

PATIENTS AS CONSUMERS: COURTS, CONTRACTS, AND THE NEW MEDICAL MARKETPLACE

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The persistent riddle of health-care policy is how to control the costs while improving the quality of care. The riddle's once-promising answer—managed care—has been politically ravaged, and consumerist solutions are now winning favor. This Article examines the legal condition of the patient-as-consumer in today's health-care market. It finds that insurers bargain with some success for rates for the people they insure. The uninsured, however, must contract to pay whatever a provider charges and then are regularly charged prices that are several times insurers' prices and providers' actual costs. Perhaps because they do not understand the health-care market, courts generally enforce these contracts. This Article proposes legal solutions to the plight of the patient-as-consumer and asks what that plight tells us about market solutions to the health-care quandary.

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[Professionals] may, as in the case of a successful doctor, grow rich; but the meaning of their profession, both for themselves and for the public, is not that they make money but that they make health, or safety, or knowledge, or good government or good law. . . . [Professions uphold] as the criterion of success the end for which the profession, whatever it may be, is carried on, and [subordinate] the inclination, appetites and ambition of individuals to the rules of an organization which has as its object to promote the performance of function.

—R. H. Tawney
The Acquisitive Society

INTRODUCTION: PATIENTS AS CONSUMERS IN A NEW MARKETPLACE

Patients have always been consumers.¹ Before health insurance was common, they shopped in a market for medical services just as they shopped in a market for toasters and tailors. The fifteen percent of us who lack health insurance still shop that way. Even insured patients shop: they make copayments and have coinsurance; they pay extra for doctors and hospitals outside the insurer's network and for drugs outside the insurer's formulary.²

Patients have always been consumers, but, today, America's battle to restrain rocketing costs of health care has transformed the world of patients as consumers: Crucially, two recent reforms have (1) pushed more patients into the medical market and (2) made that market a more parlous place.

In one of those reforms—managed care—insurers bargain with doctors and hospitals and give providers incentives to cabin costs. This helps plan members get care less expensively, which is its intent. Unintentionally, how-

1. See generally Nancy Tomes, *Patients or Health-Care Consumers?*, in HISTORY AND HEALTH POLICY IN THE UNITED STATES 83 (Rosemary A. Stevens et al. eds., 2006).

2. See generally Dahlia K. Remler & Sherry A. Glied, *How Much More Cost Sharing Will Health Savings Accounts Bring?*, 25 HEALTH AFF. 1070 (2006); James C. Robinson, *Renewed Emphasis on Consumer Cost Sharing in Health Insurance Benefit Design*, 2002 HEALTH AFF. W139, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.139v1> (web exclusive).

ever, managed care relegates uninsured patients to a new marketplace, a marketplace of uncommon harshness dominated by doctors, hospitals, and insurers. Briefly, insurers aggressively negotiate rates for plan members; uninsured patients must “bargain” individually with providers who are determined to recoup what they bargained away to insurers.

Managed care, then, has momentarily changed the market for patients who must be consumers. The latest reform—consumer-directed health care—drives more insured patients into that market.³ Assisted by a new tax shelter for “health savings accounts,” employers and individuals are buying insurance with high deductibles that require patients to pay most medical costs out of pocket.⁴ To qualify for the tax shelter, deductibles may range from \$1,100 for individuals to \$11,000 for families.⁵ This is supposed to induce patients to shop like consumers for good care at low prices.⁶

What happens when patients buy care in the new medical market? What happens when consumer-directed health care makes even insured patients negotiate prices with doctors and hospitals? The standard hope is that the market will provide, that the market will spread decent products at reasonable prices before consumers, who will choose the right goods at the right rates. The key but unappreciated fact, however, is that the market for uninsured medical services is a calamity. Patients can rarely amass enough information about services and prices to make good decisions about hiring doctors and buying care. Patients are frequently committed to their doctors, and their doctors normally decide which hospitals to use. Doctors and hospitals commonly require patients to sign contracts obliging them to pay whatever bills the provider cares to present. Providers regularly present and aggressively collect staggering bills unrelated to their costs or to the prices they negotiate with insurers. This is a market few can negotiate wisely, but in which missteps can destroy patients economically. No surprise, then, that

3. See generally TIMOTHY STOLTZFUS JOST, *HEALTH CARE AT RISK: A CRITIQUE OF THE CONSUMER-DRIVEN MOVEMENT* (2007); Amy B. Monahan, *The Promise and Peril of Ownership Society Health Care Policy*, 80 TUL. L. REV. 777, 803–05 (2006).

4. A deductible of \$3,500, for instance, covers all the annual medical expenses for about eighty percent of people. See John V. Jacobi, *Consumer-Directed Health Care and the Chronically Ill*, 38 U. MICH. J.L. REFORM 531, 562 (2005); Paul Fronstin, *Health Savings Accounts and Other Account-Based Health Plans*, EMP. BENEFIT RES. INST. ISSUE BRIEF, Sept. 2004, at 1, 11, available at <http://www.ebri.org/pdf/briefspdf/0904ib1.pdf>; Mark W. Stanton, *The High Concentration of U.S. Health Care Expenditures*, AHRQ RES. ACTION, June 2006, available at <http://www.ahrq.gov/research/ria19/pendria.pdf>.

5. Office of Pub. Affairs, U.S. Dep’t of Treasury, 2007 HSA Indexed Amounts, <http://www.treas.gov/offices/public-affairs/hsa/07IndexedAmounts.shtml> (last visited Oct. 6, 2007).

6. Patients are simultaneously encouraged to be consumers by other developments. For example, some physicians are establishing cash-only practices that refuse insurance. See Sandra J. Carnahan, *Law, Medicine, and Wealth: Does Concierge Medicine Promote Health Care Choice, or is it a Barrier to Access?*, 20 STAN. L. & POL’Y REV. 101 (2006); Frank Pasquale, *The Three Faces of Retainer Care: Crafting a Tailored Regulatory Response*, 7 YALE J. HEALTH POL’Y L. & ETHICS 39, 50 (2007). Also, retail chains are opening clinics offering basic services for everyday ailments. See MARY KATE SCOTT, *HEALTH CARE IN THE EXPRESS LANE: THE EMERGENCE OF RETAIL CLINICS* (Cal. HealthCare Found. 2006), available at <http://www.chcf.org/documents/policy/HealthCareInTheExpressLaneRetailClinics.pdf>; Ranit Mishori, *Is “Quick” Enough? Store Clinics Tap a Public Need, but Many Doctors Call the Care Inferior*, WASH. POST, Jan. 16, 2007, at F1.

the costs of illness—particularly medical bills—contribute to more than half of the personal bankruptcies in the United States.⁷

What should the law do when patients become consumers in this harsh market? Most basically, should patients be treated like any other consumers, and providers like any other vendors? More specifically, how should the law superintend the negotiation of contracts to pay for medical services? Should the law limit those contracts substantively? Do courts have a repertoire of doctrines for ameliorating the market's failure or at least safeguarding patients in extreme cases? If not, can doctrines be developed to make the worlds of managed care and consumer-directed health care safer for patients?

Scholars have strangely neglected these questions. Lawmakers have not recognized their existence, dimensions, or urgency. This is understandable, for lawmakers must rely on scholars to keep up with the medical markets' rapid changes. But while medical markets have been well studied, scholars have virtually ignored the legal questions the new market presents.⁸

We do not imagine that courts can solve the problems of health-care finance. But we believe that courts can and should shield patients from the cruelest consequences of the new market. Sickness, fear, and ignorance make patients inherently vulnerable. When patients must be consumers, their vulnerability deepens as they find themselves trapped in a market that starves them of information, alternatives, and leverage, a market that precludes prudent choice. The law ordinarily safeguards vulnerable consumers in perilous markets, and it eagerly protects patients when they choose medical treatments. More specifically, the common law endows courts with several doctrines that speak to the problems of patients as consumers. The law should recruit and develop these doctrines to shelter patients in the market managed care has created and consumer-directed health care will depend on.

7. Melissa B. Jacoby, *The Debtor-Patient Revisited*, 51 ST. LOUIS U. L.J. 307, 313 (2007); Melissa B. Jacoby & Elizabeth Warren, *Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress*, 100 NW. U. L. REV. 535, 548 (2006); Robert W. Seifert & Mark Rukavina, *Bankruptcy is the Tip of a Medical-Debt Iceberg*, 25 HEALTH AFF. W89 (2006), <http://content.healthaffairs.org/cgi/reprint/25/2/w89> (web exclusive).

8. The first modern scholarship to address these issues appeared in 2006. *E.g.*, Mark A. Hall, *Paying for What You Get and Getting What You Pay for: Legal Responses to Consumer-Driven Health Care*, 69 LAW & CONTEMP. PROBS., Autumn 2006, at 159; Jacoby & Warren, *supra* note 7; E. Haavi Morreim, *High-Deductible Health Plans: New Twists on Old Challenges from Tort and Contract*, 59 VAND. L. REV. 1207 (2006); George A. Nation III, *Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured*, 94 KY. L.J. 101 (2006). For an example of legal scholarship from over a century ago, see JOHN ORDONAU, *THE JURISPRUDENCE OF MEDICINE IN ITS RELATIONS TO THE LAW OF CONTRACTS, TORTS, AND EVIDENCE* 1–93 (1869). Almost nothing appears in between.

I. THE MISERABLE MARKET FOR MEDICAL FEES

A. Introduction to the Problem of the Medical Marketplace

Patients increasingly are consumers. Consumers buy from vendors with interests of their own. Consumers must make well-judged purchases in the market—must evaluate their needs, assess their alternatives, hunt for the best price, and pay the consequent bill. In their rapture for deploying patients to tame medical costs, proponents of consumer-directed health care have descanted on the virtues of markets. But even smart and energetic consumers can struggle, even in good markets. How well can patients manage in the medical market?

For consumers to evaluate prices, they must know them. Here the problems begin: “Medicine is the one capitalist enterprise to reveal its price tag only after the purchase or transaction is completed.”⁹ When patients approach a doctor or hospital, they almost never know and can rarely discover what things will cost. Few contracts with doctors and hospitals specify prices. Sometimes there is no contract; the obligation to pay is implied. Physicians’ agreements usually refer delphically to “fees,” “payments,” “accounts,” or “balances.”¹⁰ Likewise, hospital-admission forms obscurely commit patients to paying all “charges” not covered by insurance.¹¹ In short, doctors and hospitals insist that patients accept their standard charges, and patients learn what they bought and what it cost only on receiving a bill (if they are marvelously lucky and receive a bill they can understand).

Should courts enforce onerous bills contracted in this lamentable way? If the market otherwise functions decently, perhaps.¹² But the health-care

9. Howard F. Stein, *The Money Taboo in American Medicine*, MED. ANTHROPOLOGY, Fall 1983, at 1, 11 (emphasis omitted).

10. We verified this common knowledge (available to all who notice what they sign when they go to the doctor) through the most casual of empiricism. One morning in 2006 after one of us had his teeth cleaned, he visited the eight doctors’ offices in the vicinity to collect forms patients sign regarding financial responsibility. This “convenience sample” included offices with one to four physicians covering the following areas of practice: internal medicine, pediatrics, gynecology, neurology, general surgery, and cosmetic surgery. Only the cosmetic surgeon used a form that allowed a price to be stated. Others referred generically to “charges,” “fees,” “payments,” “account,” or “balance” not paid by insurance. Most of the forms explicitly made the patient responsible for payment, but two left the obligation implicit. Usually, these forms are completed on the patient’s first office visit. Only one office had such contractual language on an “encounter form” that patients sign each visit.

11. See, e.g., DiCarlo v. St. Mary’s Hosp., No. 05-1665, 2006 WL 2038498, at *1 (D.N.J. July 19, 2006) (enforcing a hospital contract that stated only that patients must pay “all charges”); Cox v. Athens Reg’l Med. Ctr., Inc., 631 S.E.2d 792, 796 (Ga. Ct. App. 2006) (“[T]he contract . . . simply provides that the patients will pay ‘in accordance with the rates and terms of the hospital.’”); Doe v. HCA Health Servs. of Tenn., Inc., 46 S.W.3d 191, 194 (Tenn. 2001) (“As part of the hospital’s pre-admission process, Jane Doe signed a hospital form . . . which read in part as follows: . . . I understand I am financially responsible to the hospital for charges not covered by [insurance].”)(emphasis omitted)).

12. See *Perdue v. Crocker Nat’l Bank*, 702 P.2d 503, 512 (Cal. 1985) (en banc) (“While it is unlikely that a court would find a price set by a freely competitive market to be unconscionable . . . , the market price set by an oligopoly should not be immune from scrutiny.” (citation omitted)); Frank

market is neither fair nor efficient. Rather, it is littered with the dangers of which Professor Eisenberg warns:

[A] market that involves a monopoly sets the stage for the exploitation of distress; a market in which transactions are complex and differentiated rather than simple and homogeneous sets the stage for the exploitation of transactional incapacity; a market in which actors do not simply take a price established by a general market and are susceptible to transient economic irrationality sets the stage for unfair persuasion; a market that involves imperfect price-information sets the stage for the exploitation of price-ignorance.¹³

Lawmakers know little about the strange medical market and thus leave patients to flounder in it. In this Part, therefore, we will chart the market's operation and its consequences. In the next Part, we will ask how the law should succor patients tossed in such stormy seas.

B. Insurers as Purchasers of Health Care

In one large part, the health-care market works plausibly enough. Insurers (public and private) negotiate prices for much of the care many patients receive. Insurers bargain from strength and can sell more insurance if they offer the low rates that come with low fees.¹⁴ And while patients pay what insurers don't reimburse, insurers usually secure for the insured the same discounts they negotiate for themselves.¹⁵ Insurers thus eliminate real controversy¹⁶ over whether negotiated prices are reasonable in contract or

P. Darr, *Unconscionability and Price Fairness*, 30 HOUS. L. REV. 1819 (1994) (showing that courts are more likely to find unconscionable price when market imperfections are greater).

13. Melvin A. Eisenberg, *The Bargain Principle and its Limits*, 95 HARV. L. REV. 741, 799 (1982) (arguing for greater judicial scrutiny of prices when markets are not competitive).

14. Indeed, physicians often complain that these forces work too well and have sought special protection under antitrust laws to negotiate collectively with insurers. See, e.g., William S. Brewbaker, *Physician Unions and the Future of Competition in the Health Care Sector*, 33 U.C. DAVIS L. REV. 545 (2000); Martin Gaynor, *Why Don't Courts Treat Hospitals Like Tanks for Liquefied Gases? Some Reflections on Health Care Antitrust Enforcement*, 31 J. HEALTH POL. POL'Y & L. 497, 505 (2006). Most economists, however, do not think insurers' market strength excessive. See, e.g., Roger Feldman & Douglas Wholey, *Do HMOs Have Monopsony Power?*, 1 INT'L J. HEALTH CARE FIN. ECON. 7 (2001); Gaynor, *supra*, at 507. Likewise, hospitals' ability to negotiate higher rates with private insurers to make up shortfalls from government programs indicates that they are not overwhelmed by private insurers. See Allen Dobson et al., *The Cost-Shift Payment "Hydraulic": Foundation, History, and Implications*, 25 HEALTH AFF. 22 (2006) (documenting the extent of hospitals' ability to increase rates paid by private insurers); Paul B. Ginsburg, *Can Hospitals and Physicians Shift the Effects of Cuts in Medicare Reimbursement to Private Payors?*, 2003 HEALTH AFF. W3-472, W3-475, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.472v1> (web exclusive) (analyzing providers' market power in view of their ability to shift costs to private insurers).

15. See Jerry Cromwell & Philip Burstein, *Physician Losses from Medicare and Medicaid Discounts: How Real Are They?*, 6 HEALTH CARE FIN. REV. 51, 55 (1985); Mark A. Hall & Clark C. Havighurst, *Reviving Managed Care with Health Savings Accounts*, 24 HEALTH AFF. 1490, 1496 (2005).

16. However, it will not always be clear whether a service is covered by a plan and therefore whether the plan's discount or payment rules apply. For instance, if a patient exceeds the maximum amount a policy covers, it may be unclear whether further treatment that normally would be covered remains subject to the policy's terms.

common-law terms¹⁷: although insurance markets are hardly perfect (and so perhaps should be regulated), they discourage nastily excessive fees in prototypical situations.¹⁸

Nevertheless, no insurance covers everything, so even insured patients can be vulnerable when medical care is not covered by insurance or when care is sought outside a provider network. Insurance usually excludes treatment that is experimental, cosmetic, custodial, or otherwise not “medically necessary,” and it often excludes or restricts other kinds of care, like treatment for pre-existing conditions or for mental illness and treatment using “alternative” therapies.¹⁹ Insurers’ negotiated prices do not apply to these. And insurers’ discounts are not assured where the policy’s coverage limits are exceeded, even for necessary care.²⁰

C. Shopping for Prices

Nobody knows how often patients pay nondiscounted fees,²¹ but such fees account for virtually all the caselaw we have surveyed over patients’ bills.²² To resolve these disputes intelligently, courts must understand how

17. One exception might be so-called discount-only plans that provide no insurance protection but simply sell individual patients access to negotiated rates. See Gerard Britton, *Discount Medical Plans and the Consumer: Health Care in a Regulatory Blindspot*, 16 LOY. CONSUMER L. REV. 97, 111–12 (2004). However, because these surrogate fee schedules are not necessarily negotiated at arm’s length by someone with a clear stake in obtaining the lowest rates, they too might be inflated.

18. This is true even when the insurer is only a third-party administrator for a self-insured employer because insurers give these employers the same discounts insurers negotiate to reduce their own financial liability. Cf. Janice S. Lawlor & Mark A. Hall, *Do Employers Voluntarily Include Patient Protections in Self-Insured Managed Care Plans?*, MANAGED CARE INTERFACE, Jan. 2005, at 76.

19. Mark A. Hall & Gerard F. Anderson, *Health Insurers’ Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637 (1992).

20. For discussions on caps on insurance coverage, see Jon Gabel et al., *Individual Insurance: How Much Financial Protection Does It Provide?*, 2002 HEALTH AFF. W172, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.172v1> (web exclusive), Sherry Glied et al., *Bare-Bones Health Plans: Are They Worth the Money?*, COMMONWEALTH FUND, May 2002, available at http://www.commonwealthfund.org/usr_doc/glied_barebones_518.pdf.

