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Obscene Contracts: 
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Hospital Billing of the Uninsured

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I. Introduction

A headline in a national newspaper reads: "Full Price: A Young Woman, An Appendectomy, And a $19,000 Debt." The story concerned Rebekah Nix, a twenty-five-year-old college graduate and former magazine fact checker who spent two days in New York Methodist Hospital in Brooklyn for an appendectomy. She was billed $19,000: $14,000 for the hospital stay and $5,000 for physician's fees.

There is nothing surprising about the fact that medical services are expensive. What is shocking is that services are much more expensive for patients like Ms. Nix who are uninsured. While Ms. Nix's bill was $14,000, New York Methodist is reimbursed only about $2,500 by health maintenance organizations ("HMOs") for the same two-day hospital stay.

Unfortunately, Ms. Nix's story is not unusual. Consider the case of Mr. Shipman, a forty-three-year-old former furniture salesman from Herndon, Virginia. He experienced severe chest pain one night and was taken by

1 Professor of Law and Business at Lehigh University. As a general definition of the word obscene Black's offers "Objectionable or offensive to accepted standards of decency." BLACK'S LAW DICTIONARY 971 (5th ed. 1979). Thus, generally "obscene contracts" are those that are objectionable or offensive to accepted standards of decency. The legal doctrine most often used to prevent enforcement of such contracts is unconscionability. However, to determine whether a specific contract is unconscionable is difficult because the doctrine, like obscenity, is described in broad and general terms. As Justice Stewart noted, obscenity is tough to define, "[b]ut I know it when I see it." Jacobellis v. State of Ohio 378 U.S. 184, 194 (1964) (Stewart, J., concurring)—so too with unconscionable contracts, exact definition is elusive but you know them when you see them—and hospital admission contracts that require uninsured patients to pay the hospital's "full charges" are a case in point.


3 Id.

4 Id.

5 Id.

ambulance to a community hospital emergency room and then to Inova Fairfax Hospital, where doctors performed a cardiac catheterization and inserted a stent. Mr. Shipman checked himself out of the hospital the next morning against medical advice, because he lacked health insurance and was concerned about the expense. He was right to be concerned. Mr. Shipman's two-day health crisis left him with a $37,000 medical bill. However, the same services Mr. Shipman received would have been reimbursted by Medicaid at $7,165 and by Medicare at $16,047. Obviously the fact that Ms. Nix and Mr. Shipman are expected to pay for the medical services they received is not surprising or unreasonable. What is shocking and unfair is that in each case the hospital would have accepted a fraction of the amount Mr. Shipman and Ms. Nix were expected to pay if the payor were Medicaid, Medicare, an HMO, or a private insurer. In effect, hospi-

7 Id.
8 Id.
9 Id.
10 Id.
11 Even a patient who is in an emergency situation and unconscious at the time of receiving medical services is obligated to pay for the services under the equitable doctrine of unjust enrichment. See, e.g., Eagle v. Snyder, 604 A.2d 253, 270 (Pa. Super. Ct. 1992) (quoting Husik v. Lever, 95 Pa. Super. 258, 260 (1928) ("In the absence of an express agreement as to amount, the law implies a promise to pay for a physician's services as much as they are reasonably worth."); JOHN EDWARD MURRAY JR., MURRAY ON CONTRACTS § 19 (3d ed. 1990) ("To avoid unjust enrichment, the law permits the party who has conferred the benefit to recover the reasonable value of the benefit."); JOHN D. CALAMARI & JOSEPH M. PERILLO, THE LAW OF CONTRACTS §§ 1-12 (2d ed. 1977) (citing Greenspan v. Slate, 97 A.2d 390 (N.J. 1953)) ("[I]f 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.").

However, the unconscious patient has a distinct advantage over uninsured patients such as Ms. Nix or Mr. Shipman, because under the doctrine of unjust enrichment, the unconscious patient is only obligated to pay the reasonable value of the service received, whereas uninsured patients are liable to pay many times the reasonable value of the service they receive. See Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alternatives, Inc., 832 A.2d 501, 508-11 (Pa. Super. Ct. 2003) (stating that, after their contract expired, Healthcare's subscribers continued to receive medical services at Temple. Temple billed Healthcare at its published rates or full charges for such services. The court held that Temple had a right to be paid the reasonable value of its services under a theory of unjust enrichment. However, the court held that Temple's full or published charges were not reasonable because they were paid by only one to three percent of patients.).

12 See Lucette Lagnado, Medical Mark Up: California Hospitals Open Books, Showing Huge Price Differences; State Law Requires Disclosing Charges for Goods, Services; Big Bills for Uninsured; Why a Leech Retails for $81, WALL. ST. J., Dec. 27, 2004, at A1 ("List prices are usually charged only to uninsured patients. Health plans negotiate big discounts and the government essentially dictates what it will pay."). The reasons for this are the result of the current third party reimbursement system. Each hospital maintains a "charge master" or list of its retail or "full charge" prices for every good or service offered by the hospital. See Mark H. Gallant and John R. Washlick, Charity Care and Patient Discounts ... Love or Corruption?, in LOVE OR CORRUPTION: HOW OR WHEN CAN HOSPITALS DISCOUNT THEIR "USUAL CHARGES"? 1 (2004) [hereinafter Love
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The charge masters are updated frequently to capture price increases. Id. The systems and methods for creating a charge master are non-standardized among hospital systems and hospitals. Id. Even within a hospital system each hospital's charge master may be different, reflecting different prices or different items. Id. However, only the uninsured are expected to pay these "full charges" or "list prices," because all of the third party payors pay less. Id. at 1–2. Under Medicare, the federal program for the elderly and disabled, the hospital receives a flat rate based on the diagnosis for all care, including drugs. See Lagnado, supra. Medicaid, the federal-state program for the poor, pays a negotiated amount, see id., which varies from state to state. See Love or Corruption, supra. ("Medicare/Medicaid typically dictates payment levels for 40–60% of patients .... Why haven't hospitals heavily discounted fees to the 'uninsured?' ... [B]ecause tiered charges are impractical administratively, pose issues under federal rules requiring uniform charges, and charge reductions can significantly undermine revenues under percentage of charge contracts."). "Health-maintenance organizations pay about 60% of the list price." Lagnado, supra. Commercial insurers also pay negotiated rates, which are contractually discounted. Id.; see also Temple, 832 A.2d at 506. (In concluding that the hospital's published rates exceeded the reasonable value of its services, the court stated: "[i]n other words, ninety-four percent of the time, the Hospital received less than eighty percent of the Hospital's published rates."). The court in Temple also noted that the hospital's "full published charges in 1994 were approximately 172% of its actual costs, while in 1995 and 1996, the published rates were approximately 300% of its actual costs," and "that private payors typically paid 121% of the cost of hospital services in 1994, 119% in 1995, and 112% in 1996," while "[Medicare and Medicaid] generally pay less." Id. at 509.

In addition to the uninsured, tortfeasors/automobile insurance and liability carriers may reimburse medical expenses based on the hospital's full charges, though this has been criticized. See generally William R. Jones, Jr., Managed Care and the Tort System: Are We Paying Billions In Phantom Healthcare Charges?, Ariz. Atty., at 28 March 1996 (critiquing this practice and suggesting reforms).

The following quote from the article concerning Shipman is telling.
Mr. Shipman negotiated a discount from at least one physician involved in his care. Joseph Kiernan, a cardiologist who practices at Inova Fairfax, billed Mr. Shipman $6,800, but when the Shipmans told him they couldn't afford to pay that much, he slashed some $3,000 off the bill, bringing it down to about $3,800. That is still more than what big government payers such as Virginia Medicaid would have paid. A spokesman for the state agency says it would have reimbursed the physician slightly over $1,000; Medicare says it would have paid about $900. "We feel that patients should be somewhat responsible for the medical costs," Dr. Kiernan says. For uninsured patients who are uninsured but not indigent, "we come up with a compromise solution." Lagnado, supra note 4.

The physician is involved in price discrimination—charging more to customers that he perceives as being able to pay the premium charge. In addition to the obvious profit maximization incentive to engage in price discrimination, there also appears to be a "cost shifting" incentive present in healthcare. For example, Jeff Laramie, owner of the ambulance company that transported Mr. Shipman, stated that, "[p]rivate payers generally pay along the lines of 70% to 80% of the charges ... [and] charges are high to compensate for low reimbursements

13 See Mark Klock, Unconscionability and Price Discrimination, 69 Tenn. L. Rev. 317, 327, 354, 366, n.323 (2002) (discussing price discrimination as charging different prices to different customers for the same goods or services and arguing that price discrimination is unconscionable).

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hospital is willing to accept for its goods and services varies depending on who the patient is, or more precisely, on the identity of the payor.14

Ms. Nix and Mr. Shipman represent the common fate suffered by the 45 million uninsured Americans when they receive medical treatment; they are billed at the hospital's "regular rates," "full charges," or "list prices."15 These charges are generally at least double and may be up to eight times what the hospital would accept as payment in full for the same services from Medicare, Medicaid, HMOs, or private insurers.16 The labels for these charges, "regular," "full," or "list," are misleading, because in fact they are actually paid by less than five percent of patients nationally.17 Moreover, medical bills are now a leading cause of personal bankruptcies.18 As a result, the billing and debt collection practices of hospitals have become a heated political and social issue.19

14 See supra note 10 and accompanying text.

15 See generally Lagnado, supra note 2; Lagnado, supra note 6; Love or Corruption, supra note 12.

16 See Lagnado, supra note 6, at B4 (noting that "Hal Cohen, a health-care consultant who has studied hospital markups in all fifty states ... says some U.S. hospitals charge as much as 10 times their costs."). The same article notes that Shipman was billed more than eight times the amount that Medicare would have paid for the physician charge. Id.

Unfortunately, the exact predetermined fixed rates paid by managed care plans are carefully guarded secrets. Our research disclosed that every private managed care contract contains a confidentiality provision. The providers in our locality who would talk to us estimated that one-third to one-half of all of their patients' bills were paid by some form of private managed care; and on average, their fixed fee for the services they rendered to managed care patients was no more than 50 percent of their billed charges.

17 See, e.g., Vencor, Inc. v. Nat'l States Ins. Co., 303 F.3d 1024, 1029 n.9 (9th Cir. 2002) ("It is worth noting that in a world in which patients are covered by Medicare and various other kinds of medical insurance schemes that negotiate rates with providers, providers' supposed ordinary or standard rates may be paid by a small minority of patients."); Temple, 832 A.2d at 508 ("[T]he hospital was paid its full published charges in only one to three percent of its cases."); Lagnado, supra note 12 (noting that almost no one other than the uninsured is asked to pay list prices).

