rates; the hospital ranks among the top 13% of all hospitals nationwide in charges (including both for-profit and non-profit hospitals); the hospital’s cost-to-charge ratio is 394%, meaning that on average the hospital charges almost four times their costs to uninsured patients; the hospital ranks in the top 10% of hospitals nationwide in terms of cost-to-charge ratio. Id. at 1268. The court noted that the establishment of a reasonable price requires consideration of several factors; the prices charged by other hospitals in the area, the actually paid by the hospitals other patients, and the hospital’s cost structure. Importantly, the court noted that there is evidence that all hospital’s set greatly inflated charges and therefore even if the hospital’s charges are in line with the charges of other hospitals in the area this is no guaranty that the hospital’s charges are reasonable. The court stated: “In addition to a market analysis, the case law reveals that the price charged for the same services to other patients within the same hospital is
recommended. The first and best approach is to use a market-based reimbursement price.\textsuperscript{251} If, with respect to the hospital or other provider in question, there is a reasonably well-functioning free market for healthcare, then that market will determine the appropriate price.\textsuperscript{252} The other approach, which must be used in cases where there is

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

\textit{Id.} at 510.

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

\textit{Id.} at 1272-73.

\textsuperscript{251} See Nation, \textit{Fair & Reasonable, supra} note 1 at 460-465 (discussing both approaches and noting that the prices actually paid by private insurers are a good place to start in calculating the value of medical services because these contracts reflect most strongly an effectively operating free market.) (notes omitted).

\textsuperscript{252} \textit{Id.}; \textit{See also}, \textit{See}, e.g., Nassau Anesthesia Assocs. P.C. v. Chin, 924 N.Y.S.2d 252, 255 (N.Y. Dist. Ct. 2011) (referring to the average amount the hospital would have accepted as full payment from third-party payors such as private insurers and federal health programs and noting that the hospital's billing manager calculated this amount as $4252.11); Temple \textit{supra} note 140 ("Reasonable value [of hospital services] … is the value paid by the relevant community. The relevant community in this case comprises the Hospital’s patients who are covered by insurance policies
not a properly-functioning market, is the Medicare-based approach.\textsuperscript{253} Under this approach, the person seeking to determine the price starts with the price that Medicare would pay the hospital for the care in question.\textsuperscript{254} These two approaches are discussed below at subsections 2 and 3, respectively.\textsuperscript{255}

1. Why Courts Should Not Use CDM Rates

\textsuperscript{253} See, A Review of Hospital Billing and Collection Practices Before the Subcomm. on Oversight and Investigations of the H. Comm. on Energy and Commerce, 108th Cong. 21 (2004) (statement of Gerard F. Anderson, Director, Johns Hopkins Center for Center for Hospital Finance and Management) (suggesting that a fair and reasonable price can be arrived by taking the Medicare DRG based reimbursement and adding 25% to that amount; in other words, a reasonable price can be arrived by taking 125% of the Medicare DRG based reimbursement); see Nation, \textit{Fair & Reasonable}, \textit{supra} note 1 at 460-465 (discussing Professor Anderson's approach); Richman et al \textit{supra} note 243 ("Another useful proxy might be Medicare reimbursement rates, because those rates--offered by the government and excepted by providers, who were permitted to refuse--also approximate the lower end of the range of prices that a reasonably informed negotiation would produce.") \textit{Id.} at 397.

\textsuperscript{254} See \textit{supra} note 253.

\textsuperscript{255} Another approach to establishing a reasonable price is to determine the provider's cost of providing the service and then add a reasonable profit to it. See Colomar \textit{supra} note 250 (In addition to what a hospital charges others for the same services, and what the market charges in general, another relevant factor that emerges from the pertinent case law is the particular hospital's internal cost structure.... On the other hand, rate increases untethered to any appreciable increase in costs would raise questions about the reasonableness of the rate increases and the overall reasonableness of the charges.... This means that Mercy, as alleged, charged Plaintiff six times what it cost Mercy to treat her.... the Court cannot conclude as a matter of law that charging 600% above costs is reasonable.").
It is important to note that neither the market approach or the Medicare approach rely directly on the CDM prices established by providers. This is both intentional and important. In addition, it is also important to recognize that usual, customary, and reasonable charges (often referred to as UCR charges) are based directly on CDM prices; for the reasons discussed below, UCR-based charges also should not be used to establish the fair and reasonable market value of healthcare.

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256 The most important information for courts and legislatures to understand is that paid charges, and not billed charges, represent usual, customary, fair, and reasonable healthcare prices. See Nation, Accident supra note 6 at 695; see generally, Nation, Chargemaster, supra note 2.