21. Some evidence: About 10%–20% of health insurance claims come from providers outside the primary network. Karl Huff, *White Space Management of Health Care Claims: Maximizing Savings from Non-Network Exposure*, AHIP COVERAGE, July–Aug. 2005, at 37, 37. And people with health insurance pay out of pocket for about 25% of physicians’ costs, 15% of emergency room costs, and 5% of hospitalization costs. See Erika C. Ziller et al., *Out-of-Pocket Health Spending and the Rural Underinsured*, 25 HEALTH AFF. 1688, 1691 ex.1 (2006); KAISER FAMILY FOUND., DISTRIBUTION OF OUT-OF-POCKET SPENDING FOR HEALTH CARE SERVICES (2006), <http://www.kff.org/insurance/snapshot/chcm050206oth.cfm> (last visited Oct. 6, 2007).

22. See *infra* notes 240–244. Most of these cases involve patients without insurance, but in the following cases the reasonableness of charges was challenged even though the patients had some type of health insurance: *Valley Hospital v. Kroll*, 847 A.2d 636, 638 (N.J. Super. Ct. Law Div. 2003); *Temple University Hospital v. Healthcare Management Alternatives, Inc.*, 832 A.2d 501, 508–09 (Pa. Super. Ct. 2003); *Eagle v. Snyder*, 604 A.2d 253, 253–54 (Pa. Super. Ct. 1992); *Doe v. HCA Health Services of Tennessee, Inc.*, 46 S.W.3d 191 (Tenn. 2001); *River Park Hospital, Inc. v. BlueCross BlueShield of Tennessee, Inc.*, 173 S.W.3d 43, 60 (Tenn. Ct. App. 2002); *H.E. Butt Grocery Co. v. Rencare, Ltd.*, No. 04-03-00190-CV, 2004 WL 199272, at *1 (Tex. Ct. App. Feb. 4, 2004).

uninsured services are priced. Patients, doctors, hospitals, illnesses, and treatments vary so enormously that generalizing about medical pricing is a fools' game. But play it we must. Our generalization: the patient's illness, the patient's relationship with the physician, and the patient's disadvantages in selecting physicians combine to make it miserably difficult for patients to shop skillfully for fair prices.

1. *The Effects of Illness on the Patient as Consumer*

Being a consumer is harder than it looks, especially when buying unfamiliar things in unfamiliar situations. Consumers chronically inform themselves laxly, understand their preferences hazily, and analyze their choices carelessly. An extensive and expanding law of consumer protection responds to these frailties with a varied array of doctrines.²³ For example, that law forbids unduly dangerous and even unduly disadvantageous sales—as usury laws do. It relieves people of some improvident contracts, if only through a *locus poenitentiae*. It requires warnings about many products—truth-in-lending laws being a prime example (of this popular if bootless technique). It provides remedies for harms done by defective products.

What, then, of the patient as consumer? All the consumer's frailties and frustrations afflict the patient. But in addition, illness can cripple the patient as consumer. How?

Illness disables. Sick bodies rebel, and the ill are defeated.

Illness pains. The faltering body hurts. Sometimes intensely; sometimes perpetually. Even “a little loss of animal toughness, a little irritable weakness and descent of the pain-threshold, will bring the worm at the core of all our usual springs of delight into full view, and turn us into melancholy metaphysicians.”²⁴

Illness exhausts. The sick lose the physical strength and emotional fortitude to keep houses clean, families cared for, friendships alive, and employers satisfied. They struggle even to rise from bed, brush their teeth, or make breakfast.

Illness erodes control. One doctor explains that the most destructive part of illness is “the loss of control. Maintaining control over oneself is so vital to all of us that one might see all the other phenomena of illness as doing harm . . . doubly . . . as they reinforce the sick person's perception that he is no longer in control.”²⁵ Control is always an illusion; call no man happy until he dies. But control especially eludes the ill.

23. See generally AM. BAR ASS'N, THE AMERICAN BAR ASSOCIATION GUIDE TO CONSUMER LAW (1997), available at <http://www.abanet.org/publiced/practical/books/consumer/home.html>; ANDREW L. SANDLER ET AL., CONSUMER FINANCIAL SERVICES (2006); JONATHAN SHELDON & CAROLYN L. CARTER, UNFAIR AND DECEPTIVE ACTS AND PRACTICES (6th ed. 2004).

24. WILLIAM JAMES, THE VARIETIES OF RELIGIOUS EXPERIENCE 140 (rev. reprint 1902).

25. ERIC J. CASSELL, THE HEALER'S ART 44 (1976).

Illness enforces dependence. Everyone is dependent, but illness reduces the sick to uncustomary and even plenary reliance on others. Arthur Frank learned from his cancer that “[d]ependence is the primary fact of illness.”²⁶

Illness disorients. Sickness alters lives, often globally, often incomprehensibly: “The merest schoolgirl, when she falls in love, has Shakespeare or Keats to speak her mind for her; but let a sufferer try to describe a pain in his head to a doctor and language at once runs dry.”²⁷ So the sick suffer a disturbing, exhausting strangeness.

Illness baffles. Patients yearn to know their prognosis but rarely understand the origin, mechanism, or trajectory of a disease. Worse, medicine “is engulfed and infiltrated by uncertainty.”²⁸

Illness terrifies. “I break out in a hot sweat, become dizzy with the secret but powerful secretion of adrenaline, my mind boils with disparate thoughts as the world transforms itself into an elaborate disaster.”²⁹ And “mere explanations of course provide no relief, because all I now know is that I am deeply and irrevocably out of my mind.”³⁰ The sick fear all the harms we have catalogued, and not least the lesser ones. When Arthur Frank talks “to people about to begin chemotherapy, a common reaction is for fears of immediate side-effects, particularly hair loss, to be more of a topic than fears of the treatment not working.”³¹ But the ill fear much beyond these homely horrors: And I looked, and behold a pale horse: and his name that sat on him was Death.

Illness isolates. The pain, debility, uncertainty, and fear that those around him do not know, their sufferer cannot fully share. Illness is “always a place where there’s no company, where nobody can follow.”³²

Who, so beset, can muster the energy and acuity to buy a telephone sensibly, much less medical care? How can patients be the consumer a market needs?

Someone who is ill and seeking help—unlike someone who is purchasing a pair of socks or a pound of sausages—is often vulnerable, certainly worried, sometimes uncomfortable, and frequently frightened. [The term c]ustomer, like the other obvious choices—clients, consumers, and users—erases something that lies at the heart of medicine: compassion and a relationship of trust.³³

26. ARTHUR W. FRANK, *AT THE WILL OF THE BODY* 112 (1991).

27. VIRGINIA WOOLF, *On Being Ill*, in *THE MOMENT AND OTHER ESSAYS* 15, 15 (uniform ed., Hogarth Press 1952) (1947).

28. JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 166 (1984).

29. ROBERT JON PENSACK & DWIGHT ARNAN WILLIAMS, *RAISING LAZARUS* 122–23 (1994).

30. *Id.*

31. ARTHUR W. FRANK, *THE WOUNDED STORYTELLER: BODY, ILLNESS, AND ETHICS* 45 (1995).

32. FLANNERY O’CONNOR, *THE HABIT OF BEING* 163 (1979).

33. Raymond Tallis, *Commentary: Leave Well Alone*, 318 *BRIT. MED. J.* 1756, 1757 (1999); see also Judith H. Hibbard & Edward C. Weeks, *Consumerism in Health Care: Prevalence and Predictors*, 25 *MED. CARE* 1019 (1987) (questioning whether patients are willing to act as consumers);

2. Shopping for Treatments: Patients in the Hands of Doctors

Not only can illness cripple the patient as seeker of information and maker of decisions, but the sick must engage with doctors in ways that unfit them for the market. Patients rely so much on their doctors that their purchasing choices are severely constricted, so constricted that it is hardly too much to say that doctors wield something like monopoly power over patients.

We just described what illness can do to patients. In their weakness, in their vulnerability, in their fear, patients crave the solace of doctors, confide themselves to doctors, trust doctors.³⁴ Patients want a therapeutic relationship with their doctors, a relationship which produces and prospers on reliance, attachment, and mutual confidence. This generates what economists call “monopolistic competition.”³⁵ It generates a system that is “inherently monopolistic.”³⁶ Patients rarely abandon doctors, reject doctors’ recommendations, or demand second opinions.³⁷ So, as one court recognized,

[t]he doctor dictates what brand [of drugs] the patient is to buy . . . [and] orders the amount of drugs and prescribes the quantity to be consumed. In other words, the patient is a captive consumer. There is no other profession or business where a member thereof can dictate to a consumer what brand he must buy, what amount he must buy, and how fast he must consume it and how much he must pay with the further condition to the consumer that any failure to fully comply must be at the risk of his own health. . . . [T]he patient then becomes a totally captive consumer and the doctor has a complete monopoly.³⁸

Why? The patient’s bond with the doctor is not easily created nor lightly sacrificed. Doctor and patient develop information about and confidence in

Deborah Lupton et al., *Caveat Emptor or Blissful Ignorance? Patients and the Consumerist Ethos*, 33 Soc. Sci. Med. 559, 567 (1991) (critiquing the attempt to convert patients to medical consumers as inconsistent with “universal cultural beliefs in developed capitalist societies” about the desired relationship to physicians); Wendy K. Mariner, *Standards of Care and Standard Form Contracts: Distinguishing Patient Rights and Consumer Rights in Managed Care*, 15 J. Contemp. Health L. & Pol’y 1 (1998) (outlining differences between patients and medical consumers).

34. See generally Mark A. Hall, *Law, Medicine and Trust*, 55 STAN. L. REV. 463 (2002).

35. For a review of the economic literature, see PAUL J. FELDSTEIN, HEALTH CARE ECONOMICS 253–54 (5th ed. 1998). Feldstein notes that “[t]he physician services market is believed to be characteristic of ‘monopolistic competition’ both because of the large number of competitors within a market and because each physician has a somewhat differentiated service, thereby providing . . . physician[s] with” some power to increase their prices without losing a lot of business. *Id.*; see also Thomas G. McGuire, *Physician Agency*, in 1A HANDBOOK OF HEALTH ECONOMICS 461, 475 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000) (“In virtually all characterizations of physicians in economics journals and textbooks, the physician is portrayed as having some market power. Monopolistic competition . . . is the expressed favorite [characterization] of many writers.”).

36. See Joseph P. Newhouse, *A Model of Physician Pricing*, 37 S. ECON. J. 174, 175, 182 (1970) (“[E]ach physician can act like a monopolist toward those patients who choose to use him.”).

37. CARL E. SCHNEIDER, THE PRACTICE OF AUTONOMY: PATIENTS, DOCTORS, AND MEDICAL DECISIONS (1998).

38. *Magan Med. Clinic v. Cal. State Bd. of Med. Exam’rs*, 57 Cal. Rptr. 256, 263 (Ct. App. 1967). Haavi Morreim called our attention to this decision in Morreim, *supra* note 8, at 1236.

each other, information and confidence that must laboriously be re-created when the patient changes doctors. This is not unique to medicine,³⁹ but illness inspires especially “thick” and vital personal relationships that patients hate to disturb. In short, there “is a very powerful and special bond between doctor and patient,” so even “when a transaction does not directly involve a physician financially,” the doctor still plays “a dominant role.”⁴⁰ Doctors’ “monopoly” power is intensified by patients’ almost irredeemable ignorance about almost all of almost every transaction.

Unlike a person shopping for a car, a suit or a haircut, the medical patient does not know what it is they [sic] need, what it should cost, or even, once paid for, how much good the treatment really did. Instead of a clear specification of what is to be expected from both parties, the patient must trust the doctor to do what is right and to bill fairly for the necessary care⁴¹

Patients have even less choice about hospital services. Doctors usually choose hospitals for patients and dictate most hospital expenditures.⁴² Yet doctors’ decisions are shaped by factors patients would not consult. Because doctors are typically not hospital employees, hospitals must attract doctors to attract patients.⁴³ Because physicians prefer hospitals with the best equipment, staff, and professional amenities, competition among hospitals drives patients’ costs up, not down.⁴⁴

In short, doctors are not monopolists in the starkest, strictest sense. But the market’s structure, the patient’s situation, and the patient’s ties to the physician effectively make patients hardly more than buyers without choice.

3. Shopping for Doctors

Patients, then, depend too much on their doctors to be free and active consumers of medical treatments. Yet patients are hardly better consumers when they pick the doctors on whom so much turns. Consider prices. Physicians advertise little and advertise fees less. They post no prices.⁴⁵ All this used to be blamed on collusion among doctors,⁴⁶ since the AMA’s Code of

39. See Frank B. Cross, *Law and Trust*, 93 GEO. L.J. 1457 (2005).

40. THOMAS E. GETZEN, *HEALTH ECONOMICS* 102 (1997).

41. *Id.* at 114.

42. Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 434 (1988); Lisa M. Schwartz et al., *How Do Elderly Patients Decide Where to Go for Major Surgery?*, 331 BRIT. MED. J. 821 (2005).

43. See, e.g., David Dranove & Mark A. Satterthwaite, *The Industrial Organization of Health Care Markets*, in 1B HANDBOOK OF HEALTH ECONOMICS, *supra* note 35, at 1114 (“[H]ospitals compete for admissions by providing services that complement physician work effort . . .”).

44. FELDSTEIN, *supra* note 35, at 327.

45. See generally Berkeley Rice, *How to Market Your Practice*, MED. ECON., Mar. 4, 2005, at 53 (describing typical approaches to marketing by physicians); Gail G. Weiss, *Lead Patients to Your Door*, MED. ECON., July 26, 2002, at 55 (describing the same).

46. This was largely because of Reuben A. Kessel’s somewhat polemical analysis in his seminal article, *Price Discrimination in Medicine*, 1 J.L. & ECON. 20 (1958). Beginning in the 1970s, however, health economists began to argue that physicians’ market power long predated the

Ethics forbade advertising. However, when this ban was declared an anti-trust violation in 1980,⁴⁷ little changed.⁴⁸ Nor do doctors discuss charges with patients. Only ten percent of Pittsburgh patients remembered being told what care would cost,⁴⁹ and in our casual survey of North Carolina physicians, only a plastic surgeon said he mentioned fees in advance.⁵⁰

Doctors dislike discussing fees.⁵¹ Hippocrates warned:

Should you begin by discussing fees, you will suggest to the patient either that you will go away and leave him if no agreement be reached, or that you will neglect him and not prescribe any immediate treatment. . . . I consider such a worry to be harmful to a troubled patient, particularly if the disease be acute.⁵²

Even today, Professor Stein detects a “taboo in official American health culture: namely, a prohibition upon allowing the physician to appear concerned with financial matters.”⁵³ Introducing money violates “the sacred by the profane.”⁵⁴ Those “‘selling’ their services are loathe to affix a price tag to those services at the time of the transaction or as an official precondition to ‘delivering’ them. Somehow it would be immoral to do so.”⁵⁵ Professor

AMA’s efforts to control the medical profession and that any such control could not explain doctor’s pricing behavior, such as free care or below-cost pricing for low-income patients. *See, e.g.*, Robert T. Masson & S. Wu, *Price Discrimination for Physicians’ Services*, 9 J. HUM. RESOURCES 63, 74 (1974); Newhouse, *supra* note 36, at 176; Roy J. Ruffin & Duane E. Leigh, *Charity, Competition, and the Pricing of Doctors’ Services*, 8 J. HUM. RESOURCES 212 (1973). Kessel’s account is now generally regarded as seriously incomplete, if not mostly wrong. *See, e.g.*, McGuire, *supra* note 35, at 464–65 (recounting this intellectual history and rejecting Kessel’s thesis).

47. *Am. Med. Ass’n v. FTC*, 638 F.2d 443 (2d Cir. 1980), *aff’d by an equally divided court*, 455 U.S. 676 (1982).

48. John A. Rizzo & Richard J. Zeckhauser, *Advertising and the Price, Quantity, and Quality of Primary Care Physician Services*, 27 J. HUM. RESOURCES 381, 388–89 n.12 (1992) (documenting that “physician price advertising continues to be quite rare” because the FTC seldom receives complaints based on price advertising by physicians, and polls show that “physicians are strongly opposed to price advertising”).

49. Thomas P. O’Toole et al., *Full Disclosure of Financial Costs and Options to Patients: The Roles of Race, Age, Health Insurance, and Usual Source for Care*, 15 J. HEALTH CARE POOR UNDERSERVED 52, 56 (2004).

50. *See supra* note 10. This is consistent with the American College of Physicians’ Ethics Manual, which provides that “[f]inancial arrangements and expectations should be clearly established,” Lois Snyder & Cathy Leffler, *Ethics Manual: Fifth Edition*, 142 ANNALS INTERNAL MED. 560, 571 (2005), but which omits the words “in advance” that had appeared in earlier versions, *e.g.*, Ad Hoc Comm. on Med. Ethics, Am. Coll. of Physicians, *American College of Physicians Ethics Manual*, 101 ANNALS INTERNAL MED. 129, 132 (1984) (“At the beginning of treatment it is good practice for patients to have a general knowledge of physicians’ fees and the probable overall costs of medical care.”).

51. *See generally* Fridolf Kudlien, *Medicine as a “Liberal Art” and the Question of the Physician’s Income*, 31 J. HIST. MED. 448 (1976) (reviewing the history of physicians’ practices and ethics regarding fees).

52. John Fabre, *Medicine as a profession: Hip, Hip, Hippocrates: extracts from The Hippocratic Doctor*, 315 BRIT. MED. J. 1669, 1669 (1997).

53. Stein, *supra* note 9, at 1.

54. *Id.* at 3.

55. *Id.* at 11. This “position has been articulated so frequently to me by apprentice and veteran physicians alike that it might be called official.” *Id.* at 8.

Stein thinks physicians “fear that to introduce monetary matters into an already unequal (i.e., parent-child) relationship would only widen the inequality, and would, moreover, demystify the parental, sacred, qualities that are necessary for an effective clinical relationship.”⁵⁶ And perhaps physicians—who are generally far wealthier than their patients—are embarrassed to discuss fees patients may find inexplicably high and crushingly burdensome.

Because physicians do not volunteer prices, patients must ask. But do you want to begin treatment by haggling over prices? You’re sick, anxious, and intimidated. So you let the doctor set the boundaries and tone of your relationship. In one study, only twelve percent of the people questioned had *ever* negotiated with a provider to get a lower price.⁵⁷ And in our pilot interviews in 2006 with a convenience sample of thirteen people, only a few patients (who knew their doctors well) were comfortable asking about costs.⁵⁸

Consider the well-educated, self-reliant woman trained in economics who injured her foot and asked a physician to refer her to a radiology clinic. The X-ray having shown a fracture, she hobbled to a nearby podiatrist. Told the podiatrist didn’t “take walk-ins” (which she thought ironic), she pleaded successfully to be seen. Since she had high-deductible insurance, the podiatrist prescribed a boot rather than a cast. Did this conscientious consumer ever ask about money?