18 See Lucette Lagnado, Taming Hospital Billing, WALL ST. J., June 10, 2003, at B1 (noting that "medical debt has emerged as a leading cause of personal bankruptcy"); World-Wide, WALL ST. J., Feb. 2, 2005, at A1 (noting that a "Harvard study in the journal Health Affairs found [that] [m]edical bills trigger half of all personal bankruptcies").

19 Moreover, this is likely to continue given the ever increasing cost of health care. Glenn Menick, a professor of healthcare finance at the University of Southern California expects health care costs to increase by eight percent to nine percent per year over the next five
This article argues 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, and as a result the most that the patient is liable to pay the hospital is the reasonable value of the medical goods and services received. Moreover, reasonable value should be defined as the average reimbursement actually collected, not billed, by the hospital for the diagnostic code that applies to the medical services received by the patient.  

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

II. UNCONSCIONABILITY: AN OVERVIEW

A. History of the Doctrine

The doctrine of unconscionability concerns fairness. The doctrine can be used to refuse enforcement of all or part of an agreement that is deemed by a court to be sufficiently unfair as to be unconscionable. The doctrine

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

21 See Friedrich Kessler et al., Contracts: Cases and Materials 560 (3d ed. 1986) (noting that courts of equity developed the doctrine of unconscionability to protect victims of sharp dealing).

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

Courts and legislatures have grown increasingly sensitive to imposition, conscious or otherwise, on members of the public by persons with whom they deal, who through experience, specialization, licensure, economic
has a long, if somewhat checkered, history.\textsuperscript{23} \textit{Earl of Chesterfield v. Janssen}\textsuperscript{24} is cited as the source of the doctrine in English law.\textsuperscript{25} In the United States, the Supreme Court stated in \textit{Hepburn v. Dunlop \& Co.}\textsuperscript{26} that a contract should be set aside if in conscience it should not be enforced.\textsuperscript{27} In \textit{Hume v. United States},\textsuperscript{28} the Supreme Court quoted \textit{Earl of Chesterfield} in noting that a bargain is unconscionable if it is “such as no man in his senses and not under delusion would make on the one hand, and as no honest and fair man would accept on the other.”\textsuperscript{29}

The doctrine of unconscionability is recognized in Article 2 of the Uniform Commercial Code.\textsuperscript{30} Article 2 states:

\begin{quote}
strength or position, or membership in associations created for their mutual benefit and education, have acquired such expertise or monopolistic or practical control in the business transaction involved as to give them an undue advantage. Grossly unfair contractual obligations resulting from the use of such expertise or control by the one possessing it, which result in assumption by the other contracting party of a burden which is at odds with the common understanding of the ordinary and untrained member of the public, are considered unconscionable and therefore unenforceable.
\end{quote}

\textit{Id.} at 856 (citation omitted).

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

\textit{Id.} at 857.


\textsuperscript{25} See Brown, \textit{supra} note 23, at 289 (“As early as 1697, English law already had an equitable rule against the enforcement of unconscionable contracts.”).

\textsuperscript{26} \textit{Hepburn v. Dunlop \& Co.}, 14 U.S. 179 (1816).

\textsuperscript{27} \textit{Id.} at 197.

\textsuperscript{28} \textit{Hume v. United States}, 132 U.S. 406 (1889).

\textsuperscript{29} \textit{Id.} at 415; see also \textit{Eyre v. Potter}, 56 U.S. 42, 60 (1933) (behavior sufficiently outrageous to shock the conscience of the court).

\textsuperscript{30} See U.C.C. § 2-302 (1990). This section, perhaps more than any other in Article 2, has been the subject of controversy. \textit{See supra} note 23 and accompanying text.
If the court as a matter of law finds the contract or any clause of the contract to have been unconscionable at the time it was made the court may refuse to enforce the contract, or it may enforce the remainder of the contract without the unconscionable clause, or it may so limit the application of any unconscionable clause as to avoid any unconscionable result.  

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

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

If a contract or term thereof is unconscionable at the time the contract is made a court may refuse to enforce the contract, or may enforce the remainder of the contract without the unconscionable term, or may so limit the application of any unconscionable term as to avoid any unconscionable result.

The comments to section 208 are similar to the official comments to U.C.C. section 2-302 in that they indicate that the doctrine of unconscionability is widely applied by courts to consumer sales contracts and in certain circumstances to sales contracts between merchants as well.

31 U.C.C. § 2-302(1) (1990); see Brown, supra note 23, at 291 (noting that "[i]t took a decade before the courts began using ... 2-302"; "[b]y 1968, fewer than 20 cases were decided on the basis of § 2-302.").
33 JAMES J. WHITE & ROBERT S. SUMMERS, UNIFORM COMMERCIAL CODE 206, 134 (4th ed. 1995) (noting that the section is "enshrined in the statutory law of forty-nine states."). California omitted § 2-302 when it adopted the code, but unconscionability is part of California law by statute. See, e.g., CAL. CIV. CODE § 1670.5 (Deering 2004).
34 See Brown, supra note 23, at 291 ("[Unconscionability] is widely applied by courts to consumer sales contracts and in certain circumstances to sales contracts between merchants as well.").
35 See Restatement (Second) of Contracts § 208 (1981).
37 See U.C.C. § 2-102 (1990) ("[T]his Article applies to transactions in goods ... ").
38 See Restatement (Second) of Contracts § 208 (1981).
39 Id.
nability allows a court to refuse to enforce part or all of an agreement because the contract or term is so unfair as to be unconscionable rather than resort to "adverse construction of language"40 of the contract or clause.41 Also similar to the code's section 2-302, no definition of unconscionability is provided.42

There are at least two reasons for the doctrine's checkered history. First, the idea of invalidating a contract, otherwise enforceable, because it is deemed by a court to be unfair seems to violate a basic principle of contract law: freedom of contract.43 That is, a competent person has the freedom (within the boundaries set by the established policing, formation, and disclosure doctrines such as fraud, duress, etc.) to enter into any agreement they see fit, profitable or unprofitable, fair or unfair.44 Thus, the doctrine of unconscionability seems to violate the principle of freedom of contract.45 It has, however, been argued that, in fact, the doctrine strengthens the principle of freedom of contract by preventing its abuse.46 Under the framework

41 See Restatement (Second) of Contracts § 208 cmt. a (1981) ("[T]he rule of this Section permits the court to pass directly on the unconscionability of the contract or clause rather than to avoid unconscionable results by interpretation.").
42 Id.
43 See Klock, supra note 13, at 333 ("[T]here is a fundamental tension between the doctrine and basic contract law, which holds that the level of consideration is irrelevant to contract formation.") Klock goes on to state:
   Unconscionability, for which no redundant defenses exist, is indeed inconsistent with fundamental contract theory. Basic contract theory requires only competent parties making an agreement with bilateral consideration to make an enforceable contract. The consideration can be as nominal as a peppercorn for the agreement to be legally enforceable. Courts do not inquire into the distribution of benefits between the parties. This legal fact is deeply rooted in a strong faith in the efficiency of free markets. Individuals do not voluntarily enter into agreements that they expect to make them worse off than before the agreement. If the agreement was made voluntarily, everyone is presumed to have been made better off by the agreement. This presumption can be justified by economic thought which, given a few simple axioms, demonstrates that markets will channel resources to their most valued use and maximize society's wealth when all market participants are permitted to freely make their own decisions. Government intervention cannot improve the allocation of resources and can even impede it. Unconscionability is an inherently paternalistic doctrine that is intended to protect individuals from the consequences of their own decisions and allows them to avoid detrimental terms.
   Id. at 343-44 (citations omitted).
44 See Calamari & Perillo, supra note 11, at §§ 1-3, 1-4.
45 See supra notes 43–44 and accompanying text.
46 See, e.g., Williams v. Walker-Thomas Furniture Co., 350 F.2d 445, 449 (D.C. Cir. 1965) ("Whether a meaningful choice is present in a particular case can only be determined by consideration of all the circumstances surrounding the transaction. In many cases the meaningful-
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discussed below, the doctrine applies only when the element of free choice is compromised, albeit not sufficiently to allow application of any of the more established doctrines such as fraud or duress.47

The second difficulty with the doctrine is its lack of definition. Neither the code, the restatement, nor the courts have developed a consistent specific definition of an unconscionable contract.48 Many definitions are tautologies: a contract is unconscionable because it contains unconscionable terms.49 This lack of definition has given rise to much of the criticism leveled at the doctrine. The most serious is that the doctrine is inconsistently applied because it encourages courts to simply substitute their own ex post judgment regarding fairness for the ex ante judgments of the parties.50 An analytical framework for unconscionability involving both procedural and substantive elements suggested by Arthur Allen Leff has, however, been widely accepted by courts and commentators.51 The doctrine's problems notwithstanding, unconscionability seems to be flourishing.52 It is frequently raised in cases, written into legislation, and written about by legal scholars.53

47 See Leff, supra note 23, at 487–89.

48 See Frank P. Darr, Unconscionability and Price Fairness, 30 Hous. L. Rev. 1819, 1830 (1994) ("The lack of definition or pretense of structure in section 2-302 of the code has led to unending criticism from legal academics."); Brown, supra note 23, at 291 ("Common law definitions of unconscionability are likewise so unclear and inconsistent that they provide little, if any, guidance.... American Law Institute's Restatement... also fail[s] to provide any guidance whatsoever.").

49 See U.C.C. § 2-302 cmt. 1 (1990) ("The basic test is whether, in the light of the general commercial background..., the clauses involved are so one-sided as to be unconscionable under the circumstances existing at the time of the making of the contract.").

50 See Alan Schwartz, A Reexamination of Nonsubstantive Unconscionability, 63 Va. L. Rev. 1053, 1062-63 (1977) (noting that if courts modify certain contracts ex post they will cease to be available ex ante).

51 See Brown, supra note 23, at 296 ("Professor Leff's article... probably comes closest to defining unconscionability."). While most courts accept Leff's analysis, a number of commentators have offered alternatives. See, e.g., Klock, supra note 13, at 376 (incorporating the idea of discrimination into the definition of unconscionability); Darr, supra note 48, at 1840 (suggesting that unconscionability analysis should address three factors: "the perceived fairness of the contract price compared to a reference price, the perceived fairness of the transaction process, and the ability of the market to enforce the perceived fair price.").

52 See Klock, supra note 13, at 333 ("There are three pieces of evidence that indicate that the doctrine continues to survive, if not flourish."); Darr, supra note 48, at 1832 ("Despite the large amount of ink spilled in criticism of the use of unconscionability, the courts nonetheless resort to the doctrine to reject or modify contractual arrangements. The courts have found some utility in the concept. They appear to be attempting to enforce some norms of community justice in these cases.").