257 See Colomar supra note 250 (noting that if most hospitals have excessive charges comparing charges among hospitals is not a reliable indication of reasonable charges). I argue here that that is indeed the case today with respect to hospital chargemaster based prices. See supra notes 1-26 and accompanying text. Hospitals use a number of deceitful arguments to convince courts they should apply the hospital’s chargemaster rates to determine the usual, customary, and reasonable price. For example, hospitals commonly have their billing manager or other financial officer provide an affidavit or testimony stating, disingenuously, that all of the hospital’s patients are billed or charged at its chargemaster rates, and further that the patient’s billed charges, based on its chargemaster rates, represents the usual, customary, and reasonable charges of the hospital. This is very deceiving because hospitals use the word charges to confuse courts by implying charges are a proxy for payments. The hospital implies, without ever saying explicitly, its chargemaster rates are actually the rates most of the hospital’s patients pay. This of course is completely false. See Nation, Accident supra note 6 at 658-664 (discussing how hospitals take advantage of the fact that in most industries the price listed for a product is very close to the price usually paid for the product). In fact, on average, less than 5 percent of hospital patients ever pay excessive chargemaster rates. Id. Moreover, chargemaster rates are, on average, more than 300 percent of the amount hospitals are actually paid for their goods and services and are about 500 percent of Medicare rates. Id. Thus, chargemaster rates clearly are not reasonable, customary, or usual. Id.

258 See infra notes 256 - 277 and accompanying text. UCR chargers are simply another name for list or chargemaster prices — and these prices are excessive, set unilaterally by hospitals and not accepted by the marketplace. They should play no role in establishing the price of medical care. There is no percentage that can be applied to charges to ensure a reasonable price.
The great variation in the price that a patient may owe for healthcare is due to the bizarre chargemaster-based pricing system that is unique to the healthcare industry.\textsuperscript{259} Few people understand chargemaster-based pricing.\textsuperscript{260} Many providers take advantage of this ignorance to price gouge vulnerable patients.\textsuperscript{261} A large part of the confusion surrounding chargemaster-based pricing is due to the sleight of hand that occurs when providers use the word “charges” as a proxy for “prices.”\textsuperscript{262} In virtually every other context “the price” or “the charge” refers to the amount actually paid—that is, the reimbursement actually received by the seller.\textsuperscript{263} Healthcare, however, is unique in that there is a huge difference between what hospitals refer to as “list prices” or “billed charges” and actual payments or “reimbursements.”\textsuperscript{264} This is because, as noted, charges (CDM prices) are set unilaterally by hospitals, and these CDM prices are set not to be paid but to be discounted in negotiations with third-party payers.\textsuperscript{265} Reimbursements are the true measure of market value in the context of healthcare, as indeed they are in any other market.\textsuperscript{266} As courts begin to understand the misleading nature of chargemaster-based pricing, their opinions are starting to reject the claim

\textsuperscript{259} See Nation, Chargemaster \textit{supra} note 2 at 750-760 (discussing the chargemaster based pricing system).
\textsuperscript{260} Id.
\textsuperscript{261} Id. \textit{Id.}
\textsuperscript{262} Id. \textit{Id.}
\textsuperscript{263} Id. \textit{Id.}
\textsuperscript{264} Id. \textit{Id.}
\textsuperscript{265} Id. \textit{Id.}
\textsuperscript{266} Id.
made by hospitals that chargemaster-based prices are reasonable and represent the market value of healthcare.\footnote{See, e.g., In re North Cypress Medical Center Operating Co., Ltd., No. 16-0851 (Tex. 2018) (The majority opinion held that it “defies logic” to conclude that the reimbursement rates paid by insurers and government payers “have nothing to do with the reasonableness of charges” for uninsured patients, particularly because insurance and government reimbursements “comprise the bulk of a hospital’s income for services rendered.” The Majority went on to note that: Commentators lament the increasingly arbitrary nature of chargemaster prices, noting that, over time, they have “lost any direct connection to costs or to the amount the hospital actually expect[s] to receive in exchange for its goods and services.” George A. Nation III, Hospital Chargemaster Insanity: Heeling the Healers, 43 PEPP.L.REV. 745, 755 (2016) (citing Christopher P. Tompkins et al., The Precarious Pricing System for Hospital Services, 25 HEALTH AFF. 45, 48 (2006)) (majority opinion available \url{here}); Bowden v. Medical Center, 773 S.E.2d 692 (Ga. 2015) (similar).}