A: No, because I figured I’m here, I’m not going to insult him by saying “how much do you charge?” . . . I could have gone to the other [medical office in the same building], but let’s say the other one upstairs is higher, am I going to come back downstairs now that I’ve insulted him? So it’s a little difficult to ask him his price

Q: In general, you said it’s insulting to ask the doctor. Is that generally true?

A: For me it is. . . . [I do ask my dentist about costs,] but with doctors somehow, there’s a little more respect there . . . in the sense that you don’t want to get off on the wrong foot with the doctor, even the foot doctor [chuckle].

Q: Yeah, after all, you don’t want your doctor thinking badly about you.

56. *Id.* at 9; see also Atul Gawande, *Piecework: Medicine’s Money Problem*, NEW YORKER, Apr. 4, 2005, at 44 (“Doctors aren’t supposed to be in it for the money, and the more concerned a doctor seems to be about making money the more suspicious people become about the care being provided.”).

57. Sara R. Collins et al., *Gaps in Health Insurance: An All-American Problem*, COMMONWEALTH FUND, Apr. 2006, at 20, available at http://www.commonwealthfund.org/usr_doc/Collins_gapshltins_920.pdf.

58. The person described in the next paragraph, for instance, said she would be much more willing to ask her regular doctor about the costs of treatment than to ask the hospital because she “would be comfortable with the trust relationship I’ve got with [my physician].”

A: Yeah, getting revenge somehow, perhaps.⁵⁹

If the circumstances and psychology of medical care deterred this strongly motivated, well-educated, cost-conscious, and self-confident patient from asking about prices, who would be braver?

If doctors can't discuss costs, could they communicate prices in some other way? Several generations ago, physicians did post fees. One influential guide advised nineteenth-century physicians to hang up a fee table "in a semi-prominent position in your office, that you may refer patients to it whenever occasion requires. . . . You can, when necessary, point to it and ask for your fee, and let them know you keep no books for [transient] office patients."⁶⁰ This is how retail-store clinics work today.⁶¹ But when fee schedules were common, doctors, like these clinics, offered only a few dozen services.⁶² Now, doctors provide thousands of services, procedures, supplies, devices, and drugs.

Hard as it is to find out what doctors' bills may mean, it is horribly harder to anticipate hospitals' charges. Once, hospitals resembled specialized hotels or modern nursing homes: They sold a day in a bed attended by a nurse, and prices could be specified for the room and the nursing.⁶³ But the number and costs of hospital services have multiplied and, funded by public and private insurance, hospitals have become temples of medical technology. Their "charge masters" list from 12,000 to 45,000 items.⁶⁴ Who could

59. The interview responses in this Article are taken from semistructured pilot interviews conducted in the summer of 2006.

60. D.W. CATHELL, *THE PHYSICIAN HIMSELF* 16 (Baltimore, Cushings & Bailey 1882). He added, "Of course you may omit its cash enforcement towards persons with whom you have a regular account." *Id.*

61. See *supra* note 6.

62. See GEORGE ROSEN, *FEES AND FEE BILLS: SOME ECONOMIC ASPECTS OF MEDICAL PRACTICE IN NINETEENTH CENTURY AMERICA* (Henry E. Sigerist ed., 1946).

63. See, e.g., *Guthmann v. La Vida Llana*, 709 P.2d 675, 679 (N.M. 1985) (finding that a contract for an extended-care retirement center was not unconscionable, in part because the purchaser "engaged in extensive comparative shopping"); see generally FELDSTEIN, *supra* note 35, at 566-67 (describing the market for nursing-home care); John A. Nyman, *The Private Demand for Nursing Home Care*, 8 J. HEALTH ECON. 209 (1989).

64. Hospital charge masters are described in *What's the Cost?: Proposals to Provide Consumers with Better Information about Healthcare Service Costs: Hearing Before the Subcomm. on Health of the H. Comm. on Energy and Commerce*, 109th Cong. 103 (2006) (testimony of Gerard F. Anderson, Director, Johns Hopkins Center for Health Finance and Management) [hereinafter Anderson Testimony 2006]; ALLEN DOBSON ET AL., *A STUDY OF HOSPITAL CHARGE SETTING PRACTICES* (2005), available at http://www.medpac.gov/publications/contractor_reports/Dec05_Charge_setting.pdf; Gerard F. Anderson, *From "Soak the Rich" to "Soak the Poor": Recent Trends In Hospital Pricing*, 26 HEALTH AFF. 780, 786 (2007) [hereinafter Anderson, *Soak the Rich*]; Nation, *supra* note 8, at 116-18; Uwe E. Reinhardt, *The Pricing Of U.S. Hospital Services: Chaos Behind a Veil of Secrecy*, 25 HEALTH AFF. 57, 58-59 (2006). Examples of charge masters are available at California Office of Statewide Health Planning and Development, Find Data—Hospital Chagemasters A, <http://www.oshpd.ca.gov/HQAD/Hospital/Chagemaster/2005/chrgmstrA.htm> (last visited Oct. 6, 2007).

master such a torrent of charges?⁶⁵ Furthermore, because of the way insurers pay hospitals and because of the complexity and unpredictability of medical care,⁶⁶ hospitals usually charge à la carte rather than bundling services into units that would permit price comparisons. Perhaps insurers and regulators can navigate the Hampton Court Maze of hospital charges, but patients assuredly cannot.

Yet another perplexity lurks in wait for the patient who tries to price doctors' services. Each physician deals with many insurers, each with fees negotiated in a tumultuous market that regards prices as trade secrets. One Harvard surgeon's group has a six-hundred page "master fee schedule" with "twenty-four columns across the top, one for each of the major insurance plans, and, running down the side, a row for every service a doctor can bill for."⁶⁷ Even a superb office staff might not know who would pay what until the insurer completed claims "adjudication." Thus, in one study, less than a third of the patients could ascertain prices in one call or visit.⁶⁸ Over six-hundred fictitious uninsured patients asked sixty-four California hospitals about the cost of one of twenty-five different services, such as ultrasounds or cardiac catheterizations. While three-quarters of the "inquiries were

65. See *Payne v. Humana Hosp. Orange Park*, 661 So. 2d 1239, 1242 n.3 (Fla. Dist. App. Ct. 1995) ("The charge master is reported at oral argument to be a document of hundreds of pages, in code."). The *Payne* case continues:

Payne and similarly situated patients are buying not one commodity, watermelons, but rather a long list of pills, supplies, and services, for which patients would have to review an allegedly unavailable, lengthy, coded document to know the contract price.

...

The instant case . . . presents nothing so simple as an "hourly rate" dispute; rather, an allegedly complicated and unobtainable master charge list containing hundreds of items is at issue.

Id. at 1242. The case of *Doe v. HCA Health Services of Tennessee*, 46 S.W.3d 191 (Tenn. 2001), included a similar sentiment:

[The] "Charge Master" [is] a confidential list of charges made by the hospital for all its goods and services, which is used to compute charges for all private commercial patients who are treated on a fee-for-service basis. The Charge Master is compiled and maintained by the hospital's chief financial officer on the hospital's computer system. In 1991, the Charge Master contained approximately 295 pages and listed prices for approximately 7,650 items. The Charge Master is considered confidential proprietary information and is not shown to anyone other than the officers and employees of the hospital and authorized consultants. The Charge Master is adjusted on a weekly basis to reflect current cost data; the hospital's costs are marked up by a mathematical formula designed to produce a targeted amount of profit for the hospital.

Id. at 194.

66. Porter and Teisberg argue that medical pricing could be further bundled by using entire episodes of care for particular ailments. MICHAEL E. PORTER & ELIZABETH OLMSTED TEISBERG, *REDEFINING HEALTH CARE: CREATING VALUE-BASED COMPETITION ON RESULTS* 105-111 (2006). Perhaps, but there is an irreducible core of uncertainty, complexity, and variability in medical diagnosis and treatment that has always hampered bundling unless it is imposed (such as by Medicare Diagnosis Related Groups ("DRGs")).

67. Gawande, *supra* note 56, at 44.

68. Press Release, Cal. HealthCare Found., *Where's the Price Tag? Mystery Shoppers Uncover the Frustration of Shopping for Hospital Care* (Dec. 14, 2005), <http://www.chcf.org/press/view.cfm?itemID=117607> (last visited Oct. 6, 2007).

ultimately answered with a firm or estimated price, more than a third [of the inquirers] had to make three or more calls to obtain the answer.”⁶⁹

In sum, patients dislike asking about prices and have trouble even when sturdy enough to try. Even if patients could be given estimates, only patients who knew what they needed could benefit. But who knows that before visiting the doctor? Even doctors often can’t predict treatments.⁷⁰ Even patients ask about price along the way, all the problems we’ve described remain. In addition, backing out of treatment may be dicey. As Alain Enthoven lamented, “When my injured child is lying bleeding on the operating table is hardly the time when I want to negotiate with the doctor over fees or the number of sutures that will be used.”⁷¹ For example, one educated and resourceful person⁷² we interviewed described her concerns about paying for uncovered treatment for migraines. The hospital “couldn’t give us a handle . . . on what we might be facing.” Her husband “got fairly adamant about wanting to know” and pleaded for “some kind of knowledge. ‘You don’t know how many treatments this is going to take, but what kind of ballpark things are we expecting?’” He was never told. Still, his wife “had no choice [because] I was in such pain.”

Q: So you are in the hospital in a state of vulnerability, confusion and uncertainty and you must be wondering, as the therapist says “let’s try this and let’s do that,” you must be wondering what that is going to cost, right?

A: . . . I was in such excruciating pain that if they had said “let’s amputate a leg” I would have asked no questions. I asked no questions about any procedure they were recommending. . . .

Q: Did you ever think they were running up the bill on you?

A: . . . [My husband] felt like “they are just running that up because nobody is going to say anything.”

Q: . . . [I]t is hard to fuss in the middle of things.

A: He made enough [fuss] that the girl from resource management came . . . to talk to us and calm him down. . . . “Everything is going to be all

69. *Id.*

70. See *A Review of Hospital Billing and Collection Practices, Hearing Before the Subcomm. on Oversight and Investigations of the H. Comm. on Energy and Commerce*, 108th Cong. 18 (2004) (testimony of Gerard F. Anderson, Director, Johns Hopkins Center for Health Finance and Management) [hereinafter Anderson Testimony 2004]; Paul B. Ginsburg, *Shopping For Price In Medical Care: Insurers are Best Positioned to Provide Consumers with the Information They Need, But Will They Deliver?*, 26 HEALTH AFF. W208, W210 (2007), <http://content.healthaffairs.org/cgi/reprint/26/2/w208> (web exclusive). Important exceptions include specialists who provide discrete or limited services, such as a diagnostic service done at a separate facility (for example, MRIs) or fairly simple surgery for a condition handled in a standardized way, for instance, vasectomy or uncomplicated childbirth.

71. ALAIN C. ENTHOVEN, HEALTH PLAN 34–35 (1980).

72. She is an administrator with a doctorate who is a model consumer and who manages her family’s finances and investments.

right.” Never any facts or figures to back that, but almost patronizing. At that point, [we thought] “Okay, whatever.”⁷³

Consumers must decide whether a purchase is worth its price. And that is the heart of consumer-directed health care. But medicine’s uncertainty, patients’ vulnerabilities, doctors’ mores, and the market’s structure combine to conceal prices from purchasers. Often, the patient can only agree (implicitly or explicitly) to pay whatever charges the provider imposes. As one court said:

The price term “all charges” is . . . the only practical way in which the obligations of the patient to pay can be set forth, given the fact that nobody yet knows just what condition the patient has, and what treatments will be necessary to remedy what ails him or her. Besides handing the patient an inches-high stack of papers detailing the hospital’s charges for each and every conceivable service, which he or she could not possibly read and understand before agreeing to treatment, the form contract employed by [the hospital] is the only way to communicate to a patient the nature of his or her financial obligations to the hospital.⁷⁴

True, prices can sometimes be specified, and sometimes patients can extract them.⁷⁵ These situations are touted as models for consumer-directed health care,⁷⁶ but they are exceptions, exceptions that (because the services are relatively simple) prove the rule. And true, when patients foot the bill, they do change their behavior. For example, they delay seeking care or cut back on drugs.⁷⁷ But this does not show that patients are successful consumers, since these patients often economize unwisely.⁷⁸

We have seen that across the board patients are ill equipped and badly positioned to purchase medical care well. So extreme are these disabilities that patients must often be wonderfully fortunate even to ascertain the most basic kind of market information—price. Patients, then, will rarely know enough to be successful consumers and will normally follow their doctors’ counsel in making medical purchases.

73. See *supra* note 58.

74. *DiCarlo v. St. Mary’s Hosp.*, No. 05-1665, 2006 WL 2038498, at *4 (D.N.J. July 19, 2006); see also *Nation, supra* note 8, at 116–18 (describing hospital price contracts).

75. For example, patients typically consult with physicians about the cost of cosmetic surgery. Prices of laser procedures to correct eyesight (like radial keratotomy) are commonly advertised. Ha T. Tu & Jessica H. May, *Self-Pay Markets In Health Care: Consumer Nirvana Or Caveat Emptor?*, 26 *HEALTH AFF. W217, W217–18* (2007), <http://content.healthaffairs.org/cgi/reprint/26/2/w217> (web exclusive). And walk-up clinics staffed by nurse practitioners or physicians’ assistants post a short list of standard prices. See *supra* note 6.

76. *E.g.*, MICHAEL F. CANNON & MICHAEL D. TANNER, *HEALTHY COMPETITION* 6–7 (2005).

77. MICHAEL A. MORRISEY, *PRICE SENSITIVITY IN HEALTH CARE* (2d ed. 2005), available at http://www.nfib.com/object/IO_24643.html; Thomas Rice & Karen Y. Matsuoka, *The Impact of Cost-Sharing on Appropriate Utilization and Health Status: A Review of the Literature on Seniors*, 61 *MED. CARE RES. & REV.* 415 (2004).

78. See Rice & Matsuoka, *supra* note 77.

D. Doctors' Prices and Doctors' Power

We have argued that the structure of medical care gives providers substantial market power over prices for uninsured care. However, if providers don't exploit that power to set high prices, their market situation may not matter. We now argue that doctors have been willing to use that power, that they have used it to keep prices high for some patients, but that professional and social considerations shape how doctors use their power.

Before widespread health insurance, doctors displayed their impressive market power in a notable way—they adjusted charges to fit patients' income, so some patients paid as much as three to five times more than others. In 1931, one doctor's median fee for treating acute diabetes was \$402, but his fees ranged almost fivefold, from \$232 to \$1052; X-ray treatments for severe acne could cost from \$70 to \$210.⁷⁹ For a major operation, surgeons often charged patients one month's salary.⁸⁰

These imposing variations in price demonstrate doctors' market power and the complexity of their motives in setting fees. Were maximizing income their only goal, doctors would accept only patients who could pay the marginal costs of their services. Instead, nineteenth-century physicians apparently charged the rich more so they could charge the poor less.⁸¹ We say "apparently" because sliding fees might help doctors charge everybody maximally rather than subsidize care for the poor.⁸² And indeed, by the 1930s, sliding fees were denounced as "a device for raising fees above the standard [rates] . . . rather than for lowering them for the poor, their major historical justification."⁸³

By the middle of the twentieth century, doctors' market power had expanded yet further, and doctors used that power in less benevolent ways.

79. MICHAEL M. DAVIS, PAYING YOUR SICKNESS BILLS 142–43(1931).

80. *Houda v. McDonald*, 294 P. 249, 251 (Wash. 1930); see also Max Seham, *Who Pays for the Doctor?*, NEW REPUBLIC, July 9, 1956, at 11.

81. See David Rosner, *Health Care for the "Truly Needy": Nineteenth-Century Origins of the Concept*, 60 MILBANK MEMORIAL FUND Q. HEALTH & SOC'Y 355 (1982); Ruffin & Leigh, *supra* note 46. A price-competitive market would prevent this cross-subsidy because wealthier patients would seek out cheaper doctors. Indeed, some wealthy patients did just that at the turn of the century. Dressing in tattered clothes, they would present themselves as indigent patients. Frederick Holme Wiggin, *The Abuse of Medical Charity*, MED. NEWS, Oct. 23, 1897, at 521. This was widely viewed as a blatant "abuse of charity" because it threatened the "Robin Hood" social compact that allowed doctors to charge the wealthy somewhat more in order to help provide care to the poor. Gert H. Brieger, *The Use And Abuse of Medical Charities In Late Nineteenth Century America*, 67 AM. J. PUB. HEALTH 264 (1977).

82. *E.g.*, Kessel, *supra* note 46.

83. HERMAN MILES SOMERS & ANNE RAMSAY SOMERS, DOCTORS, PATIENTS, AND HEALTH INSURANCE 54 (1961). Walton Hamilton, a former Yale law professor, explained:

"[C]harity work" and "the sliding scale" came into existence together; they are complementary aspects of the single institution of the collective provision of the physician's income; . . . [but] in our modern world the sliding-scale is an instrument easily capable of abuse. Above all, it is significant that the connection between the two has been broken, and that the older justifications are no longer relevant.

COMM. ON COSTS OF MED. CARE, MEDICAL CARE FOR THE AMERICAN PEOPLE 191 (1932).

Changes in medical education and licensure reduced the supply of doctors, and medical progress expanded the range of treatments.⁸⁴ Doctors took advantage of the leverage these developments gave them by charging “what the traffic will bear,”⁸⁵ meaning whatever desperate patients would pay for life or limb.⁸⁶ The care of poorer patients was increasingly relegated to free clinics and, later, nonprofit hospitals.⁸⁷

All this discredited the sliding scale, but health insurance killed it.⁸⁸ Insurers wanted consistency and objectivity—“usual, customary, and reasonable” (“UCR”) fees.⁸⁹ Even this did not curtail doctors’ market power. “Reasonable” meant “usual and customary,” which invited doctors to raise their fees, and many did, alarmingly.⁹⁰ The next assault on doctors’ market power came when managed care replaced UCR payments with negotiated or imposed fee schedules. This did deprive doctors of most of their leverage against government-regulated or managed-care insurance,⁹¹ although elsewhere doctors retain much of their market power.