53 See Klock, supra note 13, at 333–34 (citing examples of each); Brown, supra note 23, at 291 (noting that U.C.C. § 2-302 is "widely applied by courts....").
Leff's generally accepted analytical framework of unconscionability suggests that it is different from the defenses of fraud, duress, mistake, impossibility, or illegality because these traditional defenses focus on either the "process of contracting" or the "resulting contract," but not both. Unconscionability, according to Leff, looks at both the process and the result. Thus, there are two prongs to the unconscionability analysis: the process prong, or procedural unconscionability, and the results prong, or substantive unconscionability. While some courts are willing to find a contract unconscionable based on substantive unconscionability alone (this has most commonly occurred in excessive price cases), analysis of court decisions suggests that a majority of courts generally accept Leff's framework and require both procedural and substantive unconscionability. However, prior case law supports the application of a sliding scale, so that the existence of an extreme in one component would allow a contract to be found unconscionable even though the other component was present to a much lesser degree.

1. Procedural Unconscionability. — A contract is procedurally unconscionable if there is some defect in the contracting process such that one party has not entered into the agreement knowingly and freely. Important factors

54 See Leff, supra note 23, at 487.
55 Id.
56 Id.
57 See Brown, supra note 23, at 294–95.
58 See, e.g., Am. Home Improvement, Inc. v. Mac Iver, 201 A.2d 886, 887–89 (N.H. 1964) (contract unconscionable where homeowner agreed to pay excessive price and financing costs); Toker v. Westerman, 274 A.2d 78, 79–81 (Union County Ct. 1970) (contract unconscionable due to price more than 2 1/2 times reasonable retail value, no evidence of procedural unconscionability); Darr, supra note 48, at 1820–22 (reviewing price based unconscionability cases).
59 See Darr, supra note 48, at 1820 ("Generally, courts require... both substantive and procedural unconscionability."); WHITE & SUMMERS, supra note 33, at 151 (suggesting that both procedural and substantive unconscionability are required).
60 See Brown, supra note 23, at 305 n.175 (citing Tacoma Boatbuilding Inc. v. Delta Fishing Co., No. 165-72C3, 1980 U.S. Dist. LEXIS 17830, at *20 n.20 (W.D. Wash. Jan. 4, 1980) ("[T]he substantive/procedural analysis is more of a sliding scale than a true dichotomy."). Brown notes that this case is cited in WHITE & SUMMERS, supra note 33. WHITE & SUMMERS, supra note 33, at 151 ("[A] contract that is ninety-eight parts substantively unconscionable may require only two parts of procedural unconscionability to render it unenforceable and vice versa.").
61 See Brown, supra note 23, at 291, 297 (noting that procedural unconscionability involves surprise which "usually results where there are hidden contract terms, terms in unreadable fine print, or unusually complex technical terms that the ordinary consumer cannot understand.").
in this analysis are the relative bargaining power of the parties, whether the weaker party was free to negotiate for alteration of the terms offered (usually in a standardized preprinted form) by the stronger party, and whether the weaker party had the realistic opportunity to seek the goods or services elsewhere.\textsuperscript{62} The concept of an adhesion contract is similar to procedural unconscionability.\textsuperscript{63} Most courts find that an adhesion contract is procedurally unconscionable.\textsuperscript{64}

A procedurally unconscionable contract results in the surprise, oppression, or both of the weaker party.\textsuperscript{65} That is, the weaker party is surprised to learn of the terms of the agreement because they were hidden in fine print or obtuse language,\textsuperscript{66} or because the only way for the weaker party to acquire the goods or services was to agree to the terms dictated by the stronger party.\textsuperscript{67} Hospital admission contracts are drafted in a way that prevents the patient from knowing how much money they are agreeing to

\textsuperscript{62} See, e.g., Williams v. Walker-Thomas Furniture Co., 350 F.2d 445, 449 (D.C. Cir. 1965) ("Unconscionability has generally been recognized to include an absence of meaningful choice on the part of one of the parties together with contract terms which are unreasonably favorable to the other party."). The court went on to discuss the importance of the relative bargaining power of the parties: "[I]nquiry into the relative bargaining power of the two parties is not an inquiry wholly divorced from the general question of unconscionability, since a one-sided bargain is itself evidence of the inequality of the bargaining parties." \textit{Id.} at 450 n.7; Tunkl v. Regents of Univ. of Cal., 383 P.2d 441, 447 (Cal. 1963) (concerning an exculpatory clause in a hospital admission contract, the court noted that "the hospital certainly exercises a decisive advantage in bargaining. The would-be patient is in no position to reject the proffered agreement, to bargain with the hospital, or in lieu of agreement to find another hospital."). \textit{Tunkl} is discussed \textit{infra} at notes 168-70 and accompanying text.

\textsuperscript{63} See Wheeler v. St. Joseph Hosp., 133 Cal. Rptr. 775 (Cal. Ct. App. 1976). The case involved an agreement to arbitrate in a hospital admission contract. Regarding the definition of adhesion contract the court stated:

The term "adhesion contract" refers to standardized contract forms offered to consumers of goods and services on essentially a 'take it or leave it' basis without affording the consumer a realistic opportunity to bargain and under such conditions that the consumer cannot obtain the desired product or services except by acquiescing in the form contract.... The distinctive feature of a contract of adhesion is that the weaker party has no realistic choice as to its terms. \textit{Id.} at 783 (citations omitted). \textit{Wheeler} is discussed in more detail \textit{infra} at notes 171-90 and accompanying text.

\textsuperscript{64} See, e.g., Ting v. AT&T, 319 F.3d 1126, 1148 (9th Cir. 2003), \textit{cert. denied}, 540 U.S. 811 (2003) ("A contract is procedurally unconscionable if it is a contract of adhesion.").

\textsuperscript{65} See, e.g., Phoenix Baptist Hosp. & Med. Ctr., Inc. v. Aiken, 877 P.2d 1345, 1350 (Ariz. Ct. App. 1994) (concerning hospital admission contract signed by husband for medical services provided to his wife and purporting to make husband personally liable for such services, the court noted that "the trier of fact could conclude either that [the husband] did not understand the implications of the agreement, or that he felt he had no choice but to immediately sign the preprinted form.").

\textsuperscript{66} \textit{Id.}

\textsuperscript{67} \textit{Id.}
pay the hospital. In addition, the admission contract does not make clear that uninsured patients are, by agreeing to pay the hospital's "full charges," agreeing to pay many times the amount insured patients pay for the same medical services. Moreover, these agreements are entered into in circumstances where the patient has little opportunity to understand the terms offered and no choice but to agree to whatever terms the hospital dictates. The lack of a commercial setting, a bargaining table, or time to read and negotiate all contribute substantially to the procedural unconscionability of hospital admission contracts. The overriding factor, however, in finding hospital admission contracts procedurally unconscionable is that urgent medical services are necessities, and time is virtually always important. Thus, even if a patient understands the terms in the hospital admission contract and decides he does not want to agree to them, he is in no position to shop for an alternative supplier of urgently needed medical services. The patient must agree to the terms the hospital offers, because the patient

68 See infra notes 104-67 and accompanying text.

69 As noted above, the fact that hospital admission agreements do not contain a specific price for the medical services to be provided is not the fault of the hospital. In contrast, the fact that hospitals refer to "regular rates" or "full charges" is both deceptive and the hospital's fault. The phrases "regular rates," "full charges" or "list prices" imply that these are the amounts that all or at least most patients pay. In fact, less than five percent of patients pay this amount. See supra notes 10-17 and accompanying text. Thus, the agreement to pay "regular rates" results in unfair surprise and oppression to uninsured patients.

70 See St. John's Episcopal Hosp. v. McAdoo, 405 N.Y.S.2d 935 (N.Y. Civ. Ct. 1978). It is reasonable in this situation for defendant to have seen himself as powerless to do anything other than sign the form. A hospital emergency room is certainly not a place in which any but the strongest can be expected to exercise calm and dispassionate judgment.... Plaintiff hospital is surely no stranger to the trauma and anxiety experienced by those confronted with emergency medical crises. Armed with this knowledge it should have prepared the form it uses to impose liability so that the person being asked to sign it can readily grasp its meaning, even through quick reading. Moreover, plaintiff should not be permitted to enforce a contractual obligation entered into under such tension-laden circumstances, as those defendants described. Id. at 937. McAdoo is discussed infra at notes 198-204 and accompanying text.

71 Id.

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

73 A valid distinction may be drawn between necessary medical services, whether rendered on an emergency basis or on a planned basis, and elective medical services such as elective cosmetic surgery. See infra notes 204-14 and accompanying text.

74 See infra notes 204-14 and accompanying text.
requires the services. In the case of planned necessary medical services, the patient feels he must go to the hospital selected by his physician. This, of course, is not the fault of the hospital, nor does it alone make hospital admission contracts unconscionable and thus unenforceable. The fact that patients are forced by circumstances to agree to whatever terms the hospital offers does make hospital admission contracts procedurally unconscionable. However, the hospital admission contract will be unenforceable only if, in addition to being procedurally unconscionable, it is also substantively unconscionable or grossly unfair.

2. Substantive Unconscionability.—Substantive unconscionability is concerned with the terms of the agreement between the parties and not with the process from which they resulted. Specifically, a contract is substantively unconscionable if it is grossly unfair or contains terms that are so one-sided or unfair as to shock the conscience of the court. A contract or a provision of a contract may be found substantively unconscionable if it provides for the allocation of risks between the parties in an unreasonable or unexpected manner. Oppression or overreaching by the stronger party are hallmarks of substantive unconscionability. One court noted that a contract is substantively unconscionable if it results in the assumption by the weaker party “of a burden which is at odds with the common under-

75 See infra notes 204-14 and accompanying text.
76 See Wheeler v. St. Joseph Hosp., 133 Cal. Rptr. 775, 789 (Cal. Ct. App. 1976) (“A patient like Mr. Wheeler realistically has no choice but to seek admission to the hospital to which he has been directed by his physician and to sign the printed forms necessary to gain admission.”). Wheeler is discussed infra at notes 171-90 and accompanying text.
77 See infra notes 80-103 and accompanying text. Notwithstanding the fact that patients are in no position to properly negotiate or even focus on the terms of the admission agreement when they seek necessary medical services, there is nothing unreasonable in requiring patients to pay the reasonable value of the medical services they receive. Cf. supra note 11 and accompanying text (recovery in quasi contract for medical services rendered to a patient incapable of entry into a contract).
78 See supra notes 68-72 and accompanying text.
79 See infra notes 80-103 and accompanying text.
80 See Leff, supra note 23, at 509 (substantive unconscionability refers to the “gross overall imbalance of an entire contract.”).
81 See Brown, supra note 23, at 293 (discussing substantive unconscionability in terms such as unfair, harsh, one-sided, oppressive, or the unjustified reallocation of the risks of the bargain in an unreasonable or unexpected manner).
82 Id.; see, e.g., Ellsworth Dobbs, Inc. v. Johnson, 236 A.2d 843, 856 (N.J. 1967) (assumption of burden by weaker party that is at odds with consumer understanding is unconscionable).
83 See, e.g., U.C.C. § 2-302 cmt. 1 (1990) (“The principle is one of the prevention of oppression and unfair surprise ....”).
standing of the ordinary and untrained member of the public," or if the
terms are contrary to common fairness.84