In the case of Medicare and Medicaid, the government sets the price it will pay.\footnote{See supra notes 1-26 and accompanying text.} These are set prices and not market-determined prices. Private health insurers negotiate contracts with hospitals, usually every year, and those contracts state specifically how much the health insurer will pay for services received by patients covered by that insurer. The reimbursement prices paid by commercial health insurers are the only truly market-derived prices for health care.\footnote{See supra notes1-26 and accompanying text.} As noted, self-pay patients are usually billed at excessive chargemaster prices.\footnote{See supra notes 26-78 and accompanying text.} This practice is unfair and cruel to the individual patients; at the same time, it contributes significantly to the excessive and ever-growing price of healthcare in the United States.\footnote{See, e.g., See, Anderson et al supra note 73 (the sizable differences in health spending between the US and other countries were explained mainly by health care prices). \url{https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05144} Zack Cooper et al, Hospital Prices Grew Substantially Faster Than Physician Prices For Hospital-Based Care in 2007-14, Health Affairs Vol. 38 no. 2 Feb. 2019 (Evidence suggests that growth}
I have discussed in detail elsewhere the reasons why CDM prices should play no part whatsoever in the establishment of the fair and reasonable market value of healthcare. In summary, CDM prices are wildly excessive. They are not market prices because they are set unilaterally by providers. They are rejected by the marketplace: no one knowledgeable about healthcare billing and payment agrees to pay these prices, and on average less than five percent of patients overall pay these extreme rates.

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

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272 See Nation, *Fair & Reasonable, supra* note 1 at 457-470.
273 *Id.* It is important to note that this does not mean that many patients do not have their lives ruined by hospitals and other providers aggressive but ultimately unsuccessful efforts to collect these excessive rates and in that particular context of third party liability, hospitals often misuse hospital lien statutes to recover either all for a large percentage of these excessive rates.
274 See *supra* notes 1-26 and accompanying text.
275 See *supra* notes 1-26 and accompanying text.
However, as noted elsewhere, hospitals never miss an opportunity to try to collect these unreasonable rates whenever possible and pursue these

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276 CDM-based prices are unconscionable. See, e.g., Moran v. Prime Healthcare Management Inc., California Court of Appeal, Fourth District, Division 3 (Moore, J); September 14, 2016 (published October 5, 2016); 2016 WL 5815785

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

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

Id. at 2016 WL 58157854. The court noted that a claim of contractual unconscionability, has both a procedural and a substantive element, the former focusing on oppression or surprise due to unequal bargaining power, the latter on overly harsh or one-sided results. The court also noted that the procedural element of an unconscionable contract generally takes the form of a contract of adhesion, which, imposed and drafted by the party of superior bargaining strength, relegates to the subscribing party only the opportunity to adhere to the contract or reject it, while substantively unconscionable terms may take various forms, but may generally be described as unfairly one-sided. The court noted that the patient alleged that all emergency room patients had to sign the admission agreement before being treated, and that these allegations, in the context of a summary judgement motion, support a finding of procedural unconscionability. As for substantive unconscionability, the court stated that the price term of a contract can establish substantive unconscionability.

The court noted that when evaluating the price charged courts consider, among other factors, not only the market price, but also the cost of the goods or services to the seller. The court stated:

This case concerns the cost of medical care provided to uninsured patients visiting a defendants' hospital emergency room. Plaintiff has alleged that
exorbitant reimbursements aggressively, notwithstanding the pain and suffering it causes patients.\textsuperscript{277}

2. \textbf{Market-Based Pricing}

Unfortunately, there is not a properly-functioning free market for healthcare with respect to self-pay patients.\textsuperscript{278} However, there is, in many cases, a well-functioning free market for healthcare with respect to in-network commercial insurance companies.\textsuperscript{279} Hospitals enter into contracts with various health insurance companies wherein they negotiate the reimbursement levels that the insurance company will pay for its members who receive care from the hospital.\textsuperscript{280} These contracts are typically renegotiated annually.\textsuperscript{281} Moreover, insurance companies and hospitals often have relatively equal bargaining power and knowledge regarding healthcare billing and reimbursement.\textsuperscript{282} As

\begin{center}
\textsuperscript{277} See supra notes 1-78 and accompanying text.
\textsuperscript{278} See Nation Fair & Reasonable supra note 1 at 458-459.
\textsuperscript{279} \textit{Id}. at 460-461
\textsuperscript{280} \textit{Id}.
\textsuperscript{281} \textit{Id}.
\textsuperscript{282} \textit{Id}.
\end{center}

\textit{Id}. at [pincite needed]. The court concluded that the patient had alleged facts sufficient to claim that the price term in the admission agreement based on chargemaster rates was unconscionable. See supra notes 204-224 and accompanying text.
a result, these negotiated contracts often represent the true free market value for health care.\footnote{283}