We know that doctors retain market power because they have responded to the concessions given up in bargaining in two ways: by “cost shifting” (raising prices for uninsured patients) and by “demand inducement”

84. ROSEMARY STEVENS, *IN SICKNESS AND IN WEALTH: AMERICAN HOSPITALS IN THE TWENTIETH CENTURY* (1989).

85. HUGH CABOT, *THE DOCTOR’S BILL* 123 (1935).

86. Cf. Leonard M. Fleck, *The Costs of Caring: Who Pays? Who Profits? Who Panders?*, HASTINGS CENTER REP., May–June 2006, at 13 (criticizing the practice of modern drug companies to price some cancer drugs at \$100,000 a year based on “the inherent value of these life-sustaining technologies”) (citing Alex Berenson, *A Cancer Drug Shows Promise, at a Price That Many Can’t Pay*, N.Y. TIMES, Feb. 15, 2006, at A1); Kessel, *supra* note 46 (criticizing physicians’ pricing behavior).

87. Charles E. Rosenberg, *Social Class and Medical Care in Nineteenth-Century America: The Rise and Fall of the Dispensary*, 29 J. HIST. MED. & ALLIED SCI. 32 (1974).

88. See SOMERS & SOMERS, *supra* note 83, at 53 (noting that, in 1955, physicians’ use of a sliding scale “appear[ed] to be in decline . . . consistent with . . . the growth of health insurance”); Masson & Wu, *supra* note 46, at 76; Jonathan Spivak, *Doctors’ Fees: “Ability to Pay” Begins Giving Way to More Nearly Uniform Charges*, WALL ST. J., July 30, 1959, at 1. More recently, the national Community Tracking Survey reports an “alarming” increase (from 23.7% in a 1996–97 survey to 31.8% in a 2004–05 survey) in the proportion of physicians who provide no reduced-price or free care to patients on account of financial need. Peter J. Cunningham & Jessica H. May, *A Growing Hole in the Safety Net: Physician Charity Care Declines Again*, CENTER FOR STUDYING HEALTH SYS. CHANGE TRACKING REP., Mar. 2006, available at <http://www.hschange.com/CONTENT/826/826.pdf>; Marc A. Rodwin, Medical Commerce, *Physician Entrepreneurialism, and Conflicts Of Interest*, 16 CAMBRIDGE Q. HEALTHCARE ETHICS 387, 393 (2007).

89. Cromwell & Burstein, *supra* note 15, at 54; Benson B. Roe, *The UCR Boondoggle: A Death Knell for Private Practice?*, 305 NEW ENG. J. MED. 41 (1981).

90. Martin S. Feldstein, *The Rising Price of Physician’s Services*, 52 REV. ECON. STAT. 121 (1970); Anne A. Scitovsky, *Changes in the Costs of Treatment of Selected Illnesses, 1951–64*, 57 AM. ECON. REV. 1182 (1967).

91. See McGuire, *supra* note 35, at 527 (“[T]he prices chosen by health plans are probably best regarded as being determined by demand and supply.”); Mark V. Pauly & Mark A. Satterthwaite, *The Pricing of Primary Care Physicians’ Services: A Test of the Role of Consumer Information*, 12 BELL J. ECON. 488, 489 (1981) (describing physicians in metropolitan areas as “price setters”).

(convincing patients to use more services).⁹² But while doctors have clearly used these devices,⁹³ they have not necessarily maximized their profits—doctors “often do not set their prices as high as the market will bear.”⁹⁴ One theory is that doctors are restrained by a sense of professional duty. Another explanation is the “target income” hypothesis, which supposes that physicians develop goals for their income and use market power to achieve them.⁹⁵ Thus economists generally see doctors as profit-satisficers rather than profit-maximizers.⁹⁶

While physicians have not consistently exploited their market power, the enormous disparities between what insured and uninsured patients pay suggest that doctors sometimes charge exploitative fees, fees that may call for judicial intervention. In particular, the differences between what doctors charge insured and uninsured patients are eye-popping. For example, one study calculated that physicians overall charge 79% more than they receive from insurers.⁹⁷ Differentials vary.⁹⁸ For basic office or hospital visits, primary-care physicians typically charge one-third to one-half more than they receive from insurers (i.e., insurers get discounts of 25%–33%).⁹⁹ Markups are substantially higher for high-tech tests and specialists’ invasive procedures. Across a range of specialty services (echocardiography, coronary catheterization, liver biopsy, upper GI endoscopy, circumcision, flexible sigmoidoscopies, hysterectomy, appendectomy, gall bladder removal, and arthroscopic knee surgery), physicians charge roughly two to two-and-a-half

92. For reviews of this literature, see FELDSTEIN, *supra* note 35, at 286–87; Martin Gaynor, *Issues in the Industrial Organization of the Market for Physician Services*, 3 J. ECON. & MGMT. STRATEGY 211 (1994); and McGuire, *supra* note 35, at 503–19.

93. Cf. Uwe E. Reinhardt, *Commentary*, 53 MED. CARE RES. & REV. 274, 285 (1996) (“[I]t has always been widely taken for granted that physicians can recoup from private payers a substantial proportion of any income losses they suffer as a result of cost-containment efforts . . .”).

94. Ginsburg, *supra* note 14, at 477. Another prominent health economist reached the same conclusion more than thirty years earlier. Newhouse, *supra* note 36, at 182 (finding “some evidence that physicians do not maximize short-run profits” despite their “inherently monopolistic” power).

95. See generally, McGuire, *supra* note 35, at 522–26 (describing, but rejecting, the target-income theory).

96. Masson & Wu, *supra* note 46, at 63–64.

97. Ginsburg, *supra* note 70.

98. A comprehensive study in the 1980s found that physicians’ fees had more than double the markup, relative to resource costs, for invasive procedures than for ordinary office visits, with imaging and laboratory procedures falling in between. W.C. Hsiao et al., *Results and Policy Implications of the Resource-Based Relative-Value Study*, 319 NEW ENG. J. MED. 881, 885–88 (1988).

99. Wayne J. Gugliolmo, *Bridging the Reimbursement Gap*, MED. ECON., Nov. 8, 2002, at 96, 98; Dorothy L. Pennachio, *Fees & reimbursements*, MED. ECON., Oct. 10, 2003, at 96, 97; Dorothy L. Pennachio, *How do your fees mesh?*, MED. ECON., Nov. 5, 2004, at 26, 28.

The degree of markup (or discount) tends to vary by type of insurance, with private insurance paying roughly 10–25% more than Medicare. ZACHARY DYCKMAN & PEGGY HESS, *SURVEY OF HEALTH PLANS CONCERNING PHYSICIAN FEES AND PAYMENT METHODOLOGY* (2003), [http://www.medpac.gov/publications/contractor_reports/Aug03_PhysPaySurvey\(cont\)Rpt.pdf](http://www.medpac.gov/publications/contractor_reports/Aug03_PhysPaySurvey(cont)Rpt.pdf).

times what insurers pay.¹⁰⁰ In contrast, before aggressive managed care discounts, physicians' markups over Medicare and private insurance were roughly 25%–50% for both primary care and specialty procedures.¹⁰¹

These striking figures reveal the impressive market power that doctors can and do wield. However, doctors' fees are rational and moderate compared with hospitals' magnificently baroque and extravagant charges. To them we now turn.

E. Hospital Prices

We have already said that hospital prices for uninsured patients are incomprehensible. We now will show that those prices are little disciplined by the market and often unfair. Before managed care, hospitals billed insured and uninsured patients similarly. In 1960, “[t]here were no discounts; everyone paid the same rates”—usually cost plus ten percent.¹⁰² But as some insurers demanded deep discounting, hospitals vigorously shifted costs to patients with less clout.¹⁰³ Since uninsured patients are protected in this Darwinian marketplace by neither insurers nor regulators, hospitals are loosed to charge what they will.

The egregious failure of the hospital market is revealed by the astonishing differences between what hospitals nominally charge and what insured patients pay.¹⁰⁴ Insurers pay about forty cents per dollar of listed charges.¹⁰⁵ Thus hospitals bill uninsured patients 250% more than insured patients. This disparity has exploded over the past decade: since the early 1990s, list prices have increased almost three times more than costs, and markups over costs have more than doubled, from 74% to 164%.¹⁰⁶

100. See Pennachio, *supra* note 99. These averages conceal wide variations. A recent physician's narrative on medical fees, for instance, described one surgeon who charged more than ten times Medicare rates for some procedures. Gawande, *supra* note 56, at 48.

101. See Cromwell & Burstein, *supra* note 15, at 53, 58.

102. Anderson Testimony 2004, *supra* note 70, at 18.

103. See Jason S. Lee et al., *Medicare Payment Policy: Does Cost Shifting Matter?*, 2003 HEALTH AFF. W3-480, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.480v1.pdf> (web exclusive) (reporting broad consensus that hospitals are able to shift costs to private insurers); Michael A. Morrissey, *Cost Shifting: New Myths, Old Confusion, and Enduring Reality*, 2003 HEALTH AFF. W3-489, W3-490, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.489v1.pdf> (web exclusive) (explaining that cost-shifting behavior indicates both ability to exercise market power and previous restraint in doing so); *supra* note 14.

104. The absence of meaningful price competition can also be seen in the extreme differences in the list prices for the same service among hospitals in the same market. Among California hospitals, for instance, a *Wall Street Journal* reporter found that a basic chest x-ray with two views ranged from \$120 to \$1,519; a comprehensive metabolic panel ranged from \$97 to \$1,733; a CT scan of the head (without contrast) went from \$882 to \$6,599; a single tablet of Tylenol could be no charge or \$7. Lucette Lagnado, *Medical Markup: California Hospitals Open Books, Showing Huge Price Differences*, WALL ST. J., Dec. 27, 2004, at A1.

105. Anderson, *Soak the Rich*, *supra* note 64, at 780; Reinhardt, *supra* note 64, at 57.

106. MEDICARE PAYMENT ADVISORY COMMISSION, A DATA BOOK: HEALTHCARE SPENDING AND THE MEDICARE PROGRAM, JUNE 2004, at 103, available at <http://www.medpac.gov/>

At some hospitals the disparities are smaller, but at others they are larger still.¹⁰⁷ Undiscounted charges are often three or four times the rates given insurers, and there are “contracts where the discount from list price was over [ninety] percent.”¹⁰⁸ Charges alleged or found in recent lawsuits include \$20,000 for two nights’ hospitalization for pregnancy complications,¹⁰⁹ \$12,863 for a day’s treatment for shortness of breath,¹¹⁰ “\$52 for a single tablet of Tylenol with codeine,”¹¹¹ and a half million dollars for twenty-three days of treatment—twice what Medicare insurance allowed.¹¹² The *Wall Street Journal* described a patient treated two days for a suspected heart attack, for whom the “bill for the hospital stay totaled \$29,500. That bill did not include an additional \$6800 from the cardiologist, \$1000 for the ambulance ride, and \$7500” for a stent.¹¹³ Had the patient qualified for “state-sponsored healthcare through Medicaid, the hospital would have accepted a payment of only \$6000 for the twenty-one hour hospital stay, \$1000 for the cardiologist, and \$165 for the ambulance ride. The list price for the stent was \$3195, less than fifty percent of what [the patient] was charged.”¹¹⁴

Rational markets do not produce such bizarre prices.¹¹⁵ Surveying “the chaos that now reigns behind the opaque curtain of proprietary prices in the U.S. hospital system,” Uwe Reinhardt laments hospital price-setting that

publications/congressional_reports/Jun04DataBook_Entire_report_links.pdf; MEDICARE PAYMENT ADVISORY COMMISSION, A DATA BOOK: HEALTHCARE SPENDING AND THE MEDICARE PROGRAM, JUNE 2006, at 101, available at http://www.medpac.gov/publications/congressional_reports/Jun06DataBook_Entire_report.pdf.

107. In Ohio, for instance, hospital markups over costs in 2003 ranged by metro region averages from 83% to 217%, SEIU DISTRICT 1199 CARE FOR OHIO, TWICE THE PRICE 5 (2005), <http://s57.advocateoffice.com> (follow “Twice the Price” hyperlink) (last visited Oct. 6, 2007), and across all hospitals from 37% to 279%, *id.* at 18–20.

108. Anderson Testimony 2006, *supra* note 64, at 106. For instance, in 2002, the average charge among Philadelphia-area hospitals for medical management of a heart attack was over \$30,000, whereas “[m]ost insurers paid less than \$10,000.” Anderson Testimony 2004, *supra* note 70, at 20. A website that tracks hospital prices reported that a Philadelphia hospital charged \$15,000 for a cornea transplant that private insurers reimburse \$4,700 for. Michael Mason, *Bargaining Down that CT Scan is Suddenly Possible*, N.Y. TIMES, Feb. 27, 2007, at F5.

109. Kolari v. N.Y.-Presbyterian Hosp., 382 F. Supp. 2d 562, 569 (S.D.N.Y. 2005).

110. Colomar v. Mercy Hosp., Inc., 461 F. Supp. 2d 1265, 1267–68 (S.D. Fla. 2006).

111. Hall v. Humana Hosp. Daytona Beach, 686 So. 2d 653, 655 (Fla. Dist. Ct. App. 1996).

112. Valley Hosp. v. Kroll, 847 A.2d 636, 639 (N.J. Super. Ct. Law Div. 2003); *cf.* Burdette Tomlin Mem’l Hosp. v. Estate of Malone, 845 A.2d 615, 616 (N.J. Super. Ct. App. Div. 2003) (describing how hospital charged patient over three times what Medicare would have allowed).

113. Leah Snyder Batchis, Comment, *Can Lawsuits Help the Uninsured Access Affordable Hospital Care? Potential Theories for Uninsured Patient Plaintiffs*, 78 TEMP. L. REV. 493, 493 (2005) (footnotes omitted) (summarizing the story reported by Lucette Lagnado, *Anatomy of a Hospital Bill: Uninsured Patients Often Face Big Markups on Small Items*, WALL ST. J., Sept. 21, 2004, at B1).

114. Batchis, *supra* note 113, at 493.

115. Hospital pricing is partly driven by the way Medicare pays hospitals—typically a fixed amount per visit. For patients who stay much longer than normal, Medicare pays an extra amount based on how the hospital sets its standard charges, but only if the hospital actually bills and collects its full “list prices” from non-Medicare patients. Anderson, *Soak the Rich*, *supra* note 64, at 785; Nation, *supra* note 8, at 121–23.

“appears to be ad hoc, without any external constraints.”¹¹⁶ Hospital executives confess that “the vast majority of [charges] have no relation to anything, and certainly not to cost,”¹¹⁷ and see “no method to this madness.”¹¹⁸ If there is a method, it is perverse and destructive, because competition spurs higher prices.¹¹⁹ In short, “effectively, there [is] market failure” in pricing uninsured hospital services.¹²⁰

Weird pricing *might* not matter if hospitals charged the rich more so they could charge the poor less.¹²¹ Hardly. *All* uninsured patients—rich and poor alike—face staggering markups. When patients don’t pay, hospitals rush their accounts to collection agencies that belligerently exploit their legal weapons, including home foreclosures and personal bankruptcies.¹²²

Perhaps this is changing. Faced with congressional hearings and class-action litigation, some hospitals advertise “patient-friendly” pricing they claim is clearer, saner, and fairer.¹²³ Some hospitals give uninsured patients discounts¹²⁴ in reaction to criticism of charging the most vulnerable patients

116. Reinhardt, *supra* note 64, at 59, 66.

117. DOBSON ET AL., *supra* note 64, at 7.

118. Reinhardt, *supra* note 64, at 57.

119. *See supra* text accompanying notes 43–44. Thus, hospitals’ markups of charges over costs and over insurers’ payments are much higher in urban areas with a greater concentration of hospitals than in rural areas. Anderson, *Soak the Rich*, *supra* note 64, at 782 ex.1. For instance, the states with the greatest markups are California, New Jersey and Pennsylvania, and those with the lowest are Idaho, Montana, Vermont and Wyoming. In high markup states, hospitals’ charges average more than 4 times their costs, or 3.5 times their net receipts. In low markup states, charges average less than 2 times their costs, or less than 1.7 times their gross receipts. *Id.* at 783 ex.2. (Maryland is also among the group of low-markup states, but that is because it is the only state in the country with strict regulation of hospital charges. *See* Gerard F. Anderson, *All-payer Rate Setting: Down But Not Out*, HEALTH CARE FINANCING REV., SUPP. 1991, at 35, 37 [hereinafter Anderson, *All-payer Rate Setting*].)

120. Anderson Testimony 2004, *supra* note 70, at 20.

121. Arguably, higher charges to uninsured patients might be fair if richer patients paid them in full and hospitals used the surplus from very high markups to offset losses from uninsured patients who can pay little or nothing. Hospital administrators report that they collect only about ten percent of their charges to uninsured patients. E-mail from Terry Rappuhn, Project Leader, Patient Friendly Billing Project, to Mark A. Hall, Professor of Law and Public Health, Wake Forest University (Feb. 16, 2007 11:59:00 EST) (on file with authors); *see also* Joel S. Weissman et al., *Bad Debt and Free Care in Massachusetts Hospitals*, 11 HEALTH AFF. 148, 154 ex.2 (1992) (reporting that Massachusetts hospitals in 1988 wrote off as bad debt ninety-three percent of their charges to self-pay (uninsured) patients). This suggests that hospitals forgive much of what uninsured patients owe, but usually only after billing these patients in full and sending bills to collection, sometimes causing bankruptcy.

122. *See supra* text accompanying note 7.

123. Andrea B. Staiti et al., *Balancing Margin and Mission: Hospitals Alter Billing and Collection Practices for Uninsured Patients*, CENTER FOR STUDYING HEALTH SYS. CHANGE ISSUE BRIEF, Oct. 2005, available at <http://www.hschange.com/CONTENT/788/788.pdf>.

124. *Id.* A few states require these discounts in order for hospitals to maintain their charitable, tax-exempt status. *See* John D. Colombo, *Federal and State Tax Exemption Policy, Medical Debt and Healthcare for the Poor*, 51 ST. LOUIS U. L.J. 1, 4 (2007); Jacoby & Warren, *supra* note 7, at 541–42.

the highest fees.¹²⁵ The American Hospital Association advises hospitals to “offer discounts to patients who do not qualify under a charity care policy for free . . . care,”¹²⁶ and it reports that some hospitals “have developed a sliding-fee scale that specifies different percentage discounts from gross charges depending on patients’ household incomes.”¹²⁷ But such pricing is hardly ubiquitous, is unproved, and perhaps appeals less to for-profit than non-profit hospitals. In any event, as long as some hospitals have patients sign open-ended contracts, bill them multiples of competitive prices, and hound them for money they don’t have, courts need to protect them.