An excessive price may support a finding of substantive unconscion-
bility.85 Excessive prices also provide an indication of defects in the bar-
gaining process.86 One commentator has concluded that "price unconscio-
nability is part of the basic foundation of contract law." Courts, however,
have been inconsistent in setting a standard for when a price becomes uncon-
scionably excessive.88 Some courts have found that an excessive mark up results in substantive unconscionability.89 Other courts have found a price to be substantively unconscionable if the contract price is higher than those charged by other merchants for the same or similar goods.90 Other
courts focus on whether the price returns too great a profit to the seller.91
In addition, a price might be considered exorbitant in part because of the
economic status of the purchaser.92

Commentators also have been inconsistent in setting a standard for an
unconscionable price.93 Some suggest that a substantively unconscionable
price results when the seller engages in price discrimination.94 An argument
may be made that charging a different price based solely on the identity

84 See Ellsworth Dobbs, Inc., 236 A.2d at 856..
85 See Brown, supra note 23, at 299 (noting that excessive price cases are a common type
of substantive unconscionability case).
86 See RESTATEMENT (SECOND) OF CONTRACTS § 208 cmt. c (1981) ("[G]ross disparity in
the values exchanged may be an important factor in a determination that a contract is uncon-
scionable . . .").
87 See Darr, supra note 48, at 1822 ("[P]rice unconscionability is part of the basic founda-
tion of contract law.") (citations omitted).
88 See Brown, supra note 23, at 299 (noting that the price cases "lack a consistent standard
for determining whether or not a price is excessive").
89 See, e.g., Frostifresh Corp. v. Reynoso, 274 N.Y.S.2d 757 (N.Y. Dist. Ct. 1966), rev'd on
other grounds, 281 N.Y.S.2d 964 (N.Y. App. Div. 1967) (Seller's cost was $348 and the install-
ment sale price was $1,145.80); Am. Home Improvement, Inc. v. Mac Iver, 201 A.2d 886 (N.H.
1964) (goods priced at $959 sold for $2,568).
retail value of $300 sold for $1,440); Toker v. Westerman, 274 A.2d 78 (Union County Ct. 1970)
(freezer with retail value of $400 sold for $1,230).
91 See Brown, supra note 23, at 301 ("Courts might consider a price excessive because it
returns too great a profit to the seller or because it represents a substantially higher price than
similarly situated merchants charge for like items.").
92 See Williams v. Walker-Thomas Furniture Co., 350 F.2d 445, 448–49 (D.C. Cir. 1965)
(the district court described one of the appellants, Ora Lee Williams, as being a person of
limited education separated from her husband and maintaining herself and her seven children
by means of public assistance.)
93 Cf. Darr, supra note 48, at 1841 (three requirements for excessive price to be uncon-
scionable: high price based on a standard such as cost, fair market value, or historic price; pro-
cess problems; and market failure in sense of no private enforcement of price norms); Klock,
supra note 13, at 373 (excessive price is unconscionable only in context of market failure).
94 See Klock, supra note 13, at 367.
of the buyer with no cost justification is always unconscionable. Others suggest that an unconscionably excessive price can only be determined by comparing the contract price to some reference price. One commentator suggests that it is necessary to find a sufficient disparity (possibly two to one) between the price charged by the seller and the average of all retail prices charged for like goods in the community in which the consumer resides. Commentators also imply that an excessive price is “two or three times greater than at least one other available price—in the low income neighborhood or elsewhere.” Yet another commentator suggests a three-prong test consisting of a price significantly in excess of a reference price (substantive prong), contracting process problems resulting in overreaching (procedural prong), and the inability of the market to enforce a fair price (a third requirement, market failure).

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

III. Hospital Billing Practices

Problems with pricing are inherent in contracting for medical services. With the exception of purely elective medical procedures, medical services

95 Id.
97 Id.
98 See White & Summers, supra note 33, at 144.
99 See Darr, supra note 48 (supra at note 93).
100 See supra notes 59–60 and accompanying text.
101 See supra notes 59–60 and accompanying text.
102 See supra notes 86–101 and accompanying text.
103 See infra notes 242–97 and accompanying text.
104 See Darr, supra note 48, at 1834 (discussing the distinction between auction and price tag markets and market failure regarding pricing.). The conditions that lead to the inability of the market to enforce a fair price according to Darr include, limited likelihood of a future sale, difficult informational problems in determining either the need for the product or its quality relative to price, high relational effects between the parties that prevent the ero-
are necessary, and thus there is much less change in the demand for medical services as a result of rising prices than for other types of goods or services. Moreover, at the time of contracting, patients usually do not know with any degree of certainty what medical services or goods they are buying or the specific price they are agreeing to pay for such goods or services. Patients are simply following their physician’s advice when seeking medical care from a hospital. In many cases, a patient literally entrusts his life to his doctor’s judgment. Specifically, neither the hospital nor the patient knows at the time the contract is entered into the extent and thus the price of the medical services the patient will require. As a result, the

Id. at 1841. All of these conditions exist with regard to the uninsured patient purchase of medical services. See infra notes 106–108 and accompanying text. Indeed, with respect to price, the market for medical services is not an auction or a price tag market; it is a blind market because neither party knows the price at the time of contracting. Thus, courts must intervene under the doctrine of unconscionability to set a fair price.

The fact that medical services are necessities prevents markets from operating normally and necessitates the courts’ involvement to set a fair price. See Darr, supra note 48, at 1832 (“Except in the rare case of necessities, it is difficult to imagine that a party could not walk away from a transaction or that a party could be surprised by a price term . . . .”).

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

“Unless advised by his doctor to the contrary, the patient normally feels he has no choice but to seek admission to the designated hospital and to accede to all of the terms and conditions for admission . . . . [N]or did Mr. Wheeler have a choice among hospitals . . . . A patient like Mr. Wheeler realistically has no choice but to seek admission to the hospital to which he has been directed by his physician . . . .”)

See, e.g., Canterbury v. Spence, 464 F.2d 772, 782 (D.C. Cir. 1972) in which the court stated:

The patient’s reliance upon the physician is a trust of the kind which traditionally has exacted obligations beyond those associated with arms-length transactions. His dependence upon the physician for information affecting his well-being, in terms of contemplated treatment, is well nigh abject . . . . Long before the instant litigation arose, courts had recognized that the physician had the responsibility of satisfying the vital informational needs of the patient. More recently, we ourselves have found “in the fiducial qualities of [the physician-patient] relationship the physician’s duty to reveal to the patient that which in his best interests it is important that he should know.”

Id. (citations omitted).

See Lagnado, supra note 12, at A1 (“For years, details on hospital charges were kept secret. Hospitals deemed their prices proprietary, to be kept off limits from institutional rivals,
patient often has no idea at the time of contracting how much he is agreeing to pay. The actual amount is not known until long after the creation of the contract. Typically patients agree to an open-ended obligation by agreeing to pay the hospital’s “full charges” (or some similar language) for all services and goods provided. Finally, the hospital pricing policy is the product of a maze of confusing and contradictory regulations resulting from the third-party reimbursement system.

insurers and even consumers. Patients often had no idea what costs they were racking up until they got their bill.”; see, e.g., Phoenix Baptist Hosp. & Med. Ctr., Inc. v. Aiken, 877 P.2d 1345, 1347 (Ariz. Ct. App. 1994) (agreement signed by patient provided “[patient] is hereby individually obligated to pay the account of the hospital in accordance with the regular rates and terms of the hospital...”); Wheeler, 133 Cal. Rptr. at 779 n.2 (agreement signed by patients provided “he hereby individually obligates himself to pay the account of the hospital in accordance with the regular rates and terms of the hospital.”).

100 See supra note 109.
111 See supra note 109.
112 See supra note 109.
113 See, e.g., Mercy Catholic Med. Ctr. v. Thompson, 380 F.3d 142, 144–45 (3d Cir. 2004), in which the court summarizes some of the more recent developments in the federal Medicare program as follows:

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

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

From its inception, Medicare reimbursed hospitals for all reasonable incurred costs related to providing medical care to patients. The Medicare Act defines “reasonable cost” as “the cost actually incurred,” less any costs “unnecessary in the efficient delivery of needed health services.” 42 U.S.C. § 1395x(v)(1)(A). Under the historical system of reasonable cost reimbursement, no reimbursement distinction turned on whether costs were reported as operating costs (the day-to-day expenses incurred in running a business) or graduate medical education costs. Medicare paid its full pro rata share of all allowable graduate medical education costs and operating costs actually incurred, consistent with the statutory requirement preventing shifting the costs of services incurred on behalf of Medicare beneficiaries to other patients or third
Hospitals devote significant time and effort to establishing and updating their charge master, which is a detailed list of full charges for each good and service provided.\textsuperscript{114} However, hospitals establish these charges with the clear expectation that they will receive only a portion of these so-called “full charges.”\textsuperscript{115} For example, in one case expert testimony was given that the hospital’s “full” or “published” charges for 1995 and 1996 were about 300% of the hospital’s costs.\textsuperscript{116} The same testimony states that hospitals actually recover their full charges only one to three percent of the time.\textsuperscript{117} More recently, the national average full-charge rate was about 345% of costs.\textsuperscript{118} Private payors such as insurance companies and HMOs pay a negotiated rate, which is contractually discounted.\textsuperscript{119} The reimbursement on average is about 40% of a hospital’s “full” or “published” charge.\textsuperscript{120} It

\textsuperscript{114} See supra notes 12-20 and accompanying text.
\textsuperscript{115} See supra notes 12-20 and accompanying text.
\textsuperscript{117} Id. at 508.
\textsuperscript{118} See Love or Corruption, supra note 12, at 3 (discussed supra at note 16).
\textsuperscript{119} See supra notes 12-20 and accompanying text.
\textsuperscript{120} See Temple, 832 A.2d at 509 (“In addition, Dr. Dobson testified that private payors typically paid 121% of the cost of hospital services in 1994, 119% in 1995, and 112% in 1996. Government payors generally pay less.”).
is estimated that HMOs pay about 55% to 60% of list price,\textsuperscript{121} while government payors, such as Medicare and Medicaid, “generally pay less.”\textsuperscript{122} Each contract insurer and health maintenance organization negotiates its own reimbursement rate, and information regarding reimbursement rates is kept confidential.\textsuperscript{123} Technically, every patient is billed the “full charges,” because this allows the hospital to establish that these inflated prices are really its “usual charges.” This is important because Medicare regulations prohibit providers from charging Medicare “substantially in excess” of the hospital’s “usual charges.”\textsuperscript{124}

However, while all patients and payors are billed the “full charges,” the only ones actually expected to pay these charges are those patients without medical insurance.\textsuperscript{125} Hospitals feel financial pressure to set their “full charges,” or charges reflected on their charge master, as high as possible, because the higher the “full charge” the greater the reimbursement amount the hospital receives since reimbursement rates are often set as a percentage of the hospital’s “full charge.”\textsuperscript{126} Another factor that causes the “full charges” to be so high is the annual budgeting process, which takes into account bad debt, contracted discounts, and “cost shifting.”\textsuperscript{127} Given these factors, the “full charge” amount must be set at a high level to make the hospital’s budget balance.\textsuperscript{128} In addition, federal “stop loss and outlier” reimbursement provisions also encourage hospitals to set high charges and raise them often.\textsuperscript{129}

\textsuperscript{121}Id. (thus, list prices are set at 300% of cost while reimbursement is 112% of cost—e.g., if cost is $5.00, list price is 15 and reimbursement by private payors is 112% of cost or $5.60 or 5.60/15.00 = 37% of list price).