As I have discussed in detail elsewhere, the average reimbursement price paid by in-network commercial health insurers is often the best starting point for determining the fair and reasonable market-based price of healthcare for self-pay patients.\footnote{284} However, commercial health insurance companies provide benefits to hospitals that self-pay patients do not provide.\footnote{285} These benefits include—for non-emergency patients\footnote{286}—the increased patient volume that results from gaining access to all of the insurer’s customers and—for all insured patients—quick and reliable payment of hospital invoices.\footnote{287} As a result, it may be appropriate to adjust the average commercial insurer reimbursement rate upward by ten to 15 percent\footnote{288} when determining the fair market based value of health care for self-pay patients.\footnote{289}

\footnote{283}{Id.}
\footnote{284}{Id. at 461-465}
\footnote{285}{Id.}
\footnote{286}{Id. For emergency care, the Medicare-based rate should apply because there is no market for emergency care; patients exercise no choice concerning the hospital to which they are taken.}
\footnote{287}{Id.}
\footnote{288}{Id. Another commentator, using different methodology and arriving at a different formula nonetheless arrives at a similar amount as representing a fair reimbursement amount for self-pay patients. Id. at 463-464 (discussing a proposal by Dr. Gerard Anderson to calculate the price for self-pay patients at the Medicare reimbursement rate plus 25 percent).}
\footnote{289}{It is important to note that even with such an adjustment these rates are still far less than the excessive CDM rates. Specifically, if on average commercial insurers pay 160\% of the Medicare rate, then with this adjustment self-pay patients would pay about 170\% to 175\% of the Medicare rate, or 34\% to 35\% of the CDM rate, given that, on average, the CDM rate is 500\% of the Medicare! See supra note 11.}
Notwithstanding the fact that, as discussed, some adjustment may be necessary, a market-based rate is clearly preferable and easily attainable.\textsuperscript{290} Hospitals have the necessary information readily available and can easily calculate their average commercial insurer reimbursement rate; courts are beginning to recognize patients’ rights to discover this information.\textsuperscript{291} An additional benefit to using an average is that no proprietary information of any particular insurer or hospital need be disclosed.\textsuperscript{292} Finally, this approach would allow hospitals to continue to set their prices at any amount they wish, but would allow them to enforce those prices against self-pay patients only if the marketplace (commercial health insurers) accepts and pays those prices.\textsuperscript{293} It also would have the beneficial effect of encouraging providers to join insurers’ networks.\textsuperscript{294}


\textsuperscript{291}See supra note 257; See Uwe E. Reinhardt, The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy, 25 HEALTH AFF. 57, 58 (2006) (noting that each private insurer negotiates the dollar level of payments with each hospital every year).

\textsuperscript{292}Hospitals typically claim that such information is proprietary. The litigation related discovery of such information can be accomplished by use of a protective order, but I think an average still provides a better overall base. See Nation, Fair & Reasonable supra note 1 at 460-461.

\textsuperscript{293}See Nation, Balance Billing, supra note 6 at 172-173 (discussing the importance in a free market of allowing sellers to set their own prices– as long as buyers are free to reject them as too high).

\textsuperscript{294}Another reasonable approach to establishing the price is binding arbitration, which a number of states use. A potential problem with arbitration is the increased administrative expense associated with it. Some proposed bills address this problem by requiring that the arbitration results be made public. This type of arbitration is a good alternative, as long as the arbiters are instructed to consider negotiated in-network rates and Medicare rates, but not provider charges in any form. See George
3. **Medicare-Based Pricing**

   Government insurers—Medicare and Medicaid—pay rates set by the Centers for Medicare and Medicaid Services (CMS); these rates are not the result of market competition.\(^{295}\) Technically, hospitals do not have to agree to accept government insurance.\(^{296}\) Hospitals agree to accept Medicare rates only when they sign a provider agreement with CMS.\(^{297}\) Practically speaking, however, given the fact that the U.S. government spends almost 20 percent of its budget on healthcare, it is unrealistic for most hospitals not to accept Medicare patients.\(^{298}\)

   The rates paid by government insurers typically represent the lowest rates that hospitals agree to accept as full payment; Medicaid rates are lower than Medicare rates.\(^{299}\) Many have argued that Medicaid rates are actually too low: that is, that they

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\(^{296}\) See Nation, Fair & Reasonable, supra note 1 at 463 – 64 (discussing the proposal by Dr. Gerand Anderson to calculate the price for self-pay patients at the Medicare reimbursement rate +25%).