F. Summary

Adequate markets permit—indeed, help—consumers shop for good services at good prices. Even in such markets, however, consumers often stumble when buying unfamiliar products. Furthermore, several features of illness and its treatment prevent prudent shopping in medical markets.¹²⁸ First, the debilitation of illness and the urgency of medical care make patients lax consumers and inhibit them from switching providers. Second, patients often cannot really choose treatment or provider, since options are often few and since patients depend on doctors in selecting hospitals and specialists. Third, doctors dislike telling patients about costs and patients dislike asking. Fourth, patients’ treatments are often unpredictable. Fifth, doctors’ and especially hospitals’ prices are so complex and arbitrary that patients could not hope to understand them were they revealed. Sixth, providers protect themselves by presenting patients with form contracts obliging them to pay whatever the provider eventually asks. In sum, patients regularly begin treatment not knowing their needs, their alternatives, or their costs. Almost helplessly, they agree to pay whatever providers charge for whatever services they supply. This is a desperate market in which consumers can only struggle as flies to wanton boys.

No one should dream that the market’s failure can easily be fixed or that the failure is due to a remediable cause, like the presence of insurance. The failure’s roots go deep into the nature of medical care. In a simpler world half a century ago, “it was assumed that competitive market forces had a role in determining pre-insurance prices for medical services, including physician’s fees and hospital rates as well as the price of drugs, devices, and ancillary services.”¹²⁹ Even in that simpler world, however,

125. Beverly Cohen, *The Controversy Over Hospital Charges To The Uninsured—No Villains, No Heroes*, 51 VILL. L. REV. 95 (2006); Batchis, *supra* note 114.

126. AM. HOSP. ASS’N, HOSPITAL BILLING AND COLLECTION PRACTICES 3 (2003), <http://www.aha.org/aha/content/2004/pdf/guidelinesfinalweb.pdf>.

127. HEALTHCARE FIN. MGMT. ASS’N & AM. HOSP. ASS’N, HOSPITALS SHARE INSIGHTS TO IMPROVE FINANCIAL POLICIES FOR UNINSURED AND UNDERINSURED PATIENTS (2005), http://www.hfma.org/NR/rdonlyres/1D57ACA0-0AA1-43DA-8E7B-8A604DDEE664/0/2005_pfb_report.pdf.

128. See Ginsburg, *supra* note 70.

129. Roe, *supra* note 89, at 43.

few patients either knew or tried to discover whether their health care could be purchased at different prices; prices were never published or advertised. Patients generally had faith in their physicians and assumed the fees were fair and valid—whether or not they could afford to pay them. They obediently entered whatever hospital they were sent to and took their prescriptions to the pharmacy or provider that the physician suggested. Experience indicates that few patients, even those who complained about the costs, did any shopping around for better prices.¹³⁰

These enduring features of therapeutic relationships give rise to monopolistic market power that is ripe for exploitation. To be sure, exploitation is not pervasive. Doctors, on average, apparently are more restrained than hospitals,¹³¹ perhaps because they have longer relationships with patients, have a stronger sense of professional obligation, or feel fewer of the pressures that distort hospital pricing.¹³² Nevertheless, many physicians and most hospitals exploit their market power to induce patients to agree to pay what they are asked and then charge the uninsured fabulously more than the insured.

II. JUDICIAL PROTECTION OF THE PATIENT

How ought courts respond to the plight of the hapless patient charged predatory prices in a dysfunctional market? Should courts treat medical contracts like ordinary commercial contracts and leave patients to their bargain? If not, what can courts do for patients?

A. *Should Courts Protect Patients?*

As we have shown, the very disabilities that make people patients make them poor consumers. The relationships among patients, doctors, and hospitals make ordinary commercial relations uneasy and undesirable. And providers can compel patients to sign blank checks which providers can complete in dismaying ways. The law already recognizes consumers' susceptibility, patients' vulnerability, and doctors' power in numerous ways; protecting patients when they must be consumers logically extends that recognition.

The law responds to patients' exceptional vulnerability by altering several assumptions about commercial relationships. For example, the law spurns caveat emptor and the presumption that parties contract at arm's length and instead makes the doctor a fiduciary:

[T]here is more between a patient and his physician than a mere contract under which the physician promises to heal and the patient promises to

130. *Id.*

131. They may also have less inherent market power than hospitals.

132. Also, hospitals tend to provide more public goods in the form of undercompensated essential services than do physicians. *Cf.* Jill R. Horwitz, *Does Nonprofit Ownership Matter?*, 24 YALE J. ON REG. 139 (2007) (documenting unprofitable services provided by hospitals).

pay. There is an implied promise . . . that the physician will refrain from . . . conduct that is inconsistent with the “good faith” required of a fiduciary. The patient should . . . be able to trust that the physician will act in the best interests of the patient thereby protecting the sanctity of the physician-patient relationship.¹³³

As Cardozo famously wrote, “Many forms of conduct permissible in a workaday world for those acting at arm’s length, are forbidden to those bound by fiduciary ties.”¹³⁴ Fiduciaries are “held to something stricter than the morals of the market place. Not honesty alone, but the punctilio of an honor the most sensitive, is then the standard of behavior.”¹³⁵

Courts have been skeptical of claims that hospitals are fiduciaries,¹³⁶ although commentators have been more enthusiastic.¹³⁷ Still, a few courts have held that hospitals have fiduciary duties to disclose medical errors to patients¹³⁸ and not to exclude physicians unreasonably.¹³⁹ Other courts have declined to call hospitals fiduciaries but have refused to enforce waivers of liability and (less often) mandatory arbitration provisions because of the hospital’s relationship to the vulnerable patient.¹⁴⁰ One California court, for

133. *Petrillo v. Syntex Labs., Inc.*, 499 N.E.2d 952, 961 (Ill. App. Ct. 1986). For description and analysis of this body of law, see PETER D. JACOBSON, *STRANGERS IN THE NIGHT: LAW AND MEDICINE IN THE MANAGED CARE ERA* 222–49 (2002); MARC A. RODWIN, *MEDICINE, MONEY, AND MORALS* 179–211 (1993); and Maxwell J. Mehlman, *Dishonest Medical Mistakes*, 59 VAND. L. REV. 1137, 1147–49 (2006).

134. *Meinhard v. Salmon*, 164 N.E. 545, 546 (N.Y. 1928).

135. *Id.*

136. *E.g.*, *Sherwood v. Danbury Hosp.*, 896 A.2d 777, 797 (Conn. 2006) (“The plaintiff has provided scant reason to conclude that a hospital owes a patient the duty of a fiduciary.”).

137. *E.g.*, Robert Gatter, *The Mysterious Survival of the Policy Against Informed Consent Liability for Hospitals*, 81 NOTRE DAME L. REV. 1203, 1268 (2006) (“As hospitals have taken on responsibilities to organize the delivery of health care to their patients, they enter into fiduciary relationships with each of their patients as well”); Maxwell J. Mehlman, *Fiduciary Contracting: Limitations on Bargaining Between Patients and Health Care Providers*, 51 U. PITT. L. REV. 365, 366 n.6 (1990) (“Hospitals, as health care providers, must also fulfill the obligations imposed by their fiduciary relationship with their patients.”).

Some commentators also characterize health insurers as fiduciaries for certain purposes. JACOBSON, *supra* note 133, at 222–49; Clifford A. Cantor, *Fiduciary Liability In Emerging Health Care*, 9 DEPAUL BUS. L.J. 189, 212 (1997); Peter D. Jacobson & Michael T. Cahill, *Applying Fiduciary Responsibilities in the Managed Care Context*, 26 AM. J.L. & MED. 155 (2000).

138. These statements arise in the context of tolling the statute of limitations based on fraudulent concealment. *E.g.*, *Keithley v. St. Joseph’s Hosp.*, 698 P.2d 435, 439 (N.M. Ct. App. 1984) (stating that a hospital’s and physician’s breach of its fiduciary duty to disclose medical information to patients may toll the statute of limitations).

139. *Silver v. Castle Mem’l Hosp.*, 497 P.2d 564, 570–71 (Haw. 1972) (asserting that “[a] hospital occupies a fiduciary trust relationship between itself, its [physician] staff and the public it seeks to serve”); *Greisman v. Newcomb Hosp.*, 192 A.2d 817, 824–25 (N.J. 1963) (explaining that a hospital’s authority to exclude physicians is “rightly viewed . . . as [a] fiduciary power[] to be exercised reasonably and for the public good”). Professor Dallan, however, questions this characterization, noting that, in this context, patients do “not entrust hospitals with any confidential information or property, nor does the hospital make decisions on behalf of the public. A hospital’s credentialing decisions are made based on the interests of the hospital itself.” Craig W. Dallan, *Understanding Judicial Review of Hospitals’ Physician Credentialing and Peer Review Decisions*, 73 TEMP. L. REV. 597, 666 (2000).

140. MARK A. HALL ET AL., *HEALTH CARE LAW AND ETHICS* 422–23 (7th ed. 2007).

instance, acknowledged that “[t]o the ordinary person, admission to a hospital is an anxious, stressful, and frequently a traumatic experience . . . [in which the patient] normally feels he has no choice but to . . . accede to all of the terms and conditions for admission, including the signing of all forms presented to him.”¹⁴¹ To believe otherwise would “require us to ignore the stress, anxiety, and urgency which ordinarily beset a patient seeking hospital admission.”¹⁴²

Generally, however, courts regard hospitals as ordinary commercial enterprises, and so courts sometimes say they may “conduct . . . business largely as [they] see[] fit.”¹⁴³ However, courts have devised inventive ways to oblige hospitals to provide treatment, like finding (on exiguous evidence) that patients rely on a hospital’s perceived assurance of treating people in emergencies.¹⁴⁴ Moreover, courts have curbed hospitals by attributing quasi-public status to them. Thus when physicians challenge their exclusion from hospital staffs, courts (in about half the states to consider the question) have ruled that even private hospitals are, like the classic innkeepers and common carriers, businesses affected with a public interest and therefore constrained in their affairs.¹⁴⁵ True, these cases address hospitals’ obligations only to doctors, not to patients.¹⁴⁶ But hospitals generally acknowledge public-service obligations to patients, if only to gain the accreditation they need for financial success. (Accredited hospitals need not treat patients without charge, but they must accept patients with any form of payment—cash, insurance, Medicare, or Medicaid.)¹⁴⁷

In addition, courts relax normal contracting rules by enforcing doctors’ duty to treat even when patients do not promise to pay or even insist they cannot pay.¹⁴⁸ The duty’s scope is set largely by norms regarding patients’ rights and doctors’ standard of care,¹⁴⁹ norms usually unalterable by

141. *Wheeler v. St. Joseph Hosp.*, 133 Cal. Rptr. 775, 786 (Ct. App. 1976) (refusing to enforce an agreement to arbitrate).

142. *Id.* at 789.

143. *Wilmington Gen. Hosp. v. Manlove*, 174 A.2d 135, 137 (Del. 1961).

144. *See generally* Karen H. Rothenberg, *Who Cares?: The Evolution of the Legal Duty to Provide Emergency Care*, 26 HOUS. L. REV. 21 (1989).

145. *See generally* Dallon, *supra* note 139.

146. A rare exception is *Payton v. Weaver*, 182 Cal. Rptr. 225 (Ct. App. 1982), which considered whether a hospital may refuse to treat a disruptive patient. The court stated in dictum that a hospital “is arguably in the nature of a ‘public service enterprise,’ and should not be permitted to withhold its services arbitrarily, or without reasonable cause,” but it declined to impose a duty to treat because the argument had not been raised and because it was reluctant to impose on a single hospital the burden of caring for such an onerous patient. *Id.* at 230; *see also* Stella L. Smetanka, *Who Will Protect The “Disruptive” Dialysis Patient?*, 32 AM. J.L. & MED. 53 (2006).

147. The Joint Commission on Accreditation of Healthcare Organizations requires, *inter alia*, that hospitals accept patients without discrimination and regardless of their source of payment. HALL ET AL., *supra* note 140, at 118.

148. ORDRONAU, *supra* note 8, at 29; 23 SAMUEL WILLISTON & RICHARD A. LORD, A TREATISE ON THE LAW OF CONTRACTS §§ 62:12, 62:13, 62:15 (4th ed. 2002).

149. *See generally* GEORGE J. ANNAS, THE RIGHTS OF PATIENTS (3d ed. 2004); GEORGE J. ANNAS, STANDARD OF CARE: THE LAW OF AMERICAN BIOETHICS (1993).

contract.¹⁵⁰ Although physicians are not common carriers or in a public calling,¹⁵¹ most of their legal obligations are similarly independent of any contract.

There are even circumstances when courts arguably *over*-protect patients in interpreting contracts. Courts regularly give patients relief when insurers refuse to pay for treatments on the ground that the treatment was not medically necessary or otherwise not covered by the insurance contract.¹⁵² Some commentators have argued that courts have too often interpreted such contracts indefensibly out of sympathy for dangerously ill and dying plaintiffs.¹⁵³

In short, patients' vulnerability has long led courts to treat medical transactions differently from ordinary commercial transactions. And in non-economic spheres, the law specifically recognizes that patients' vulnerability may lead them into poor decisions. For example, the doctrine of informed consent acknowledges that patients follow their doctor's guidance in making medical decisions: "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 . . . is well-nigh abject."¹⁵⁴ Informed consent seeks to protect ignorant and dependent patients by having doctors equip them to make good decisions, even decisions that are not in the doctor's interests.¹⁵⁵

In short, regulating markets and protecting consumers is a standard part of law's agenda. Law specifically ameliorates the harshness of applying commercial law to medical contracts in multiple ways. The logical extension of that work is to protect patients in an agonizing situation—when they must shop in a merciless market and must incur unknown and uncontrollable obligations for intolerable sums.

But can courts do the job? One court doubted it could set a "reasonable charge" for hospital services "without wading into the entire structure of providing hospital care and the means of dealing with hospital solvency."¹⁵⁶ It could not "solve the problems of the American health care system, prob-

150. *Tunkle v. Regents of the Univ. of Cal.*, 383 P.2d 441 (Cal. 1963); Mehlman, *supra* note 137.

151. However, a limited set of public service norms apply to physicians via the Americans with Disabilities Act, which regards physicians' offices as places of public accommodation. *See Lyons v. Grether*, 239 S.E.2d 103, 105 (Va. 1977) (requiring physician to accept a blind patient with a guide dog); Lois Shepherd, *HIV, the ADA, and the Duty to Treat*, 37 Hous. L. Rev. 1055 (2000); Joel Teitelbaum & Sara Rosenbaum, *Medical Care As A Public Accommodation: Moving The Discussion To Race*, 29 AM. J.L. & MED. 381 (2003).

152. Hall & Anderson, *supra* note 19.

153. *See, e.g., id.*; Richard S. Saver, Note, *Reimbursing New Technologies: Why are the Courts Judging Experimental Medicine?*, 44 STAN. L. REV. 1095 (1992).

154. *Canterbury v. Spence*, 464 F.2d 772, 782 (D.C. Cir. 1972) (footnote omitted).

155. *Johnson v. Kokemoor*, 545 N.W.2d 495 (Wis. 1996).

156. *DiCarlo v. St. Mary's Hosp.*, No. 05-1665, 2006 WL 2038498, at *4 (D.N.J. July 19, 2006).

lems that the political branches of both the federal and state governments and the efforts of the private sector have, thus far, been unable to resolve.”¹⁵⁷ Similarly, in *Pegram v. Herdrich*,¹⁵⁸ the Supreme Court concluded that any line between good and bad insurance programs “would embody, in effect, a judgment about socially acceptable medical risk.”¹⁵⁹ However, that judgment would “necessarily turn on facts to which courts would probably not have ready access.”¹⁶⁰ Such “complicated factfinding and such a debatable social judgment are not wisely required of courts unless for some reason resort cannot be had to the legislative process, with its preferable forum for comprehensive investigations and judgments of social value, such as optimum treatment levels and health-care expenditure.”¹⁶¹

Deferring to markets and legislative policy made sense in *Pegram*, which bluntly challenged a well-established feature of well-established policy—for-profit physician-owned HMOs. However, nothing about managed care or consumer-driven health care requires courts to ignore price-gouging. On the contrary. Good private law is crucial to good markets, to ensuring that fair contracts are fairly enforced. As Uwe Reinhardt observed, “forcing sick and anxious people to shop around blindfolded for cost-effective care mocks the very idea of consumer-directed care.”¹⁶² Legislatures that recruit markets to reform health-care finance surely expect courts to help make the market work.

B. How Can Courts Protect Patients? The Supervisory Doctrines

We have argued that the law needs to protect patients when providers abuse their contractual power. Happily, courts command several doctrines for supervising contracts. Courts can (1) fill in missing contract terms or declare contracts void for vagueness, (2) amend or refuse to enforce unconscionable contracts, and (3) evaluate the fairness of fiduciaries’ behavior.

To be sure, courts deploy these supervisory doctrines cautiously because they are rightly reluctant to disturb contracts. First, contract law assumes people can bargain for themselves and know better than courts what they need. Second, courts typically doubt their competence to evaluate the fairness of contractual exchanges. Third, if courts often altered contracts, contracts would lose their predictability and hence much of their value. This is why the supervisory doctrines that allow courts to revise or reject

157. *Id.* Another court expressed a similar sentiment: “[T]he Georgia General Assembly[] [has decided] to let market forces control health care costs in Georgia. It is outside of the role of this Court to question the merits of this policy, and appellants’ remedy for any perceived failures in this scheme is with the legislature not the courts.” *Cox v. Athens Reg’l Med. Ctr., Inc.*, 631 S.E.2d 792, 797 (Ga. Ct. App. 2006).

158. 530 U.S. 211 (2000). This body of fiduciary law is created by the Employee Retirement Income Security Act of 1974 (“ERISA”).

159. *Pegram*, 530 U.S. at 221.

160. *Id.*

161. *Id.*

162. Reinhardt, *supra* note 64, at 68.

contracts set criteria that are not easily met. If those doctrines were not exigent, they might too easily be extended to make too many contracts too vulnerable.

It is thus not surprising that none of the supervisory doctrines precisely and reliably can curb all the common abuses of medical contracting, as we show in the following review of those doctrines and the case law and commentary on them. *Nevertheless*, each doctrine speaks in direct and fruitful ways to the problems in medical contracting we have described. Courts need hardly do more than develop these doctrines to shield patients from the worst excesses of medical pricing. That development should proceed as common-law development usually does—as courts solve doctrinal and valuation problems case by case. In what follows, we sketch each supervisory doctrine and suggest ways in which that common-law process can begin to deal with the epidemic of exploitative medical contracts.