\textsuperscript{122}Id.

\textsuperscript{123}See Lagnado, supra note 12, at 1 (“[H]igh list prices have been a ‘negotiating tool’ for hospitals in dealing with HMO’s that demand big discounts . . .”); Jones, supra note 12, at 29 (“Unfortunately, the exact predetermined fixed rates paid by managed care plans are carefully guarded secrets. Our research disclosed that every private managed care contract contains a confidentiality provision.”).

\textsuperscript{124}42 U.S.C.A. § 1320 a-7(b)(6) (2003); see generally Medicare Provider Reimbursement Manual (PRM) § 2203.

\textsuperscript{125}See Lagnado, supra note 12 (noting that only uninsured patients are expected to pay full charges).

\textsuperscript{126}See Love or Corruption, supra note 12, at 4–5 (listing annual budgeting, consequential reductions from insurance contracts, consequential reduction of governmental “stop loss” reimbursement, and consequential loss of Medicare outliers as reasons changes are so high and hospitals are reluctant to lower them). Interestingly, it is not a violation of federal regulations for hospitals to set high, full-charge rates that do not relate closely to costs. Id. at 8–11.

\textsuperscript{127}Id.

\textsuperscript{128}Id.

\textsuperscript{129}Id. at 5–8 (explaining why the rules for outlier reimbursement encouraged hospitals to raise their list prices and noting that while the rules are in flux, it is not clear that the problem has been solved).
While all uninsured patients are expected to pay the hospital’s “full charges,” it appears that in fact less than five percent actually pay the full charge.\(^{130}\) Even though most uninsured patients do not actually pay the full charge, the burden created by this debt and the often harsh collection tactics used on behalf of many hospitals by their debt collectors can devastate uninsured patients.\(^{131}\) Moreover, hospitals have generally refused to discount their “full charges,” because this could dramatically lower the payments they receive under existing contracts with private insurers, HMOs, and the government.\(^{132}\)

There are a number of federal rules and statutes that discourage hospitals from discounting charges and/or waiving co-insurance payments.\(^{133}\) Essentially, by reducing its full charges or by waiving co-payments, a hospital may be jeopardizing its Medicare and Medicaid reimbursement,\(^{134}\) and perhaps its reimbursement from HMOs and contract insurers as well.\(^{135}\)


\(^{131}\) See, e.g., Lagnado, supra notes 2, 6 and 12; Lucette Lagnado, Twenty Years and Still Paying, WALL ST. J., Mar. 13, 2003, at B1 (discussing Quinton White, 77 years old, and his struggle to pay for his late wife’s ballooning hospital bill for the past 20 years); Lucette Lagnado, Hospitals Try Extreme Measures to Collect Their Overdue Debts, WALL ST. J., Oct. 30, 2003, at A1 (discussing the harsh tactics used by hospitals including body attachment or civil arrest warrants to enforce the excessively high bills of the uninsured); Lucette Lagnado, Taming Hospital Billing: Lawmakers Push Legislation to Curb Aggressive Collection Against Uninsured Patients, WALL ST. J., June 10, 2003, at B1 (discussing harsh collection tactics used on behalf of hospitals); Lucette Lagnado, Dunned for Old Bills, Poor Find Some Hospitals Never Forget, WALL ST. J., June 8, 2001, at A1 (discussing harsh collection tactics of hospitals and the devastating impact on uninsured patients).

\(^{132}\) See supra notes 127–30 and accompanying text.

\(^{133}\) See Love or Corruption, supra note 12, at 12 (“A panoply of federal rules and statutes also have discouraged hospitals from discounting and waiving co-insurance payments.”). There has been some discussion of these issues, but whether progress has been made is hard to tell. See, e.g., Lucette Lagnado, Hospitals Will Give Price Breaks to Uninsured, if Medicare Agrees: They Concede Many Charges Aren’t Fair to the Needy But Blame Federal Rules, WALL ST. J., Dec. 17, 2003, at A1 (discussing the American Hospital Association’s claim that Medicare regulations prevent hospitals from reducing prices for the uninsured); Lucette Lagnado, HHS Chief Scolds Hospitals for their Treatment of Uninsured, WALL ST. J., Feb. 20, 2004, at A1 (discussing HHS’s claim that hospitals had mischaracterized government policy and were simply not correct in arguing that complex federal rules left them no choice but to bill the uninsured full price); Lucette Lagnado, New York State Hospitals Agree to Cut Prices for Uninsured, WALL ST. J., Feb. 2, 2004, at B1 (“[H]ospitals in New York State have agreed to a voluntary program to cut prices and provide charity care for their poorest patients.”); Rhonda L. Rundle, Activists for Uninsured Needle’s Hospitals—and Draws Blood, WALL ST. J., June 19, 2003, at A1 (discussing Tenet Healthcare Corp.’s announcement of a “Compact with Uninsured Patients” program in which they pledged to “start giving discounts to uninsured people similar to the discounts it offers managed-care companies”).

\(^{134}\) See supra notes 129–32 and accompanying text.

\(^{135}\) See supra notes 129–32 and accompanying text.
This is something no hospital can afford to do. As noted previously, all of these payors negotiate contractual discounts that are often expressed as a percentage of the hospital’s “usual charges.” The problem for the hospital is that if it reduces its “full charge” for uninsured patients, then it is vulnerable to the argument that its real “usual charge” is not that contained on the hospital’s charge master, but in fact the reduced rate at which it bills the uninsured. There is a narrow exception in the federal regulations that allows a hospital to waive or reduce its usual or full charges for the indigent, but this is acceptable only after the hospital determines in good faith that the individual is in “financial need” or it “fails to collect...after making good faith collection efforts.” The Provider Reimbursement Manual (PRM) does allow for write-offs (not waivers) based on financial or medical indigency, but provides that indigency “[m]ust be determined by the provider,” not based merely on a signed patient declaration of inability to pay. Providers must consider cash and assets (other than those required for daily living) which are “convertible to cash,” and must also verify the absence of any other legally responsible payment source. The file “should contain documentation of the method by which indigence was determined in addition to all backup information” used to “substantiate the [indigency] determination.” The Office of the Inspector General (“OIG”), which has the power to terminate Medicare participation, also requires vigorous collection efforts and has denied bad debt reimbursements for write-offs based on patient-provided financial information.

Moreover, Medicare provides hospitals a dollar-for-dollar credit for Medicare bad debt (i.e., unpaid deductibles or co-insurance) but only if the provider undertook reasonable collective efforts. This requires that collection efforts for Medicare and non-Medicare patients be similar.

136 See supra notes 131–33 and accompanying text.
137 See supra notes 131–33 and accompanying text.
139 See Provider Reimbursement Manual, supra note 124, at § 312.
140 Id.
141 Id.
142 Id.
144 See 42 C.F.R. § 413.80(e)(2) (requiring provider to undertake reasonable collection efforts).
145 See Provider Reimbursement Manual, supra note 124, at § 310 (noting that where a provider expends less effort to collect from some patients than from others, its policy is deemed contrary to Medicare Policy because it is inconsistent). In a February 2004 letter, the Centers for Medicare and Medicaid Services noted that hospitals may waive self-payments for indigent or medically indigent patients uniformly, but may not claim bad debt for such voluntarily reduced collections from indigent Medicare patients. Otherwise, collections policies against all non-indigent patients should be uniform. See Love or Corruption, supra note 12,
example, in *Mt. Sinai Hospital Medical Center v. Shalala*, the government refused to reimburse the hospital for bad debt, because the collection efforts used for Medicare and non-Medicare accounts were different. The hospital's attempts to collect both Medicare and non-Medicare accounts were identical during the first 120 days the debts were outstanding, and during this time the collection effort was handled directly by the hospital. After 120 days, non-Medicare debts over $50 were turned over to various collection agencies for further efforts at settling the accounts. The Medicare debt, however, was submitted to Medicare for reimbursement as bad debt. The hospital argued that given the low rate of return expected on its Medicare accounts, referral of these accounts to a collection agency would not be cost effective. In addition, the hospital argued that referral of Medicare accounts to collection agencies might prevent needy patients from seeking treatment. The court rejected these arguments, however, and the hospital was denied reimbursement of its Medicare bad debts for the years involved. Similarly, in February 2004, the Centers for Medicare and Medicaid Services (CMS) noted that hospitals may uniformly waive self payments for indigent or medically indigent patients, including Medicare patients, but the hospital may not claim bad debt reimbursement for such voluntarily reduced collections from indigent Medicare patients.

As a result of these rules and regulations, hospitals are engaged in an odd type of price discrimination. That is, the amount the hospital requires a patient to pay changes depending on who, if anyone, provides the patient's insurance. This is odd because hospitals are not segmenting the market by demand and charging more to high demand/high net worth patients. Rather, the price discrimination practiced by hospitals is a consequence of the third party reimbursement system and the ill-conceived and inconsistently applied rules that govern the reimbursement system. Notwithstanding the odd nature of hospitals' price discrimination, it is nev-

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147 *Id.* at 705.

148 *Id.*

149 *Id.*

150 *Id.* at 705–06.

151 *Id.* at 709 (the hospital was located on the west side of Chicago and served an impoverished area; 82 percent of the hospital's revenue came from Medicare).

152 *Id.*

153 *Id.* at 711.