\(^{297}\) See Nation, Chargemaster supra note 2 at 661 (noting that hospitals voluntarily agreed to accept Medicare and Medicaid patients by signing a Provider Agreement and that by signing the Provider Agreement hospitals agree to accept the amount paid by Medicare and Medicaid as full payment).


\(^{299}\) See supra notes 1-26 and accompanying text.
are below hospital cost. Some have also made that argument with regard to the Medicare rates. Although a thorough evaluation of these claims is beyond the scope of this article, it does seem likely based on the available evidence that Medicare reimbursement rates may need to be adjusted upward in order to arrive at a fair and reasonable price.

One expert has argued in favor of setting the reimbursement rate for hospitals at 125 percent of the Medicare reimbursement rate. The Medicare plus 25 percent-based rate is usually similar in amount to the average in-network commercial insurance company reimbursement rate plus ten to 15 percent, as discussed above. An important benefit to using Medicare rates is that they are readily available and updated regularly by CMS. The main drawback to using Medicare rates is that they are not market-based.

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300 See Nation, *Fair &Reasonable*, supra note 1 at 459-460 (government insurers’ reimbursement rates are said to be below fully allocated costs).


302 See Nation, *Fair & Reasonable*, supra note 1 at 463 – 65 (discussing the proposal by Dr. Gerand Anderson to calculate the price for self-pay patients at the Medicare reimbursement rate +25%).

303 Id.

304 Id.

305 Id.; see Susannah Luthi, *California Hospitals Blast New Rate Setting Proposal for Providers*, Modern Healthcare April 10, 2018 (discussing a California proposal that would mandate regulated rate setting for providers and use Medicare rates as the benchmark to calculate commercial insurance payments) (https://www.modernhealthcare.com/article/20180410/NEWS/180419994)
As such, the Medicare approach denies hospitals the ability to establish their own prices.\textsuperscript{307}

It is important to note that under the market-based price argued for above, hospitals continue to have the power to set their own prices, but those prices must be accepted by the marketplace to be enforceable against self-pay patients.\textsuperscript{308} In other words, hospitals may set their rates at any level they wish as long as they can entice insurance companies, the only other market participants with the knowledge and market power to fairly negotiate with them, to agree to pay those rates.\textsuperscript{309}

However, it may not always be possible to use the market price approach because some markets are not adequately competitive.\textsuperscript{310} In those cases, using Medicare-based prices may be necessary.\textsuperscript{311} For example, there is no competitive market for patients who enter the hospital through the emergency department.\textsuperscript{312} These patients do not choose the hospital to which they are admitted; that choice is typically made by the

\textsuperscript{306} Id.
\textsuperscript{307} See Nation, Accident, supra note 12 at 686 (noting that using the average negotiated private insurance rate +10 to 15\% allows hospitals to continue to set their prices at any level they wish as long as they can get the insurance companies– the only other market participants with the knowledge and market power to fairly negotiate with them– to agree to pay those rates) (notes omitted).
\textsuperscript{308} Id.
\textsuperscript{309} Id.; see Nation, Balance Billing, supra note 6 at 172-173 (Price Setting Freedom in a Free Market).
\textsuperscript{310} See Nation, Accident supra note 6 at 686 (noting that some markets are not adequately competitive and therefore, resorting to the Medicare based rate may be necessary).
\textsuperscript{311} Id.
\textsuperscript{312} Id. at 685 (noting that there is no benefit of new patients associated with emergency care).
ambulance company.\textsuperscript{313} Also, in the case of non-emergency admissions, if a hospital does not have at least three in-network insurance companies, then the only option is to use Medicare prices.\textsuperscript{314}

V. Conclusion

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

When a hospital admission agreement is signed in the emergency department, the extreme circumstances under which it is signed prevent the patient from being able to give free and knowing assent. Moreover, proper application of the doctrine of objective intent and the duty to read reaches the same conclusion. This application dictates that the admission agreement is not a contract. The patient’s only obligation to the hospital is

\begin{footnotes}
\item[313] \textit{Id.}
\item[314] \textit{Id.} at 686.
\end{footnotes}
based on quasi-contract, and pursuant to quasi-contract the patient is liable to pay the reasonable market value of the medical care received.

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

However, in the vast majority of non-emergency hospital admissions, the admission agreement that a patient is required to sign is a quintessential example of the modern contract of adhesion. It is a one-sided agreement drafted solely by the hospital, which is the stronger and much more well-informed party, presented to the patient on a take-it-or-leave-it basis wherein the patient has absolutely no ability to negotiate the terms of the agreement.

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

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

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

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