1. *Incomplete Contracts*

As we have seen, a core problem with medical contracts is that they rarely specify either rate or quantity. Faced with such a contract, courts can (1) fill in the price or (2) conclude that the parties omitted an essential term because they did not intend to be contractually bound.¹⁶³ Common law preferred the second option, especially when contracts were deliberately incomplete: “One of the core principles of contract law is the requirement of definiteness.”¹⁶⁴ However, influenced by the Uniform Commercial Code and the Restatement of Contracts, modern courts frequently use gap-filling conventions,¹⁶⁵ especially for “relational” contracts or for subjects where definiteness and completeness are elusive.¹⁶⁶ For us, however, the important point is that both approaches permit courts to protect vulnerable consumers, since whether a court fills in the price or concludes that no contract was intended, it can review the reasonableness of prices.¹⁶⁷ If a contract is unenforceable, quantum meruit requires patients to pay the reasonable value of what they received. If a valid contract specifies no price, the implied price must be reasonable.

163. See generally Robert E. Scott, *A Theory of Self-Enforcing Indefinite Agreements*, 103 COLUM. L. REV. 1641 (2003).

164. *Id.* at 1643.

165. Omri Ben-Shahar, “Agreeing to Disagree”: Filling Gaps in Deliberately Incomplete Contracts, 2004 WIS. L. REV. 389, 394.

166. Scott, *supra* note 163, at 1650, 1654–59. Such is the case for hospital contracts. See *supra* text accompanying notes 64–66. Physician contracts, in contrast, are not “relational” in this same sense (even though they govern a treatment “relationship”). Therefore, physician contracts are more appropriately viewed as deliberately incomplete for the reasons of social and professional norms and interpersonal psychology that Professor Scott discusses. Scott, *supra* note 163, at 1654–59. To the extent that courts enforce both types of medical contracts despite their incompleteness, this may be tacit judicial recognition of the relational features common to all medical encounters.

167. See, e.g., *H.E. Butt Grocery Co. v. Rencare, Ltd.*, No. 04-03-00190-CV, 2004 WL 199272 (Tex. Ct. App. Feb. 4, 2004) (allowing a jury to reject a provider’s justification for its usual charges and to award a lower amount); Morreim, *supra* note 8, at 1257–59.

Thus in *Pychon v. Brewster*, a colonial Massachusetts decision, a doctor's executor brought a contract action for "a long Doctor's Bill for Medicines, Travel into the Country and Attendance."¹⁶⁸ The patient said the action lay in quantum meruit, not indebitatus assumpsit, because the parties had not set an exact sum. The court rejected the defense, since "Travel for Physicians, their Drugs and Attendance, had as fixed a Price as Goods sold by a Shopkeeper."¹⁶⁹ Nevertheless, the jury could (and did) reduce the charges "to what they thought 'reasonable.'"¹⁷⁰ And recently, *Colomar v. Mercy Hospital, Inc.* held that the patient "stated a claim . . . for unreasonable pricing of an open pricing term" where the hospital allegedly charged six times its cost for services.¹⁷¹

So, where no contract exists or where a contract states no price, courts can protect vulnerable patients by imposing a reasonable price. But can providers defeat such courts simply by raising the level of contractual specificity—for example, by stipulating that patients must pay the providers' "usual charges"? Here is an opportunity to develop the common law to protect exploited patients. Put simply, the higher the standard of specificity the court demands, the more likely the contract is to fail, thus allowing the court to insist on a reasonable price. A court might decide that a phrase like "usual charges" is specific enough to put patients on notice of what they are contracting to, and then the patient would have the daunting burden of showing that the provider's price was unreasonable.¹⁷² But in light of all we have said, a court could better conclude that such calculatedly vague provisions give patients no inkling of the risks they are assuming. This of course relieves the patient of the burden of proving the provider's price unreasonable and permits the court to decide what a reasonable price would be.

Many courts, however, think hospitals cannot reasonably be asked to be more definite about uncertain charges.¹⁷³ For instance, *Shelton v. Duke*

168. Quincy 224, 224 (Mass. 1766).

169. *Pychon*, Quincy at 224.

170. *Id.* at 225 (emphasis omitted).

171. 461 F. Supp. 2d 1265, 1273–74 (S.D. Fla. 2006).

172. See, e.g., *Harrison v. Christus St. Patrick Hosp.*, 430 F. Supp. 2d 591, 595 (W.D. La. 2006) ("The term 'regular rates and terms of the hospital' does not create an open-ended contract. Thus, no analysis of whether the charges were 'fair and reasonable' is required."); *Burton v. William Beaumont Hosp.*, 373 F. Supp. 2d 707, 719 (E.D. Mich. 2005) ("Regardless of whether Beaumont's charges were reasonable, it is undisputed that plaintiffs have not paid the charges in full . . . according to the express and unambiguous contract language").

173. For example, one court stated:

The price term "all charges" is certainly less precise than price term of the ordinary contract for goods or services in that it does not specify an exact amount to be paid. It is, however, the only practical way in which the obligations of the patient to pay can be set forth . . . Besides handing the patient an inches-high stack of papers detailing the hospital's charges for each and every conceivable service, which he or she could not possibly read and understand before agreeing to treatment . . .

DiCarlo v. St. Mary's Hosp., No. 05-1665, 2006 WL 2038498, at *4 (D.N.J. July 19, 2006). Another court spoke similarly:

*University Health System*¹⁷⁴ found “regular rates” specific enough to make a contract enforceable, since medical costs are unpredictable and patients cannot practically authorize each new cost. “For this reason, it is entirely reasonable and predictable that patients would agree to pay the hospital’s regular rates for whatever services might be necessary”¹⁷⁵ More, “the rates of services contained in the ‘charge master’ were necessarily implied in the contract”; therefore, “we need not address plaintiff’s argument that the rates charged by defendant were ‘unreasonable’” under a quasi-contract theory.¹⁷⁶

Somewhat less deferential is *Doe v. HCA Health Services of Tennessee, Inc.*¹⁷⁷ The hospital sued to collect the uninsured twenty percent of the \$6,731 surgery bill and said its standard admissions form obliged the patient to pay whatever its confidential charge master specified. The court declined to enforce the contract because it referred indeterminately to “charges” and not specifically to the charge master. On quantum meruit grounds, the hospital was entitled only to the reasonable value of its services based on its costs and what other hospitals charged.¹⁷⁸

Doe is by itself flimsy precedent, since the hospital need only amend its contract to incorporate the charge master specifically. And of course courts have generally tolerated low levels of specificity in medical contracts. But the failure of the market for medical care and the vulnerability of the patients buying care (facts which courts have not grasped) justify the small step of requiring higher standards of clarity and specificity in these contracts so that courts may review the reasonableness of the prices providers thrust upon patients.

We have been discussing one supervisory doctrine that gives courts an especially clear path to reviewing the reasonableness of prices. However, this is not the only doctrinal basis for such reviews. To the other bases we now turn.

The term “regular rates and terms of the hospital” does not create an open-ended contract. Thus, no analysis of whether the charges were “fair and reasonable” is required. Pure common sense demands the conclusion that it would be virtually impossible for a health care provider to provide a complete list of every possible service to be rendered an emergency patient prior to admission.

Harrison, 430 F. Supp. 2d at 595–96 (footnote omitted). Still another court said:

[T]he plain language of the contract leaves the discretion to set the rates solely with [the hospital]. This reflects the practical reality that, in a hospital setting, it is not possible to know at the outset what the cost of the treatment will be, because it is not known what treatment will be medically necessary.

Cox v. Athens Reg’l Med. Ctr., Inc., 631 S.E.2d 792, 797 (Ga. Ct. App. 2006) (footnote omitted).

174. 633 S.E.2d 113 (N.C. Ct. App. 2006).

175. *Shelton*, 633 S.E.2d at 116.

176. *Id.* at 116–17.

177. 46 S.W.3d 191 (Tenn. 2001).

178. *HCA Health Servs.*, 46 S.W.3d at 199.

2. Unconscionability

A second doctrinal basis for policing medical prices is the double-barreled law of unconscionability. The first barrel, substantive unconscionability, concerns the fairness of the contract's terms. Procedural unconscionability concerns the fairness of the process by which the contract was reached. Both aspects speak directly to the problems of medical contracting we have examined and richly proffer materials for developing a common law of fairness in medical contracts.

The heart of procedural unconscionability (and its sibling, duress) is that patients who need care can hardly reject a provider's contract.¹⁷⁹ That compulsion does not, by itself, make the contract unenforceable:¹⁸⁰ if need *alone* vitiated promises to pay, few medical contracts could be enforced, which might undermine physicians' obligations to patients.¹⁸¹ Therefore, courts have scanted these doctrines in interpreting medical contracts, even in horrifying cases: The mother said, "I signed where she told me to sign, so they would give [my son] medical treatment because he needed it because he was bleeding out of his ears, out of his mouth, the bone out of his elbow was sticking out through the skin."¹⁸² The court replied that hospitals have not "engaged in some form of wrongful conduct by asking [patients or families] to sign the patient authorization agreement."¹⁸³ Patients "cannot seriously argue that an agreement requiring them to pay for services that they admittedly received and benefited from is unfair"¹⁸⁴ or "contrary to the[ir] reasonable expectations"¹⁸⁵ or that the patient "was under pressure greater than that felt by any debtor."¹⁸⁶

As this grisly example suggests, "the legal system often treats medical debt like any other contract claim. . . . Contract law does not require actual negotiation of the terms of a contract, and it generally enforces standard forms drafted by one party. The fact that the terms are not extensively disclosed ordinarily will not defeat enforceability."¹⁸⁷ A Georgia court, for example, refused to evaluate a hospital's bills for uninsured patients, since they were not "being charged anything other than what the hospital

179. See, e.g., *Milford Hosp. v. Champeau*, No. CV00069269S, 2001 WL 497110 (Conn. Super. Ct. Apr. 27, 2001). When the patient's wife signed the agreement, her husband was having a heart attack, and she believed her husband would not be treated if she refused to sign the agreement. *Id.* at *5.

180. John P. Dawson, *Economic Duress—An Essay in Perspective*, 45 MICH. L. REV. 253, 283 (1947).

181. For instance, British barristers were once exempt from malpractice suits because they had no contractual right to sue clients for their fees. Hall, *supra* note 8, at 163–64.

182. *Heartland Health Sys., Inc. v. Chamberlin*, 871 S.W.2d 8, 10 (Mo. Ct. App. 1993).

183. *Milford Hosp.*, 2001 WL 497110, at *5.

184. *Id.* at *6.

185. *Heartland Health Sys.*, 871 S.W.2d at 11.

186. *Greene v. Alachua Gen. Hosp., Inc.*, 705 So. 2d 953, 953 (Fla. Dist. Ct. App. 1998).

187. *Jacoby & Warren*, *supra* note 7, at 570 (footnote omitted); see also *Batchis*, *supra* note 114, at 529 ("[C]ourts are reluctant to grant [unconscionability] claims.").

normally charges uninsured patients.”¹⁸⁸ After all, the “plain language of the contract,” which required payment “in accordance with the rates and terms of the hospital,” left “the discretion to set the rates solely “with the hospital.” There “can be no breach of an implied covenant of good faith where the party to a contract has done what the provisions of the contract expressly give him the right to do.”

This demanding interpretation of procedural unconscionability is doctrinally defensible in most contractual situations, but it is indefensibly wooden applied to medical contracts. Mere need, mere urgency, may ordinarily be inadequate to justify invoking unconscionability, but medical contracts are different. First, medical need can be urgent in a harshly more immediate, cruelly more lethal sense than in the normal run of contracts for which courts developed the doctrine of unconscionability. Second, the procedural problems here go beyond mere urgency. Little about the process by which patients “negotiate” with lordly and indifferent bureaucracies can be called fair, and it is the whole process and the market in which it operates that courts should consider in developing the common law of procedural unconscionability.

Furthermore, the law of procedural unconscionability works jointly in medical contracts with the law of substantive unconscionability. In other words, the procedural and substantive aspects of unconscionability interact, since the less fair the procedure the less reason we have to think the substance reflects a meaningful bargain between the parties. (Or, on another view, the way a contract was negotiated matters little if the price charged is fair.) It requires little development of substantive unconscionability to make it useful in supervising medical contracts. We have lengthily shown that the providers’ prices for uninsured patients often have no basis in either the cost of the service or in genuinely negotiated prices (the ones secured by insurers). At some point—a point reached with disquieting regularity—such prices go beyond mere unreasonability and become unconscionable.

In other areas, courts have done just what we advocate—deployed both procedural and substantive unconscionability to prevent imposition¹⁸⁹ where markets fail and one party takes abusive advantage of the other party’s weakness. For example, equity courts applying admiralty law in salvage and rescue cases refuse to enforce promises to pay exorbitant fees for saving goods or a ship in distress¹⁹⁰ when the promise is extracted from a captain

188. Cox v. Athens Reg’l Med. Ctr., Inc., 631 S.E.2d 792, 796 (Ga. Ct. App. 2006).

189. Imposition is a form of unconscionability that consists of taking unfair advantage of a vulnerable situation by extracting a higher price than is fair. Payne v. Humana Hosp. Orange Park, 661 So. 2d 1239, 1241 (Fla. Dist. Ct. App. 1995). A few courts have also ruled that unreasonable medical pricing could constitute a violation of state unfair-trade-practice laws. Batchis, *supra* note 114, at 532.

190. RICHARD A. POSNER, ECONOMIC ANALYSIS OF LAW 118 (7th ed. 2007) (“[T]he cornerstone of the admiralty rules of salvage [is] that the salvor is entitled to a reasonable fee for saving the ship, but that a contract made after the ship gets into trouble will only be evidence of what that reasonable fee is.”); Eisenberg, *supra* note 13, at 757 (“[I]t is well established in admiralty law that a contract for salvage services—that is, a contract to rescue a vessel or its cargo—is reviewable for fairness of terms if entered into while the promisor is in distress.”).

who is “hopeless, helpless, and passive—where there [is] no market, no money, no competition.”¹⁹¹ That promise “has no characteristic of a valid contract.”¹⁹² Invoking such precedents, authorities as diverse as Melvin Eisenberg and Richard Posner call urgent medical care a paradigmatic case for judicially imposing reasonable contractual terms.¹⁹³ Similarly, Professor Eisenberg thinks it “unconscionable for [any] merchant to exploit a consumer’s price-ignorance by offering a homogeneous commodity at a price he knows or has reason to know” is “strikingly disproportionate to that at which the commodity is normally sold in readily accessible market-places.”¹⁹⁴

Thus the procedural unfairness of many medical contracts coupled with a substantively unfair price might well justify a claim of unconscionability or imposition as some courts have held.¹⁹⁵ For example, in 1777, at the dawn of contract law, a doctor treated a patient for “a fashionable [venereal] disease” in return for a note for £200. The doctor sued on the note while the patient was in debtor’s prison.¹⁹⁶ According to a newspaper report, Lord Mansfield instructed the jury “with hot indignation,” expressing “his disapprobation of the doctor’s conduct”¹⁹⁷:

He lamented the situation of the defendant who had spent his fortune and seemed to have been bullied into the securities that were the object of contention. He observed that men enervated by debauchery and vice wanted spirit to prevent imposition; that the defendant seemed one of that kind as the doctor’s conduct had induced him to sign the draft and note of hand; that it was his duty and that of the jury to rescue him if possible from destruction.¹⁹⁸

In modern cases, unconscionability has been most successful where a third person, like a family member,¹⁹⁹ volunteers in an emergency to pay an

191. *Post v. Jones*, 60 U.S. (19 How.) 150, 159 (1857).

192. *Id.*

193. See POSNER, *supra* note 190, at 134–35; Eisenberg, *supra* note 13, at 761–62.

194. Eisenberg, *supra* note 13, at 780–81. The author notes that a “doctrine prohibiting the exploitation of price-ignorance” is supported by cases striking down unconscionable prices in door-to-door sales. *Id.* at 784.

195. *E.g.*, *Hill v. Sisters of St. Francis Health Servs., Inc.*, No. 06 C 1488, 2006 WL 3783415, at *6 (N.D. Ill. Dec. 20, 2006) (holding that a claim for unconscionability is stated when a hospital billed an indigent patient \$892.72 because it was “not supposed to charge indigent patients” and the patient “had to agree to pay or forego necessary medical treatment”); see also Morreim, *supra* note 8, at 1247–48; Nation, *supra* note 8, at 124–31.

196. GAZETTEER & NEW DAILY ADVERTISER, June 18, 1777, *quoted in* Catherine Crawford, *Patients’ Rights and the Law of Contract in Eighteenth-Century England*, 13 Soc. HIST. MED. 381, 406 (2000).

197. *Id.*

198. *Id.*

199. Under the “necessaries” doctrine, spouses may be responsible for each other’s medical care and parents for the care of minor children. Jacoby & Warren, *supra* note 7, at 567–68. The cases discussed here involve situations where this doctrine was not dispositive.

adult's bills.²⁰⁰ Yet the reasoning in those cases applies excellently to cases in which patients themselves signed the contract. A New Jersey court, for instance, declined to enforce a hospital contract where the patient's wife signed a standard form that didn't describe the hospital's rates and was "conspicuously silent on the question of balance billing."²⁰¹ The form's terms "were non-negotiable. The hospital clearly exercised a decisive advantage in bargaining."²⁰² "The patient was in no position to reject the proffered agreement, to bargain with the hospital or, in lieu of agreement, to find another hospital."²⁰³ The patient's treatment "was medically necessary and the option of walking away from the deal was simply unrealistic."²⁰⁴

Similarly, a New York court absolved an estranged husband from paying for treating his separated wife's ectopic pregnancy, since he saw "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. The law of contracts is not intended to use 'superman' as its model."²⁰⁵ This was "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."²⁰⁶

In sum, patients are often unfairly induced to sign unfair contracts with undisclosed terms. Procedural and substantive unconscionability exactly deal with such circumstances, and little development of the law is needed to apply that law to medical contracts. Analogous developments have been worked out in some comparable areas of law, and unconscionability principles have already been spottily applied to medical contracts. We suspect that courts would apply those principles more broadly if they better understood how the health-care market works.