154 See *supra* note 145–51.

155 See *supra* notes 12–14 and accompanying text.

156 See *supra* notes 12–14 and accompanying text.


158 See *supra* notes 104–57 and accompanying text.
ertheless grossly unfair to uninsured patients. The result is that charges to the uninsured are outrageously high, hospitals are reluctant to write-off or forgive the debt of uninsured patients who do not pay in full, and hospitals feel forced to use tough and often harsh collection tactics to qualify for bad debt reimbursement under federal regulations.

The basic unfairness is patent; there is no good reason why one patient should be expected to pay two or more times the amount paid by other patients for the same goods and services provided by the same hospital. Additionally, the uninsured should not be forced to compensate hospitals for losses incurred as a result of federal requirements and contracts with insurers. The uninsured should also not be burdened with the obligation of paying exorbitant charges resulting from the hospital's desire to maximize reimbursement from third-party payors. The contention that the principle of freedom of contract gives a hospital the right to unilaterally set a price for its services that bears no relation to either the cost of the goods or services or to the amount customarily paid for such goods or services is untenable. The fact that an uninsured patient has signed a hospital admission form that says he agrees to pay the hospital's "full charges" does not change the unfairness of hospital pricing. Given the circumstances of hospital admissions, the nature of medical services, and the inflated level of "full charges," the argument that the patient's express agreement to pay the hospital's "full charges" should be enforced is grossly unfair and places form over substance.


160 See supra notes 104–57 and accompanying text.

161 This of course is true of all price discrimination and has caused one commentator to state "if price discrimination is not unconscionable, then what is?" Klock, supra note 13, at 353.

162 See supra note 161; Lagnado, supra note 12. With regard to the excessive list prices or full charges the author notes that, "[b]uffeted by managed care, squeezed by federal and state governments and overrun with patients who either couldn't pay or lacked coverage, hospitals felt they had no choice but to develop aggressive survival strategies." Id.

163 See infra note 133.

164 See St. John's Episcopal Hosp. v. McAdoo, 405 N.Y.S.2d 935, 937 (N.Y. Civ. Ct. 1978) ("This is exactly the type of situation in which a flexible application of the doctrine of inviolability of contract is warranted to permit appropriate judicial compassion and understanding."); Temple, 832 A.2d at 510 ("The Hospital's contention that it can unilaterally set a price for its services that bears no relationship to the amount typically paid for those services is untenable.").

165 See infra notes 104–64 and accompanying text.

166 See infra notes 104–65 and accompanying text.
doctrine of unconscionability prevents and, in so doing, strengthens the principle of freedom of contract.  

IV. CASE LAW

A. Case Law: Procedural Unconscionability

Many courts have found that hospital admission contracts are procedurally unconscionable. In *Tunkl v. Regents of the University of California*, the defendant hospital presented all incoming patients with a document titled “Conditions of Admission,” which included an exculpatory clause pursuant to which the patient released the hospital from liability for negligent or wrongful acts. In refusing to enforce the agreement, the court noted that “[t]he would-be patient is in no position to reject the proffered agreement, to bargain with the hospital, or, in lieu of agreement, to find another hospital.” The court in *Tunkl* therefore concluded that the patient had no realistic choice but to assent to the standardized agreement under which he waived his right to recover for negligently inflicted injuries.

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

> If patient, or undersigned, does not agree to the ‘Arbitration Option,’ then he will initial here ____. The undersigned certifies that he has read the foregoing, receiving a copy thereof, and is the patient, or is duly authorized by the patient as patient’s general agent to execute the above and accept its terms.

The agreement provided that the patient could opt out of arbitration either by placing his initials in the space provided or, in the alternative,

167 See supra notes 104–66 and accompanying text.
169 *Id.* at 447.
170 *Id.*
172 *Id.*
173 *Id.* at 779.
174 *Id.* at 780.
by notifying the hospital in writing within thirty days of his discharge.\textsuperscript{175} Wheeler's spouse stated that "her husband signed the admission form without reading it; no one at the hospital called their attention to the '\textit{ARBITRATION OPTION},' either before or after [her] husband signed the document, and neither [she nor her husband] was aware of its existence; [and that they] were never provided with a copy of the admission forms."\textsuperscript{176}

The court focused on the question of whether there was an enforceable agreement to arbitrate.\textsuperscript{177} The court noted that "[t]here [was] nothing in the record to show, and the plaintiffs did not contend, that [the] hospital would have denied Wheeler admission if he had declined to agree to the [arbitration provision]."\textsuperscript{178} The court also noted that California has a public policy in favor of arbitration, but only if it is voluntarily agreed to by all of the parties.\textsuperscript{179} Thus, the issue as the court saw it was whether, under the circumstances, Wheeler had voluntarily agreed to arbitrate.\textsuperscript{180}

The court recognized that the hospital admission agreement possessed all of the characteristics of a contract of adhesion.\textsuperscript{181} The court described adhesion contracts as "standardized contract forms offered to consumers... on essentially a 'take it or leave it' basis without... a realistic opportunity to bargain and under such conditions that the consumer cannot obtain the desired product or services except by acquiescing in the form contract."\textsuperscript{182} The court cited the following language from \textit{Tunki}:

The would-be patient is in no position to reject the proffered agreement, to bargain with the hospital, or in lieu of agreement to find another hospital. The admission room of a hospital contains no bargaining table where, as in a private business transaction, the parties can debate the terms of their contract. As a result, we cannot but conclude that the instant agreement manifested the characteristics of the so-called adhesion contract....\textsuperscript{183}

The court then stated that "[t]o the ordinary person, admission to a hospital is an anxious, stressful, and frequently a traumatic experience."\textsuperscript{184} As a result, the patient cannot reasonably be expected to read the printed agreement in detail much less to fully comprehend its terms.\textsuperscript{185} "[A] patient is [usually] directed by his treating doctor to be admitted to the hospital

\textsuperscript{175} \textit{Id.} at 779.
\textsuperscript{176} \textit{Id.} at 780.
\textsuperscript{177} \textit{Id.} at 781–82.
\textsuperscript{178} \textit{Id.} at 781.
\textsuperscript{179} \textit{Id.} at 782.
\textsuperscript{180} \textit{Id.}
\textsuperscript{181} \textit{Id.} at 783.
\textsuperscript{182} \textit{Id.}
\textsuperscript{183} \textit{Id.}
\textsuperscript{184} \textit{Id.} at 786.
\textsuperscript{185} \textit{Id.}
where the doctor enjoys staff privileges." The court noted that unless the patient is "advised by his doctor to the contrary, [he] normally feels he has no choice but to seek admission to the designated hospital and to accede to all of the terms and conditions for admission, including the signing of all forms presented to him." The court concluded that "[a] patient like Mr. Wheeler realistically has no choice but to seek admission to the hospital to which he has been directed by his physician and to sign the printed forms necessary to gain admission." To believe otherwise would, according to the court, "require us to ignore the stress, anxiety, and urgency which ordinarily beset a patient seeking hospital admission." The court found that Wheeler was not bound by the arbitration provision.

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

The undersigned agrees (whether signing as agent, representative, or as patient, and whether or not insured or a member of a health maintenance organization) that, in consideration of the services to be rendered to the patient, he or she is hereby individually obligated to pay the account of the hospital in accordance with the regular rates and terms of the hospital unless otherwise agreed in writing by the hospital corporation. Should the hospital account be referred for collection, the undersigned agrees to pay reasonable collection expenses, counsel fees, and court costs.

The issue in the case was whether the agreement was enforceable such that Thomas was liable from his personal assets for the medical services provided to his wife. He claimed the agreement was unconscionable and therefore unenforceable. The court, in discussing the procedural unconscionability of the agreement, noted that Thomas hurriedly "signed the agreement under extremely stressful circumstances without having had the terms of the agreement explained to him." The court held that the trier of fact could have concluded "that Thomas did not understand the implica-

186 Id.
187 Id.
188 Id. at 789.
189 Id.
190 Id. at 790.
192 Id. at 1347.
193 Id. at 1347-48.
194 Id. at 1349.
195 Id.
tions of the agreement, or that he felt he had no choice but to immediately sign the preprinted form." In denying the hospital's request for summary judgment, the court concluded that there was a material issue of fact as to the unconscionability of the procedure used to obtain the agreement.

Finally, in *St. John's Episcopal Hospital v. McAdoo*, the issue concerned whether Charles McAdoo's signature on a standard form contract prepared by the hospital bound him to pay his estranged wife's medical fees. The court noted the basic contract law principle that "a literate, competent adult ... is ordinarily held legally responsible for his contractual obligations, once ... he has signed the contract." The court went on to note that "there are circumstances under which a reasonable person might sign a contract, without reading or understanding it, so that requiring adherence to its terms would be grossly unfair." The court then 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."

Hospital admission contracts relating to necessary medical services are procedurally unconscionable even if the medical services are not sought on an emergency basis. In a case where a patient's doctor has determined that hospitalization will be necessary for the treatment of the patient's medical condition, but the treatment is not on an emergency basis, the patient may visit the hospital days or even a week or two before admission. At this initial visit, the patient may sign his admission forms and be provided with copies of them. In addition, in this somewhat more relaxed setting of admissions (rather than the emergency room), the hospital staff may take more time to explain, and the patient may be better able to understand the

196 Id. at 1350.
197 Id. at 1351.
199 Id.
200 Id.
201 Id. at 937.
202 Id.
203 Id.
204 *But cf.* St. John's Episcopal Hosp. v. McAdoo, 405 N.Y.S.2d 935, 937 (N.Y. Civ. Ct. 1978) (discussing the stress created when a patient is not given enough time to read closely or discuss medical admission forms).
205 *But cf.* Wheeler, 133 Cal. Rptr. at 786 (discussing the fact that the arbitration option contained in the admission forms was not explained nor was the patient provided with a copy of the form.).
terms of the admission contract. Theoretically it may be possible, though practically unlikely, for the patient to have the admission contract reviewed by counsel after the initial visit to admissions but prior to the patient's actual admission to the hospital. Thus, it is possible, though still unlikely, that the patient in this nonemergency context may be fully aware that he is obligating himself to pay the hospital's "full charge," and even aware that because he is uninsured, the "full charge" is many times greater than the amount an insured patient would be expected to pay for the same medical care. Even if the patient is fully aware of the provisions in the admission contract and their meaning before signing it, the admission contract is still procedurally unconscionable. The reasons for this are several, but they all spring from the nature of necessary medical services. Necessary medical services are vital, such that even if the patient has some choice as to timing, he has no real choice concerning his need for the service. A patient's hospital choice is determined largely by his doctor. That is, the patient goes to the hospital chosen by his doctor because his doctor is on the staff of this hospital. Moreover, regardless of which hospital the patient is directed to, virtually all will require his agreement to pay "full charges," which stems from the Medicare and Medicaid requirements to which virtually all hospitals are subject. Thus, even in the case of "planned" as opposed to "emergency" necessary medical services, hospital admission agreements are procedurally unconscionable.

