

# Open and Unashamed in an Era of Consumer Protection: Unconscionable Hospital Billing Practices and the Chargemaster Racket

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*“When one looks at the costs of medical care today, it should become apparent that we are responsible for more than just the physical well-being of the patient; we are in a position to bankrupt him or the society that pays for his care.”*<sup>1</sup>

## I. INTRODUCTION

When a patient receives a medical bill pursuant to a contract, common law and modern consumer protection laws apply to protect the fairness of the transaction for both the consumer and the provider, as well as the efficiency and openness of the market. Usually consumer protections may include disclosures or inspection of a product prior to signing a contract, which allow consumers to buy elsewhere if they wish, or, if it is a service to be purchased, an opportunity to receive a consultation and an estimate of costs prior to entering the bargain.<sup>2</sup>

Prior to receipt of healthcare services, hospital patients typically sign a general agreement to pay, such as the following, without any of these consumer protections:

I acknowledge full financial responsibility for, and agree to pay, all charges of the Hospital and of physicians rendering services not otherwise paid by my health insurance or other payor. Estimated patient responsibility is due at the time of service or following the medical screening exam. Any remaining charges are due and payable upon receipt of the bill.<sup>3</sup>

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1. George B. Markle IV, *We Physicians Are Fiduciary Failures*, 239 J. AM. MED. ASS’N 1629, 1629 (1978).

2. See generally Adam J. Levitin, *The Consumer Financial Protection Bureau: An Introduction*, 32 REV. BANKING & FIN. L. 321 (2013) (providing a history of the hard-fought political battle for consumer protection regulation of consumer credit leading up to the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010); Kelli Alces Williams, *Market-Based Innovation in Consumer Protection*, 51 CONN. L. REV. 155 (2019) (discussing the severe regulatory restrictions on lending to low-income home buyers after the 2008 housing crisis and the need for flexibility in consumer protection to promote fintech entrepreneurship and access to credit).

3. *Lupia v. Medicredit, Inc.*, 445 F. Supp. 3d 1271, 1277 (D. Colo. 2020) (addressing a Fair Debt Collection Practices Act claim under 15 U.S.C. § 1692

Insured patients receiving outpatient care, such as annual physicals, are unlikely to receive or even care about estimates, because they are aware of their fixed co-payment and deductible amounts and leave the actual costs of care to the insurance company or the government.<sup>4</sup> Uninsured patients who must pay out-of-pocket for medical care feel very differently.

Of course, health care is a type of service where outcomes may be difficult to predict, thus impacting the accuracy of estimates.<sup>5</sup> As the Third Circuit Court of Appeals noted in *DiCarlo v. St. Mary Hospital*, addressing a class action filed by uninsured patients directly billed for services at the highest chargemaster rate:

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, 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.<sup>6</sup>

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[hereinafter FDCA)]; see Mark Rukavina, *Medical Debt and Its Relevance When Assessing Creditworthiness*, 46 SUFFOLK U. L. REV. 967, 970 (2013) (“It is a routine practice for patients to sign treatment consent forms that include language stating that the patient will assume responsibility for payment in the event that his or her insurance company does not cover 100% of the amount of the medical claim.”).

4. See Barry R. Furrow, *Patient Safety and the Fiduciary Hospital: Sharpening Judicial Remedies*, 1 DREXEL L. REV. 439, 481–82 (2009) (stating that since the cost of medical treatment errors is externalized through absorption by a combination of insurance, employers, income support programs, and patients, the provider is disincentivized to correct them); Nathaniel V. Chittick, Note, *Hidden Charges: The Need for Transparency in Kentucky Health-Care Markets*, 49 U. LOUISVILLE L. REV. 415, 434 (2011) (suggesting that the insured are insensitive to cost when their insurance caps the patient’s contribution, and the uninsured are insensitive to cost when they know they can never afford the bill but need the service).

5. See Robert H. Schmerling, *First, Do No Harm*, HARV. HEALTH PUB.: HARV. HEALTH BLOG (Oct. 13, 2015, 8:31 AM), <https://www.health.harvard.edu/blog/first-do-no-harm-201510138421> (“The fact is that when difficult, real-time decisions must be made, it’s hard to apply the ‘first, do no harm’ dictum because estimates of risk and benefit are so uncertain and prone to error.”).