3. *Fiduciary Duty*

The third set of legal ideas courts should develop to deal with abuses in medical contracting is the law of the fiduciary. Doctors have undoubted fi-

200. In addition to the cases described in the following text, see *Phoenix Baptist Hospital & Medical Center, Inc. v. Aiken*, 877 P.2d 1345, 1349–50 (Ariz. Ct. App. 1994), which absolved a husband from paying for his wife's emergency care because he "signed the agreement under extremely stressful circumstances without having had the terms of the agreement explained to him," and "he felt he had no choice but to immediately sign the preprinted form," and *Heartland Health Systems, Inc. v. Chamberlin*, 871 S.W.2d 8, 11 (Mo. Ct. App. 1993), which rejected an unconscionability defense but stated in dictum that, "[i]f a stranger brought an accident victim to the hospital, and signed a document whose terms, unnoticed by him, obligated him to pay the hospital bill, different considerations and different expectations would no doubt come into play if the hospital sought to hold him liable for the hospital bill."

201. *Valley Hosp. v. Kroll*, 847 A.2d 636, 651 (N.J. Super. Ct. Law Div. 2003).

202. *Id.*

203. *Id.*

204. *Id.*

205. *St. John's Episcopal Hosp. v. McAdoo*, 405 N.Y.S.2d 935, 937 (N.Y. City Civ. Ct. 1978).

206. *Id.*

duciary duties to their patients,²⁰⁷ and fiduciaries must avoid or minimize conflicts of interest with their clients. Fees create an obvious conflict of interest,²⁰⁸ so must physicians minimize them? Normally, no,²⁰⁹ since “[w]ere the duty of loyalty really to require fiduciaries to act *exclusively* in the interests of their beneficiaries, it would set a standard of conduct no one could hope to meet.”²¹⁰ Consequently, physicians’ or hospitals’ fiduciary duties conventionally “relate only to the provision of care and not the payment therefor.”²¹¹

207. See *supra* text accompanying notes 133–142. A fiduciary role is not as well established, however, for hospitals or other care providers. *Id.*

208. When “lawyers set and then collect fees for their professional services, they inevitably are involved in a conflict of interest between themselves and their clients. . . . [L]awyers have an interest in receiving fees that must clash with the interest of clients in paying as little as possible.” 1 GEOFFREY C. HAZARD, JR. & W. WILLIAM HODES, *THE LAW OF LAWYERING* § 8.2, at 8–5 (2003 & Supp. 2005); accord Gabriel J. Chin & Scott C. Wells, *Can a Reasonable Doubt Have an Unreasonable Price? Limitations of Attorneys’ Fees in Criminal Cases*, 41 B.C. L. REV. 1, 29 (1999) (“[T]here is an inherent conflict between an attorney’s desire to earn as much as possible, and the client’s desire for excellent representation at the lowest possible cost.”).

209. *But cf.* Maxwell J. Mehlman, *The Patient-Physician Relationship in an Era of Scarce Resources: Is There a Duty to Treat?*, 25 CONN. L. REV. 349, 356 (1993) (“[T]he courts virtually without exception have rejected the proposition that patients and physicians should be allowed to bargain over the terms of their relationship.”). Elsewhere in his article, Prof. Mehlman recognizes that

[t]he issues are not that simple For example, the physician certainly is permitted to accept a fee from the patient. Yet the patient would arguably be better off if she could obtain the care for free. By charging a fee, the physician might be said to be placing his own interests above those of the patient. However, this does not necessarily constitute a violation of his fiduciary duty.

Id. at 371.

210. Paul B. Miller & Charles Weijer, *Fiduciary Obligation in Clinical Research*, 34 J.L. MED. & ETHICS 424, 435 (2006).

211. *DiCarlo v. St. Mary’s Hosp.*, No. 05-1665, 2006 WL 2038498, at *9 (D.N.J. July 19, 2006); see also *Wright v. Jeckle*, 144 P.3d 301 (Wash. 2006) (finding that fiduciary duty is not breached when a physician charges more than cost for a prescription drug). The only express holding to the contrary we are aware of is *Greenfield v. Manor Care, Inc.*, 705 So. 2d 926, 932 (Fla. Dist. Ct. App. 1997), abrogated on other grounds by *Beverly Enterprises-Florida, Inc. v. Knowles*, 766 So. 2d 335 (Fla. App. 2000), which ruled that a nursing home has a fiduciary duty not to overcharge a patient. See also *Havsy v. Wash. Dept. of Health Bd. of Osteopathic Med. & Surgery*, No. 53198-1-I, 2004 WL 2153876, at *4 (Wash. Ct. App. Sept. 27, 2004) (upholding the decision of regulatory agency (licensing board) that a physician “breached his fiduciary duty to [a patient] by failing to inform [the patient] of the high cost of [a diagnostic test] and of the risk that [the patient’s] insurer might not cover the . . . cost [of the test]”).

Some courts suggest that providers must help patients obtain insurance reimbursement. *E.g.*, *Murphy v. Godwin*, 303 A.2d 668, 673–74 (Del. Super. Ct. 1973) (finding a legal duty to assist patient with completing insurance application forms); *Ahnert v. Wildman*, 376 N.E.2d 1182, 1186 (Ind. Ct. App. 1978) (suggesting in dictum that the same duty exists); *Picker v. Castro*, 776 N.Y.S.2d 433 (Sup. Ct. 2003) (finding the same duty); *N.Y. City Health & Hosp. Corp. Goldwater Mem’l Hosp. v. Gorman*, 448 N.Y.S.2d 623, 624 (Sup. Ct. 1982) (holding that a public hospital has an obligation to assist patient in applying for Medicaid); *cf.* *Chew v. Meyer*, 527 A.2d 828, 832 (Md. Ct. Spec. App. 1987) (recognizing a physician’s duty to help a patient obtain a paid absence from work for health reasons). But these isolated decisions depend on narrow, not fiduciary, reasoning. For instance, in *Picker*, a psychologist refused to help as a protest against the insurance industry, even though the patient offered to pay the doctor’s hourly rate for completing the paperwork. 776 N.Y.S.2d at 434. *Gorman* is based on a public hospital’s statutory and corporate mission in relation to the Medicaid program in particular. 448 N.Y.S.2d at 624. Other cases expressly reject any

Several recent cases exemplify this response. A Michigan court rejected an “attempt to stretch the logic of the fiduciary relationship that exists between a doctor and a patient to encompass a hospital’s billing practices.”²¹² An Illinois court found “no fiduciary relationship between a hospital and its patients with respect to billing practices.”²¹³ A Georgia court found no “fiduciary relationship between a hospital and a patient with respect to pricing,” since the plaintiff could cite no precedent.²¹⁴ Another Georgia court agreed: “The mere fact that the [patients] . . . alleged they personally reposed trust and confidence in . . . [the] nonprofit hospital does not show a confidential or fiduciary relationship,” since in most “business dealings, opposite parties have trust and confidence in each other’s integrity, but there is no confidential relationship by this alone.”²¹⁵ And while “New Jersey has recognized that doctors owe a fiduciary duty to patients in making medical decisions, . . . and that nonprofit hospitals owe a fiduciary duty to the public with regard to staffing decisions,” a New Jersey court followed Georgia’s rule because no precedent “extended a hospital’s fiduciary duty to its billing practices.”²¹⁶

Nevertheless, doctors and hospitals sometimes exploit trusting patients with exorbitant charges for essential care. The issue then is not whether the provider has minimized its fees; it is whether the provider has charged unreasonable—indeed abusive—fees. The law at least acknowledges that kind of reality in another professional context: attorneys may negotiate fees at arm’s length,²¹⁷ but fees must be reasonable.²¹⁸ True, lawyers are rarely dis-

fiduciary-like duty. *E.g.*, *Mraz v. Taft*, 619 N.E.2d 483 (Ohio Ct. App. 1993) (holding that nursing home and hospital have no duty to advise patient he is eligible for Medicaid); *see generally* *Arato v. Avedon*, 858 P.2d 598, 608 (Cal. 1993) (emphasizing that a “physician is not the patient’s financial adviser” and rejecting an argument that a physician’s fiduciary duty encompasses a patient’s “business and investment affairs” (quoting *Moore v. Regents of Univ. of Cal.*, 793 P.2d 479, 485 n.10 (Cal. 1990))).

212. *Burton v. William Beaumont Hosp.*, 373 F. Supp. 2d 707, 724 (E.D. Mich. 2005).

213. *Hill v. Sisters of St. Francis Health Servs., Inc.*, No. 06 C 1488, 2006 WL 3783415, at *3 (N.D. Ill. Dec. 20, 2006) (citing *Burton*, 373 F. Supp. 2d at 723–24).

214. *Cox v. Athens Reg’l Med. Ctr., Inc.*, 631 S.E.2d 792, 798 (Ga. Ct. App. 2006).

215. *Morrell v. Wellstar Health Sys., Inc.*, 633 S.E.2d 68, 74 (Ga. Ct. App. 2006).

216. *DiCarlo*, 2006 WL 2038498, at *9 (citation omitted).

217. A comment to section 34 of the Restatement of the Law Governing Lawyers states that “clients and lawyers [are] free to negotiate a broad range of compensation terms.” *RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS* § 34 cmt. a (2000). Another comment states that “[i]n general, clients and lawyers are free to contract for the fee that [the] client is to pay.” *Id.* § 34 cmt. b; *see, e.g.*, *Brobeck, Phleger & Harrison v. Telex Corp.*, 602 F.2d 866 (9th Cir. 1979) (applying normal contract law to uphold written agreement with a large company to pay a one million dollar contingency fee for a modest amount of legal work). An ABA task force, for instance, thought lawyers “should not have any affirmative duty to disclose the existence or amount of negotiated non-standard rates for other clients when quoting rates to a client.” Task Force on Lawyer Business Ethics, *Statements of Principles*, 51 *BUS. LAW.* 1303, 1317–18 (1996).

218. *Chin & Wells*, *supra* note 208, at 2 (“For as long as lawyers have been regulated, the law has prohibited them from charging clients ‘unreasonable’ fees.”); Joseph M. Perillo, *The Law of Lawyers’ Contracts is Different*, 67 *FORDHAM L. REV.* 443, 494–95 (1998) (explaining that lawyers’ fee agreements can be reviewed for reasonableness).

The reasonableness of fees is usually evaluated, however, under a variety of specialized legal regimes that are not based directly on fiduciary principles. For instance, courts have inherent authority to police the ethics of lawyers who appear before them. *Schlesinger v. Teitelbaum*, 475 F.2d 137,

ciplined for excessive fees “in the absence of some other form of misconduct.”²¹⁹ But the fiduciary principle applies to lawyers’ fees, even if rather weakly in practice.

If the fiduciary principle applies only weakly to lawyers’ fees, should it apply only weakly to medical bills? No. The situations differ in ways that demand a stronger medical than legal fiduciary standard. First, the market constrains lawyers’ fees much better than doctors’ fees. Second, unlike patients, clients can generally negotiate terms in advance. (Similarly, the law often requires automobile mechanics²²⁰ and funeral directors²²¹ to warn consumers what they’ll be charged.) Far from insisting on advance negotiations, medical law uses a hair-trigger test to decide whether providers have assumed obligations to patients. Talking to, cursorily examining, or scheduling an appointment for a patient can initiate a doctor–patient relationship.²²² Medical law imposes professional responsibilities more quickly than the law of lawyering because patients’ needs are generally more urgent than clients’.

Doctors are fiduciaries because patients are medically at their mercy. Unnegotiated, open-ended contracts make patients as vulnerable financially as they are medically. Charging uninsured patients several times more than patients protected by private insurers or government regulators flagrantly exploits patients’ financial, physical, and psychological vulnerability. Fiduciary law is equipped with principles which cry out for application in such circumstances. The Restatement (Second) of the Law of Agency provides that if “the creation of the relation involves peculiar trust and confidence,” a fiduciary obligation may exist “prior to the employment and, if so, the agent is under a duty to deal fairly with the principal in arranging the terms of the employment.”²²³ For example, undisclosed, excessive markups in securities sales constitute fraud because a broker is “under a special duty, in view of its expert knowledge and proffered advice, not to take advantage of its

141 (3d Cir. 1973) (holding that “in its supervisory power over the members of its bar, a court has jurisdiction of certain activities of [its] members, including the charges of contingent fees”). Under the bankruptcy statute, courts try to “keep the fee at a minimum in order that creditors of a bankrupt may recoup a maximum of their losses.” 2 STUART M. SPEISER, *ATTORNEY’S FEES* § 14:9 (1973). In class action lawsuits, Rule 23(h) of the Federal Rules of Civil Procedure requires courts to allow only reasonable attorney’s fees in order “to protect the interests of the class members from abuse.” *Dunn v. H. K. Porter Co.*, 602 F.2d 1105, 1109 (3d Cir. 1979). These principles confer on courts especially “broad discretion to determine a reasonable figure” on account of the “equitable nature of an award of attorney’s fees from a common fund.” 2 JOSEPH M. McLAUGHLIN, *McLAUGHLIN ON CLASS ACTIONS: LAW AND PRACTICE* § 6:23, at 6–96 (3d ed. 2006).

219. Chin & Wells, *supra* note 208, at 6.

220. Jay M. Zitter, Annotation, *Automobile Repairman’s Duty to Provide Customer with Information, Estimates, or Replaced Parts, Under Automobile Repair Consumer Protection Act*, 25 A.L.R. 4TH 506, 507 (1983).

221. Funeral Industry Practices, 16 C.F.R. § 453.2 (2007); Michael R. Santiago, *The Industry of Death: Regulating Mortuary Services*, 30 McGEORGE L. REV. 463, 464 (1999).

222. See generally James L. Rigelhaupt, Jr., Annotation, *What Constitutes Physician-Patient Relationship for Malpractice Purposes*, 17 A.L.R. 4TH 132 (1982).

223. RESTATEMENT (SECOND) OF THE LAW OF AGENCY § 390 cmt. e (1958). This position is maintained in the current draft of the Restatement of the Law of Agency. RESTATEMENT (THIRD) OF THE LAW OF AGENCY § 8.01 (Tentative Draft No. 6, 2005).

customers' ignorance of market conditions.²²⁴ And classic fiduciary principles inhibit lawyers from changing fees during the representation. Such changes are "subject to special scrutiny" and are voidable unless the lawyer proves them "fair and reasonable to the client."²²⁵

Do the arguments for using fiduciary principles to supervise providers' prices prove too much? Do they apply, for instance, to other medical goods and services? Not necessarily. Nursing homes, for instance, operate in a market that functions reasonably well.²²⁶ Nor are drug companies good candidates for judicial supervision, despite their market power.²²⁷ First, drug companies are not fiduciaries but sell wares like any merchant.²²⁸ Second, drug prices are readily stated and readily disclosed before purchase,²²⁹ so that, unlike hospital prices, pharmaceutical prices reflect what many informed purchasers will pay in arm's length transactions. Third, people rarely make open-ended promises to pay for drugs; they pay on the spot. Plaintiffs who wish to recover money paid must show impropriety (like actual duress or fraud), not just unfair terms.²³⁰ Fourth, lower drug prices in other countries prove little about drug companies' misbehavior, since market, social, and regulatory conditions elsewhere are different.²³¹ Finally, drug compa-

224. *Charles Hughes & Co. v. SEC*, 139 F.2d 434, 437 (2d Cir. 1943); *see also Duker & Duker*, Exchange Act Release No. 2350, 6 SEC 386, 389 (Dec. 19, 1939) ("[A] dealer may not exploit the ignorance of his customer to exact unreasonable profits resulting from a price which bears no reasonable relation to the prevailing price."). Some of these cases are reasoned explicitly on the basis of the fiduciary status of investment advisers. *See* NORMAN S. POSER, *BROKER-DEALER LAW AND REGULATION* § 2.01[A] (2d ed. 1999).

225. RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 18, at 153–56 (2000).

226. *See supra* note 63 and accompanying text.

227. Pharmaceutical companies vary their prices severalfold depending on where and how drugs are purchased, with the greatest variations occurring between the United States and other countries, especially for patented drugs. PATRICIA M. DANZON, *PRICE COMPARISONS FOR PHARMACEUTICALS: A REVIEW OF U.S. AND CROSS-NATIONAL STUDIES* (1999), available at <http://knowledge.wharton.upenn.edu/papers/154.pdf>; Dawn Gencarelli, *One Pill, Many Prices: Variation in Prescription Drug Prices in Selected Government Programs*, NAT'L HEALTH POL'Y F. ISSUE BRIEF, Aug. 29, 2005, available at http://www.nhpf.org/pdfs_ib/IB807_DrugPricing_08-29-05.pdf.

228. Common law never regarded pharmacies as public callings, and physicians could always charge for medications even when law restricted them to honoraria for their own services. Crawford, *supra* note 196, at 392–95, 406–07.

229. In our personal experience, pharmacies will take back prescription drugs if the customer balks at the price after the prescription has been filled.

230. *See Hall v. Humana Hosp. Daytona Beach*, 686 So. 2d 653, 657 (Fla. Dist. Ct. App. 1996) (holding that patients could no longer contest the reasonableness of a hospital bill when they paid it after treatment was completed and there were no elements of duress).

231. Also, manufacturers say higher profits are necessary in the United States to permit them to sell drugs affordably to underdeveloped countries. If true, this global pricing strategy could be a socially progressive business strategy that courts should be loath to undermine. As Professor Epstein vividly explains:

The key characteristic of all drug markets is high fixed costs for research and development and low marginal costs for each additional product unit. Stated in its most graphic form, it may take \$1 billion to get the first pill to market, but only \$1 dollar to get the second. A system that wants all consumers to pay only the marginal cost of the pill that they consume works wonders

nies' market power derives mainly from federal patent law, to which the common law of contracts should defer.

4. A Larger View of the Supervisory Doctrines

We have discussed the supervisory doctrines separately, but they are closely related and mutually reinforcing. They address a common problem—the inefficiency and injustice created when ordinary contracting mechanisms have gone so far astray that powerful parties to a contract are able to bargain unfairly and exact extortionate terms. Then the ordinary presumption of the regularity and reliability of contracts must be abandoned. When, as here, that occurs in a new arena, the judicial task is to select from the set of supervisory doctrines the combination that best rectifies the problem.

This is just what courts have done in an analogous situation. In recent decades, family law has become more receptive to antenuptial contracts and to separation agreements.²³² Such contracts, however, are markedly more worrisome than commercial contracts, and for reasons that speak to our problem. First, marital contracts share with medical contracts the problem of specificity. Marital contracts cannot specify all the terms they might need, not least because the future is infinitely complex and greatly obscure. Second, the close relationship between the contractors makes marital contracts as unlikely as medical contracts to be negotiated at arm's length and as easily used by one party to exploit the other. Third, like medical contracts, marital contracts are made between people who are in a special relationship of trust—a confidential or fiduciary relationship—that places special duties of fairness on the parties.