B. Case Law: Substantive Unconscionability

Substantive unconscionability is often defined in terms of oppression, overreaching, and unfair surprise. A hospital admission contract is likely to be found unfair if it contains harsh terms contrary to common expectation and

206 Id.
207 See Richard M. Alderman, The Business of Medicine—Health Care Providers, Physicians, and the Deceptive Trade Practices Act, 26 Hous. L. Rev. 109, 113-14, 140 (1989) (The author notes that the health care consumer "view[s] the industry as a 'profession' separate from the average business, and often places unqualified trust in the physician," is reluctant to question any aspect of treatment, including billing and collection, and is much, much more focused on results than costs, especially at the time of seeking treatment).
208 See generally Lagnado, supra note 12 (discussing a California law requiring disclosure of charge masters by hospitals in the state).
209 See supra notes 65-79 and accompanying text.
210 See supra notes 65-79 and accompanying text.
211 See supra notes 65-79 and accompanying text.
212 See supra notes 65-79 and accompanying text.
213 See supra notes 104-67 and accompanying text.
214 See supra notes 204-11 and accompanying text.
215 See supra notes 80-103 and accompanying text.
common fairness that have been effectively forced on the patient.\textsuperscript{216} For example, in \textit{Wheeler}, the hospital admission contract included a term requiring the patient to arbitrate any claims against the hospital.\textsuperscript{217} In refusing to enforce the provision, the court concluded that it represented an unfair surprise.\textsuperscript{218}

The manifest objective of a medical entity in including an arbitration clause is to avoid a jury trial and thereby hopefully minimize losses for any medical malpractice and correspondingly to hold down the amount of any recovery by the patient.\textsuperscript{...} The law ought not to decree a forfeiture of such a valuable right where the patient has not been made aware of the existence of an arbitration provision or its implications. Absent notification and at least some explanation, the patient cannot be said to have exercised a 'real choice' in selecting arbitration over litigation. We conclude that in order to be binding, an arbitration clause incorporated in a hospital's \textit{CONDITIONS OF ADMISSION} form should be called to the patient's attention and he should be given a reasonable explanation of its meaning and effect, including an explanation of any options available to the patient.\textsuperscript{219}

In \textit{Wheeler}, the court's concern with the patient's awareness of the terms of the admission contract makes sense, because the agreement allowed the patient to opt out of arbitration by initialing the form or objecting to arbitration within thirty days of discharge.\textsuperscript{220} However, hospital admission contracts do not allow patients to opt out of agreeing to pay full charges. Moreover, the \textit{Wheeler} court recognized that the context of hospital admission is such that unexpected or harsh terms in hospital admission contracts may be unfair even if the patient is aware of them because the patient has no choice but to agree.\textsuperscript{221} The \textit{Wheeler} court stated:

\begin{quote}
A patient like Mr. Wheeler realistically has no choice but to seek admission to the hospital to which he has been directed by his physician and to sign the printed forms necessary to gain admission. To posit otherwise would require us to ignore the stress, anxiety, and urgency which ordinarily beset a patient seeking hospital admission.\textsuperscript{222}
\end{quote}

Both the \textit{Aiken}\textsuperscript{223} and \textit{McAdoo}\textsuperscript{224} courts applied similar reasoning to conclude that provisions of hospital admission contracts may be unenforce-

\textsuperscript{216} See \textit{supra} notes 80-103 and accompanying text.
\textsuperscript{218} \textit{Id.} at 786.
\textsuperscript{219} \textit{Id.} at 786.
\textsuperscript{220} \textit{Id.} at 780.
\textsuperscript{221} \textit{Id.} at 789-90.
\textsuperscript{222} \textit{Id.}
able.225 Both cases involved provisions that imposed personal liability on the signer even though the party signing the agreement was not the patient.226 Aiken took his wife to the hospital after she suffered a heart attack and signed the admission form without reading it.227 Likewise, McAdoo took his estranged wife to the hospital fearing she was near death and did not read carefully or question the admission forms he signed.228 In addressing the enforceability of the provisions imposing personal liability, both courts focused on the reasonable expectations of the party signing the agreement.229 Both courts noted that as a result of the circumstances surrounding hospital admissions the signer could not be expected to give the written agreement careful consideration.230 Thus, the courts focused on whether the provisions included in the admissions contracts were ones that a reasonable person would expect to find in such a contract.231 Aiken involved an appeal from the grant of summary judgment in favor of the hospital. The court noted, "[w]e must consider, then, whether it was beyond Thomas' reasonable expectation to have liability imposed upon his separate property."232 The court concluded that the "evidence creates a material issue of fact as to Thomas' reasonable expectation."233 In addition, in McAdoo, the court discussed "whether a reasonable person should have expected to find such a clause in the particular instrument he was signing."234 The court concluded that the clause was beyond reasonable expectations and held that the hospital "should not be permitted to enforce a contractual obligation entered into under such tension-laden circumstances."235

The agreement of a patient to pay a hospital's "full charges" or "regular rates" sounds reasonable. However, closer examination reveals that, in fact, the patient is agreeing to a grossly exorbitant and unfair price that on average is 365 percent of the hospital's cost236 and that is set with little, if any, reference to the value or cost of goods and services sold.237 Further, it is a price that is set to be discounted and is in fact heavily discounted ninety-five percent of the time.238 Moreover, most patients are expected to pay

225 See infra notes 226-41 and accompanying text.
226 See supra notes 191-203 and accompanying text.
227 Aiken, 877 P.2d at 1347-48.
228 McAdoo, 405 N.Y.S.2d at 936.
229 Aiken, 877 P.2d at 1349-50; McAdoo, 405 N.Y.S.2d at 937.
230 Aiken, 877 P.2d at 1349-50; McAdoo, 405 N.Y.S.2d at 937.
231 Aiken, 877 P.2d at 1349-50; McAdoo, 405 N.Y.S.2d at 937.
232 Aiken, 877 P.2d at 1349.
233 Id.
234 McAdoo, 405 N.Y.S.2d at 937.
235 Id.
236 See supra notes 104-67 and accompanying text.
237 See supra notes 104-67 and accompanying text.
238 See supra notes 104-67 and accompanying text.
only a fraction of this full price for the same goods and services.239 In effect, the uninsured patient, by agreeing to pay "full charges," is agreeing to pay a huge premium for all goods and services received.240 Such an agreement is well beyond the reasonable expectations of an ordinary person and is grossly and shockingly unfair.241

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

In all price unconscionability cases the same obvious and troubling questions arise.242 First, why would anyone agree (assuming there has been no fraud, duress, mistake, etc., which is a reasonable assumption or else unconscionability would not be needed to invalidate the contract)243 to pay a price that is grossly unfair?244 That is, if there is one term above all others that the buyer is likely to be acutely aware of, it is the price.245 If the price is oppressive, why did the buyer not refuse to agree and walk away from the offered bargain?246 This is especially troublesome if the oppressive price is

239 See supra notes 104–67 and accompanying text.
240 See Klock, supra note 13, at 327–33 (discussing how calling a lower price for some consumers a "discount" is simply marketing; the economic reality is that all other consumers are in fact paying a premium).
241 See Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alternatives, Inc., 832 A.2d 501, 508 (Pa. Super. Ct. 2003), appeal denied, 847 A.2d 1288 (Pa. 2004) (noting that the important question regarding a hospital's published rates is not whether they are higher or lower than other hospitals' published rates, but whether they reflect the amount the hospital actually receives for its services, and since the hospital rarely receives its published rates, those rates cannot be considered the value of the benefit conferred.).
242 See Darr, supra note 48, at 1822 ("Of all the terms in a contract, the one most assuredly understood by the buyer is the price term."). Darr goes on to note that "neither traditional rules of contract nor the classic economics on which they are based support the doctrine of price unconscionability." Id. at 1823. However, the assumptions of classic economics do not always apply in the real world. Thus, in some situations, like hospital admission, problems with the market's pricing mechanisms arise and remain uncorrected by the market.
243 See, e.g., Richard A. Epstein, Unconscionability: A Critical Reappraisal, 18 J.L. & Econ. 293, 302, 304 (1975) ("Ideally, the unconscionability doctrine protects against fraud, duress and incompetence, without demanding specific proof of any of them.") (also noting that the unconscionability doctrine can be useful when proof required for fraud etc. is difficult); Richard Craswell, Property Rules and Liability Rules in Unconscionability and Related Doctrines, 60 U. Chi. L. Rev. 1, 40–41 (1993) (unconscionability may be used to deal with situations of imperfect consent); Klock, supra note 13, at 341 (discussing the usefulness of unconscionability because "[i]there is no such thing as ... almost duress, or partial capacity .... Our system does not contemplate varying degrees of valid consent.").
244 See Darr, supra note 48, at 1822–23.
245 Id. at 1822.
246 However, Darr does recognize an exception in the case of necessities or in cases where reference price information is not readily available. Id. at 1832–41.
defined in terms of being higher than the price offered by other sellers in the same area.\textsuperscript{247} That is, why didn’t the buyer choose to buy from a different seller?\textsuperscript{248}

The other troubling question in excessive price cases is how the court is to determine a “fair” price.\textsuperscript{249} To find that the contract price is excessive and to provide an appropriate remedy, the court must determine a “fair” price for the contract.\textsuperscript{250} Even if the court can determine that the contract price is grossly unfair (for example, where there is price discrimination)\textsuperscript{251} and explain why a reasonable buyer would agree to pay a grossly unfair price in the first place (for example, where the contract terms are complicated, obtuse, and confusing),\textsuperscript{252} to resolve the case the court must somehow determine a “fair” price for the contract at issue.\textsuperscript{253} In general, having courts substitute their ex post judgment for the parties’ ex ante agreement is a bad idea.\textsuperscript{254}

\textsuperscript{247} See supra notes 96-102 (defining excessive price in terms of the price charged for like goods in the community).

\textsuperscript{248} Or more to the point: why is the buyer worthy of judicial protection if he chose not to protect himself? Of course, in the hospital admission contract cases the buyer has no choice but to sign the forms presented. See supra notes 189-215 and accompanying text.

\textsuperscript{249} Determining the fair value of anything is difficult. See 1 ARTHUR LINTON CORBIN, CORBIN ON CONTRACTS \S 127, 540-42 (1963) (“Very generally we speak of ‘value’ as if it were definite and exact, an easily ascertainable amount of money. In fact, it is always variable, always a matter on which opinions may differ, and frequently one that is very difficult to estimate.”). It is no wonder then that courts usually leave price determinations to the parties.