Lawmakers have responded to these problems with marital contracts in two ways.²³³ First, they have extended the supervisory doctrines notably beyond their standard commercial boundaries. Second, they have canvassed the whole menu of supervisory doctrines and mixed and matched them to the needs created by this change in the law of contract. They have, for example, required that marital contracts be in writing, imposed onerous notice and disclosure requirements, lightened the burden of showing procedural unconscionability, creatively combined procedural and substantive unconscionability, interpreted substantive unconscionability as requiring contracts to include particular kinds of provisions, asked whether contracts were conscionable at the time of enforcement (instead of the usual time of contracting), asked whether the parties were represented by counsel, required that separation agreements be incorporated into judicial divorce

for patients 2 through n. But who rushes to the head of the queue to pay \$1 billion for the first pill? No one—yet the firm that cannot sell the first pill will not produce the second.

Richard A. Epstein, *Conflicts of Interest in Health Care: who guards the guardians?*, 50 PERSP. IN BIOLOGY & MED. 72, 81 (2007).

232. This story is told in Chapter Five of CARL E. SCHNEIDER & MARGARET F. BRINIG, AN INVITATION TO FAMILY LAW (3d ed. 2006).

233. *Id.* at 395–511.

decrees, and so on at ingenious length.²³⁴ Compared with this full-court press, the proposals we have made for supervising medical contracts are modest indeed.

Finally, we should recall that courts long ago regulated prices of “public callings” and businesses “affected with a public interest” (like common carriers) which had elements of monopoly power.²³⁵ Now, administrative agencies generally do this work, but no such agency protects patients.²³⁶ Consequently, as the Supreme Court said of public utilities in 1876, “in matters which do affect the public interest . . . courts must determine what is reasonable.”²³⁷ Amen.

5. Determining Reasonable Rates

Our winding path through the supervisory doctrines suggests several possibilities for holding providers to justifiable prices. But how should courts evaluate the reasonableness of medical fees? Again, the short answer is that courts have doctrines at hand which can be fitted to the task in the usual common-law way. Certainly, determining reasonableness is well within judicial experience and competence. Valuation is a pervasive judicial function; tort and contract cases routinely present damage issues quite as challenging.²³⁸ Nor are these valuation problems unduly dependent on elusive legislative, social, or “polycentric” facts.²³⁹

234. *Id.*

235. BRUCE WYMAN, *THE SPECIAL LAW GOVERNING PUBLIC SERVICE CORPORATIONS* 3 (1911). Although doctors no longer are regarded as being in a public calling, they once were, and hospitals still are in many states. Moreover, several elements of doctors’ legal obligations echo the law of public callings. *See supra* notes 148–151 and accompanying text.

236. Some states once regulated hospitals like public utilities, but now only Maryland does. *See Anderson, All-payer Rate Setting, supra* note 119, at 35–36.

237. *Munn v. Illinois*, 94 U.S. 113, 134 (1876). Another Supreme Court case echoed this sentiment:

[I]t has always been recognized that, if a carrier attempted to charge a shipper an unreasonable sum, the courts had jurisdiction to inquire into that matter and to award to the shipper any amount exacted from him in excess of a reasonable rate; and also in a reverse case to render judgment in favor of the carrier for the amount found to be a reasonable charge. . . .

. . . .

. . . There is nothing new or strange in this. It has always been a part of the judicial function

Reagan v. Farmers’ Loan & Trust Co., 154 U.S. 362, 397, 399 (1894); *see generally* WYMAN, *supra* note 235, at 1232.

238. Indeed, courts routinely determine the reasonableness of medical expenses in calculating damages in personal injury suits. John Dewar Gleissner, *Proving Medical Expenses: Time for a Change*, 28 AM. J. TRIAL ADVOC. 649, 649 (2005) (“Current legal procedures and practices . . . in tort cases typically involve obtaining testimony from treating physicians concerning the necessity and reasonableness of healthcare charges.”); *see generally* L.C. Di Stasi, Jr., Annotation, *Necessity and Sufficiency, in Personal Injury or Death Action, of Evidence as to Reasonableness of Amount Charged or Paid for Accrued Medical, Nursing, or Hospital Expenses*, 12 A.L.R. 3D 1347 (1967).

239. *Nation, supra* note 8, at 135–36 (rejecting courts’ concern over regulating prices because they can refer to the average that a hospital receives from insurers as an objective, market-

A court's theory of reasonableness and a case's procedural posture will shape a court's evaluation of medical fees. Current doctrine gives us some guidance. If the contract specifies a price, the patient usually must show it is unreasonable or unconscionable. Where the price is open or implied, or a contract is absent or unenforceable, the provider usually must show the reasonableness of its prices, especially if the provider is the plaintiff.²⁴⁰

Providers often meet these burdens easily, at least by making a prima facie case that shifts the burden to the patient.²⁴¹ At a minimum, reasonableness means the provider is not charging more than its usual price.²⁴² Showing that requires more than producing a bill,²⁴³ but an administrator's testimony that the services were actually provided and that the provider charged its usual fees usually suffices.²⁴⁴ Where a fiduciary duty has been breached, however, providers may be under a greater burden to show that their usual charges are fair and reasonable.²⁴⁵

Scholars offer several theories of reasonableness. Presumably, as Professor Eisenberg suggests, definitions should be "closely related to the manner in which the relevant market deviates from a perfectly competitive market."²⁴⁶ Professor Eisenberg prefers a liberal definition to reward and encourage medical progress and to "include an appropriate share of the cost of developing and maintaining rescue capacity."²⁴⁷ In contrast, Professor Ben-Shahar contends that in incomplete contracts of all kinds, "reasonableness" should be set conservatively because that more accurately approximates the payor's expectations and encourages the payee to

determined price); cf. Lon L. Fuller, *The Forms and Limits of Adjudication*, 92 HARV. L. REV. 353, 394 (1978) (discussing "polycentric" problems that are ill-suited to adjudication).

240. *E.g.*, *Culverhouse v. Jackson*, 194 S.E.2d 585, 586 (Ga. Ct. App. 1972); *Victory Mem'l Hosp. v. Rice*, 493 N.E.2d 117, 119 (Ill. App. Ct. 1986); *H.E. Butt Grocery Co. v. Rencare, Ltd.*, No. 04-03-00190-CV, 2004 WL 199272, at *4-5 (Tex. Ct. App. Feb. 4, 2004).

241. *Wash. County Mem'l Hosp. v. Hattabaugh*, 717 N.E.2d 929 (Ind. Ct. App. 1999) ("Once a prima facie case is established on an account, the burden of proof shifts to the account debtor to prove that the claimed amount is incorrect.") (citing *Auffenberg v. Bd. of Trs. of Columbus Reg'l Hosp.*, 646 N.E.2d 328, 331 (Ind. Ct. App. 1995); *Heartland Health Sys., Inc. v. Chamberlin*, 871 S.W.2d 8, 11 (Mo. Ct. App. 1993) (holding that, once the hospital presents evidence that the overall bill was generally reasonable, "the burden of challenging any particular item or items was upon the defendants").

242. *See, e.g.*, *Sherman Hosp. v. Wingren*, 523 N.E.2d 220, 222 (Ill. App. Ct. 1988).

243. *Victory Mem'l Hosp.*, 493 N.E.2d at 119-20; *see Culverhouse*, 194 S.E.2d at 586; *Majid v. Stubblefield*, 589 N.E.2d 1045, 1048-49 (Ill. App. Ct. 1992). *Contra Wash. County Mem'l Hosp.*, 717 N.E.2d at 933 ("Statements of charges for medical, hospital, or other health care expenses for diagnosis or treatment . . . shall constitute prima facie evidence that the charges are reasonable.") (quoting IND. R. EVID. 413).

244. *E.g.*, *Majid*, 589 N.E.2d at 1048-49; *Sherman Hosp.*, 523 N.E.2d at 222-23; *Victory Mem'l Hosp.*, 493 N.E.2d at 119-20; *Heartland Health Sys.*, 871 S.W.2d at 11; *Doe v. HCA Health Servs. of Tenn., Inc.*, 46 S.W.3d 191, 198-99 (Tenn. 2001).

245. *See supra* text accompanying notes 217-219.

246. Eisenberg, *supra* note 13, at 754.

247. *Id.* at 761-63. His "Desperate Patient" hypothetical posits a \$300,000 fee for a new life-saving operation. Without a large incentive, the physician may be unwilling to invest in innovation, but prices can be set so high that too much is invested in unrewarding innovation.

compromise.²⁴⁸ And Professors Ayres and Gertner want to consult efficiency, fairness, and administrability in tailoring a range of default rules to particular circumstances.²⁴⁹

In practice, courts primarily ask (1) what the provider usually charges for the service and (2) what other providers usually charge. One court held that charges below the seventy-fifth percentile of what other hospitals charge (a standard many insurers use to determine whether prices are “usual, customary, and reasonable”)²⁵⁰ is “‘within the range’ of the overall market” as a matter of law.²⁵¹ The providers’ burden of proof is light; they rarely need cite empirical studies of prices; it usually suffices if a provider’s staff asserts vague familiarity with conditions in the local or similar markets²⁵² or, occasionally, regional or national markets.²⁵³

The second approach—asking what the provider charges other patients—is trickier than it might appear, especially for hospitals, because they must justify the chasm between patients with and patients without insurance. Some courts say providers are not bound by the discounted prices they accept from insurers. A New York line of cases holds that the “fact that lesser amounts for the same services may be accepted from commercial insurers or government programs as payment in full does not indicate that the amounts charged to defendant were not reasonable.”²⁵⁴

This is bad law and bad policy. It is bad law because these cases rest on a misreading of a precedent that is not on point.²⁵⁵ It is bad policy because

248. See Ben-Shahar, *supra* note 165. For medical care, this would usually mean what Medicaid pays.

249. Ian Ayres & Robert Gertner, *Filling Gaps in Incomplete Contracts: An Economic Theory of Default Rules*, 99 YALE L.J. 87 (1989). For instance, default rules could be set to mimic the parties’ probable intent or what most others actually agree to, or default rules could systematically favor or disadvantage one or the other parties for strategic reasons, to reward or penalize undesired behavior. See generally RESTATEMENT (THIRD) OF RESTITUTION AND UNJUST ENRICHMENT § 49(2) (Tentative Draft No. 5, 2007) (outlining four possible measures of benefit); Symposium, *Default Rules in Private and Public Law*, 33 FLA. ST. U. L. REV. 557 (2006).

250. See *supra* notes 88–91 and accompanying text.

251. *Colomar v. Mercy Hosp., Inc.*, 461 F. Supp. 2d 1265, 1270 (S.D. Fla. 2006).

252. *Majid v. Stubblefield*, 589 N.E.2d, 1045, 1049 (Ill. App. Ct. 1992) (rejecting comparison to prices in bigger and distant cities); *Victory Mem’l Hosp. v. Rice*, 493 N.E.2d 117, 120 (Ill. App. Ct. 1986) (approving testimony based on a survey of area hospitals); *Doe v. HCA Health Servs. of Tenn., Inc.*, 46 S.W.3d 191, 193 (Tenn. 2001) (citing with approval decisions that base reasonable prices on “similar charges of other hospitals in the community”).

253. E.g., *Eagle v. Snyder*, 604 A.2d 253 (Pa. Super. Ct. 1992) (holding that local pricing was not reliable because the plaintiff specialists were the only physicians who did back surgeries in the area).

254. *Huntington Hosp. v. Abrandt*, 779 N.Y.S.2d 891, 892 (App. Term 2004); accord *Kolari v. N.Y.-Presbyterian Hosp.*, 382 F. Supp. 2d 562, 576 (S.D.N.Y. 2005) (“[U]nder New York law a hospital’s charges to an uninsured patient are not unreasonable merely because a lower price is charged to government programs or other insurers.”); *Albany Med. Ctr. Hosp. v. Huberty*, 428 N.Y.S.2d 746 (App. Div. 1980).

255. They rely on *Flushing Hospital & Medical Center v. Woytisek*, 364 N.E.2d 1120, 1121–22 (N.Y. 1977), in which the reasonableness of the hospital’s normal charge was not at issue. Rather the issue was whether, under the insurance contract, the patient’s coinsurance obligation was based on the hospital’s full charge rather than the insurer’s negotiated discount. After examining the con-

ignoring prices charged insured patients ignores the market-failure problems we have described. An industry cannot make obscene price differentials right simply by making them common. As health economist Gerard Anderson told Congress, for “a price list to be reasonable it needs to reflect what is actually being charged in the market place.” And since “virtually no public or private insurer actually pays full charges, charges are an unrealistic standard for comparison. A more realistic standard is what insurers actually pay and what the hospitals have been willing to accept.”²⁵⁶

Realizing this, several courts measure market prices by hospitals' agreements with insurers.²⁵⁷ *Temple University Hospital v. Healthcare Management Alternatives, Inc.*²⁵⁸ defined reasonable as the average amount the hospital received from all payers for each service. *River Park Hospital v. BlueCross BlueShield of Tennessee*²⁵⁹ more vaguely defined reasonable as something between the hospital's full charges and its negotiated discounts. Similarly but more concretely, Professor Anderson sets “reasonable” at twenty-five percent over what Medicare pays (roughly ten percent higher than what private insurers pay).²⁶⁰ He argues that using Medicare rates to determine reasonableness is grounded in the marketplace because that approach is simple and transparent and is the method of many negotiated managed-care contracts.

In sum, reasonable medical prices can be defined in several ways on several theories, and courts have begun to work out standard approaches. But this problem is not best resolved in one *a priori* burst of one-size-fits-all theory.²⁶¹ These are routine doctrinal, evidentiary, and procedural problems courts can comfortably handle in the usual case-by-case way. They should do so, as they have done in other areas where the law requires valuation.

tract, the court held that the patient was “not entitled to derive any economic benefit from this independent [contractual] arrangement between the hospital and Blue Cross.” *Id.* at 1122.

Another contrary line of cases arises in the context of personal injury damages. These courts charge tortfeasors the full list prices for treating injured victims, despite the substantial discounts providers might give the victims' health insurers. Michael K. Beard, *The Impact of Changes in Health Care Provider Reimbursement Systems on the Recovery of Damages for Medical Expenses in Personal Injury Suits*, 21 AM. J. TRIAL ADVOC. 453 (1998); Natalie J. Kussart, Casenote, *Paid Bills v. Charged Bills: Insurance and the Collateral Source Rule* *Arthur v. Catour*, 833 N.E.2d 847 (2005), 31 S. ILL. U. L.J. 151 (2006). These are not contractual disputes, however, and they are informed by the special concerns of making tortfeasors pay the full costs of injuries they cause.

256. Anderson Testimony 2006, *supra* note 64, at 106, 109.

257. In addition to the cases discussed in text, see *Valley Hospital v. Kroll*, 847 A.2d 636, 651 (N.J. Super. Ct. Law Div. 2003) (holding that amount paid by Medicare establishes the reasonable rate).

258. 832 A.2d 501, 508–09 (Pa. Super. Ct. 2003).

259. 173 S.W.3d 43, 60 (Tenn. Ct. App. 2003).

260. Anderson Testimony 2006, *supra* note 64, at 110–11. This formula avoids the objection, accepted by one California court, *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*, 39 Cal. Rptr. 3d 456 (Ct. App. 2006), that Medicare rates might be unreasonably low or that the range of reasonable pricing might extend above its levels.

261. For instance, courts might adopt different approaches for physicians than for hospitals, or for specialists than for primary care physicians, since their market dynamics and price contracting are different. Also, hospitals have more public-goods aspects, but physicians are more readily characterized as fiduciaries. See *supra* text accompanying notes 133–142.

CONCLUSION

Patients have always feared medical bills. For years—for decades—health costs have been blazing upward, and today almost anyone can face lethal bills from doctors and hospitals, bills that can shatter one's economic health.²⁶² Attempts to control health costs have changed not only how care is paid for; they have changed what it means to be a patient. Both managed care and consumer-directed health care have propelled many people along the continuum from patient to consumer and have made the market in which the consumer shops unprecedentedly perilous.

The law has neither fully recognized nor adequately responded to the change from patient to consumer or the changes in the market in which these consumers shop. Instead, the law has dumped patients obliviously into its default category: that of conventional consumers in a commercial market who contract with vendors at arm's length and whose contracts are enforced even when prices are wholly unspecified and demonstrably unjustifiable.

This is the wrong category. The standard "freedom of contract" view works dreadfully in the medical context. Patients are not conventional consumers. They are strangers in a strange land, vulnerable because they are sick and because the market for health care is incomprehensible and dangerous. In their need, patients build relationships of dependence and trust with the people who care for them. That justifies courts in deploying contractual supervisory doctrines to set heightened standards of good faith and fair dealing, standards that give patients a remedy when providers set unreasonable fees in unreasonable ways. More specifically, the law should protect financially vulnerable patients when they are compelled to sign contracts that commit them to paying whatever the provider eventually asks and when the provider's charges are unrelated to its costs or its charges to insured patients.

While judicial supervision is necessary, while it offers some hope to some people who sorely need it, we do not imagine that even the most ambitious courts can come near to protecting consumer-patients sufficiently. Ultimately, the dilemma of the patient as consumer is created by a problem to which solutions are few, obscure, and elusive—the problem of controlling health care costs while providing decent care for everyone.

Our primary purpose has been to solicit judicial succor for patients who have been especially badly used by providers, not to propose large changes in large systems. However, the systemic consequences of our proposals are unlikely to be harmful and may be modestly beneficial. Since providers collect far less from the uninsured than they charge, abating charges might affect providers relatively little. If providers do feel some pressure to moderate their charges to the uninsured, they might have somewhat more incentive to find sound ways to control their costs.

As we suggested earlier, if judicial protection of consumers makes the medical market work better, it should make consumer-directed health care work better. On the other hand, our data and our arguments also suggest the

262. See *supra* note 7 and accompanying text.

daunting difficulties of making consumer-directed health care work at all. We have demonstrated that the market for uninsured health care works disastrously and that the disaster is inextricably rooted in the nature of illness, the patient, and the doctor–patient relationship. We see little in consumer-directed health insurance that can change any of these timeless aspects of health care.

Judicial protection of patient-consumers will hardly make the marketplace safe for patients who are responsible for their own medical bills. But the fact that judicial protection cannot do everything does not mean it should do nothing. That argument would prove far too much. Few ill-used parties to a contract and few victims of torts sue, much less win; judicial remedies are always a last resort and always leave many injured people uncompensated. But courts can help patients fallen prey to predatory pricing in a perilous market, and they should.

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