\textsuperscript{250} Id.

\textsuperscript{251} When the seller sells to other buyers at a lower price with no cost justification, the higher price is clearly excessive. See Klock, supra note 13, at 358-361.


\textsuperscript{253} In the case of hospital admission contracts the fair price is determined by the hospital itself (i.e., the average charge the hospital receives from governmental agencies and insurance companies for the services rendered to the patient), and the court is not forced to set the price. See infra notes 287-91 and accompanying text.

\textsuperscript{254} See, e.g., Melvin Aron Eisenberg, The Limits of Cognition and the Limits of Contract, 47 STAN. L. REV. 211, 212 (1995) (noting that a contract is based on the "premise that in making a bargain a contracting party will act with full cognition to rationally maximize his subjective expected utility." The author further states:

Parties are normally the best judges of their own utility, and normally reveal their determinations of utility in their promises. Bargain promises are normally made in a deliberative manner for personal gain, and promises so made should normally be kept. Bargains normally create value, enable the parties to plan their future conduct reliably, allocate commodities to their highest-valued uses, and best distribute the factors of production ....

Id. at 211-12; see also Klock, supra note 13, at 347 (listing the undesirable consequences of such action, which include: creating uncertainty as to the enforceability of contracts generally, denying the protected class of people access to the contracted for goods or services, and loss of incentive for people to protect themselves).
The law deals with the first question by requiring both procedural and substantive unconscionability for a contract to be invalidated. That is, to find an excessive price contract unenforceable due to unconscionability, the price must be oppressively high, and there must be some defect in the bargaining process. This defect will not meet all of the requirements of other policing, formation, or disclosure common law doctrines designed to deal with contracting process problems, but there must be some process problem. For example, in many price cases the buyer's behavior is explained by the fact that the buyer was unaware of the true price because it was hidden from him in the obtuse terms of the contract, complicated finance charges, hidden fees, or all three. Commentators have also suggested that buyers may lack appropriate information regarding a reference price at the time of contracting and thus may not be aware of the great disparity between the contract price and a fair price. Certainly, this reasoning can be applied to a patient's agreement to pay "full charges." That is, the patient does not know the actual dollar amount that he is agreeing to pay. Moreover, the patient does not have the necessary information regarding a reference price; thus, he does not know that he is agreeing to pay many times what other patients pay for the same goods and services.

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

For example, in Tunkl, the admission agreement provided that the patient "releases... the hospital from any and all liability for the negligent

255 See supra notes 54–103 and accompanying text.
256 See supra notes 54–103 and accompanying text.
257 See supra notes 54–103 and accompanying text.
259 See supra notes 54–79 and accompanying text.
260 See supra notes 54–79 and accompanying text.
261 See supra notes 54–79 and accompanying text.
262 See supra notes 54–79 and accompanying text.
263 See supra notes 54–79 and accompanying text.
264 See supra notes 54–79 and accompanying text.
265 See supra notes 54–79 and accompanying text.
266 Tunkl v. Regents of Univ. of Cal., 383 P.2d 441 (Cal. 1963).
or wrongful acts or omissions of its employees."267 *Tunkl* was not decided on the basis of unconscionability, but the court’s reasoning and conclusions concerning hospital admission contracts are relevant to the unconscionability analysis. The court noted, "[t]hat the services of the hospital to those members of the public who are in special need of the particular skill of its staff and facilities constitute a practical and crucial necessity is hardly open to question."268 With regard to the terms of the hospital admission contract, the court concluded that "the hospital certainly exercises a decisive advantage in bargaining."269 The court further stated "[t]he would-be patient is in no position to reject the proffered agreement, to bargain with the hospital, or in lieu of agreement to find another hospital."270 The *Tunkl* court recognized that even if the patient understands perfectly what he is signing and the legal implications thereof, and even if he concludes in his own mind that the terms are grossly unfair, he still has no choice but to agree.271 Even if the actual price to be paid and the reference price to compare it were available to the patient at the time of the signing of the hospital admission agreement, the legal conclusion that the agreement to pay "full charges" is grossly unfair would not change.272 The problem here is not limited to a lack of disclosure. The problem is that the full charges are discriminatory and are simply too high, especially for something as necessary as medical services. These high prices occur and remain unchecked because the circumstances surrounding hospital admission and pricing result in a market failure such that the problem cannot be solved by the market.273 Thus, the courts must employ the flexible tool of unconscionability to prevent the injustice and unfairness that the market, because of its failure, allows to occur.274

Hospitals set their full charges at such a high level because they expect to have the charges discounted.275 Recall that only uninsured patients are expected to pay these full charges and that less than five percent of patients ever pay the "full charges."276 Moreover, hospitals do not simply agree to discount their "full charges" and charge a reasonable price to the uninsured because they fear that under the federal regulations governing Medicare and Medicaid (a hospital’s primary source of funds), discount-

267 Id. at 442.
268 Id. at 447.
269 Id.
270 Id.
271 Id.
272 See supra notes 266–70 and accompanying text.
273 See supra notes 104–67 and accompanying text.
274 See Darr, supra note 48, at 1841 ("Under these circumstances [market failure], the courts would intervene to protect consumers from unfair prices and practices.").
275 See supra notes 114–67 and accompanying text.
276 See supra notes 114–67 and accompanying text.
ing for anyone, even for the uninsured, could drastically reduce their reimbursement from Medicare, Medicaid, contract insurers and HMOs.\supranotename{277} From a hospital's point of view, there is no compelling reason to take such an enormous risk.

The result is that the uninsured are victimized much more by circumstance than by intent. Uninsured patients like Shipman\supranotename{278} or Nix\supranotename{279} are charged such high amounts almost by mistake.\supranotename{280} The hospital's charges were not set with any real consideration that an individual would actually pay the charge.\supranotename{281} The full charges are set to be discounted.\supranotename{282} They are set so high because they must allow the hospital to receive sufficient revenue to continue to operate after the full charges have been reduced by an average of sixty percent.\supranotename{283} However, the fact that the uninsured are not intended victims does not mean that they are any less victimized by hospital billing.\supranotename{284}

The second problem in price unconscionability cases is that judicial price-setting is certainly inconsistent with a free market and is usually to be avoided.\supranotename{285} This is because a court is generally ill equipped to determine a reasonable value or fair price.\supranotename{286} However, the unique circumstances of hospital billing allows for the complete avoidance of the judicial price-setting problem.\supranotename{287} The court is not required to set the price because the hospitals

\supranotename{277} See supra notes 114-67 and accompanying text.
\supranotename{278} See supra notes 1-18 and accompanying text.
\supranotename{279} See supra notes 1-18 and accompanying text.
\supranotename{280} There is no intent on the part of hospitals to treat the uninsured unfairly. In fact, some hospitals claim to want to reduce the amount they charge to the uninsured but feel they can't under existing federal rules. See Lucette Lagnado, Medical Shift: Hospitals Will Give Price Breaks To Uninsured, If Medicare Agrees, WALL ST. J., Dec. 17, 2003, at A1 (hospitals concede many charges aren't fair to the needy but blame federal rules); cf. Lucette Lagnado, HHS Chief Rebukes Hospitals for their Treatment of Uninsured, WALL ST. J., Feb. 20, 2004, at A1 (HHS Secretary claims hospitals may cut charges to uninsured "without fear of government reprisals").
\supranotename{281} See supra notes 104-67 and accompanying text.
\supranotename{282} See supra notes 104-67 and accompanying text.
\supranotename{283} See supra notes 104-67 and accompanying text.
\supranotename{284} See supra notes 104-67 and accompanying text.
\supranotename{285} See supra note 249.
\supranotename{286} See supra note 249.
\supranotename{287} As courts have noted, the reasonable value of a hospital's goods and services is the average amount the hospital actually collects for such goods and services. This amount may be readily ascertained by examination of the hospital's contracts with governmental agencies, HMO's and contract insurers. See Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alternatives, Inc., 832 A.2d 501, 509-10 (Pa. Super. Ct. 2003), appeal denied, 847 A.2d 1288 (Pa. 2004) (hospital may not recover billed "full" charges but may recover average collection rate for years in question); see generally River Park Hosp., Inc. v. Bluecross Blueshield of Tenn., Inc., 173 S.W.3d 43 (Tenn. Ct. App. 2002).
have, in fact, already set a reasonable price. An uninsured patient should be required to pay the average amount the hospital actually receives and accepts as full payment from Medicare, Medicaid, contract insurers, and HMOs for the diagnostic code that applies to the medical goods and services received by the patient. This amount can be easily and objectively determined and does not require court involvement in judicial price-setting.

An uninsured patient's agreement to pay a hospital's full charges is unconscionable regardless of whether the uninsured patient is rich or poor. The factors that result in the unconscionability of such provisions when applied to poor uninsured patients apply equally well to wealthy uninsured patients. The unconscionability springs from several factors. First, the medical services are necessary and thus the patient, rich or poor, has no choice but to sign the forms presented by the hospital. Second, the patient, rich or poor, has no idea from the agreement that he is agreeing to pay a huge premium over the amount paid for the same goods and services by insured patients. Finally, the price discrimination practiced by hospitals and their setting of "full charges" at excessively high levels unrelated to their costs or a reasonable profit is grossly unfair and shocking. All of these factors apply to wealthy and poor uninsured patients alike.

VI. CONCLUSION

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

An uninsured patient’s agreement to pay a hospital’s full charges is substantively unconscionable because the hospital is engaged in price discrimination. That is, hospitals are charging a huge premium to the uninsured with no justification. The premium is the result of the excessively high full charges reflected on the charge masters of hospitals, which in turn are the result of the often perverse rules and regulations associated with the third-party reimbursement system. In fact, the victimization of the uninsured seems to be unintentional. Nevertheless, the uninsured are victims and need protection. While clearly the proper solution to the problem is an overhaul of the rules and regulations of the third-party reimbursement system, in the meantime the flexible doctrine of unconscionability can provide significant protection to the uninsured. Courts should use the doctrine to ensure that the most the uninsured are required to pay for necessary medical services is the average amount that the hospital providing the service accepts from third-party payors for the diagnostic code relating to the goods and services provided to the patient.

299 See supra notes 61–80, 168–214 and accompanying text.
300 See supra notes 104–67 and accompanying text.
301 See supra notes 80–105, 215–41 and accompanying text.
302 See supra notes 104–67 and accompanying text.
303 See supra notes 104–67 and accompanying text.
304 See supra notes 270–74 and accompanying text.
305 See supra note 131.
306 See supra note 113.
307 See supra notes 242–91 and accompanying text.
308 See supra notes 287–90 and accompanying text.