6. *DiCarlo v. St. Mary’s Hosp.*, 530 F.3d 255, 264 (3d Cir. 2008), *aff’d* No. 05-1665 (DRD-SDW), 2006 U.S. Dist. LEXIS 49000, at \*11 (D.N.J. July 19, 2006)

Not all courts treat the patient consumer's concerns so dismissively. Sticker shock and lack of transparency in hospital billing and rate structures have been a sore point with patients for decades.<sup>7</sup> Public distrust of hospitals and insurance providers disincentivizes consumers from seeking needed medical care for fear of unpredictable and exorbitant healthcare costs.<sup>8</sup>

To address this concern, the subsequent revision of the Patient Protection and Affordable Healthcare Act of 2010 ("ACA") brought about a new requirement for hospitals to annually publish their standard chargemaster rates for medical services.<sup>9</sup> While some hospitals complied, the mandate was not enforced.<sup>10</sup> Also, for the millions of uninsured Americans routinely billed the chargemaster rate, a rate which may be inflated significantly higher than what is billed to insured patients, few have been able to negotiate the price effectively because hospitals have not been required to publish their typical discount rate.<sup>11</sup>

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(addressing a class action filed by uninsured hospital patients charged the highest chargemaster rate after services had been provided).

7. See Exec. Order No. 13,877, 84 Fed. Reg. 30,849 (June 24, 2019) ("Opaque pricing structures may benefit powerful special interest groups, such as large hospital systems and insurance companies, but they generally leave patients and taxpayers worse off than would a more transparent system."); Maggie Lee, *State Senate Unanimously Approves Bill to Curb Hospital Sticker Shock*, GA. RECORDER (Feb. 25, 2020), <https://georgiarecorder.com/2020/02/25/state-senate-unanimously-approves-bill-to-curb-hospital-sticker-shock/> (reporting on the passage of Georgia Senate Bill 359 (2019–2020) to eliminate high cost surprise bills for out-of-network emergency care).

8. See generally Thomas C. Buchmueller & Helen G. Levy, *The ACA's Impact on Racial and Ethnic Disparities in Health Insurance Coverage and Access to Care*, 39 HEALTH AFFS. 395 (2020).

9. Patient Protection and Affordable Healthcare Act of 2010, 42 U.S.C. § 300gg-18(e) [hereinafter ACA] ("Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary [of Health and Human Services]) a list of the hospital's standard charges for items and services provided by the hospital . . .").

10. See Exec. Order No. 13,765, 82 Fed. Reg. 8,351 (Jan. 20, 2017) (criticizing the ACA for its purported failure in creating "a more free and open healthcare market"); Harris Meyer, *Hospitals Vary in Publishing CMS Chargemaster Prices*, MODERN HEALTHCARE (Jan. 7, 2019, 12:00 AM), <https://www.modern-healthcare.com/article/20190107/TRANSFORMATION04/190109931/hospitals-vary-in-publishing-cms-chargemaster-prices>.

11. See generally Jacqueline LaPointe, *The Role of the Hospital Chargemaster in Revenue Cycle Management*, REVCYCLE INTEL. (Feb. 9, 2018),

In 2020, the Supreme Court of Georgia described the chargemaster rate as follows:

Hospitals . . . set their rates by calculating a “chargemaster rate,” like the sticker price of a new car, for each service provided, and that rate applies to all patients receiving that particular service. The hospital determines its chargemaster rate by factoring in the cost of the service along with the overall costs of operating the hospital. Every patient is charged the chargemaster rate, but very few patients actually pay that amount because insurance companies, including Medicare, Medicaid, and other third-party payers, negotiate a reduced reimbursement rate . . . . Patients without any insurance or third-party payment source are billed the full chargemaster rate.<sup>12</sup>

Some, but not all, courts have assumed the chargemaster rate is valid and representative of the actual cost of care. However, for years, publication of the chargemaster rates has been widely criticized by consumer advocates as window dressing and deceptive.<sup>13</sup> In 2010, when interpreting the collateral source rule and the role of the chargemaster rate in hospital billing, the Supreme Judicial Court of Massachusetts recognized such concerns:

With the increasing role played by public and private health insurers in the American health care delivery system, doctors, hospitals, and other medical care providers have developed charge structures that may have little or no relationship to the reasonable value of the medical services at issue, because the providers ultimately negotiate

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<https://revcycleintelligence.com/features/the-role-of-the-hospital-chargemaster-in-revenue-cycle-management>.

12. Bowden v. Med. Ctr., Inc., 845 S.E.2d 555, 557 n.2 (Ga. 2020).

13. Paul Levy, *Useless Noise from CMS*, NOT RUNNING A HOSP. (May 8, 2013), <http://runningahospital.blogspot.com/2013/05/useless-noise-from-cms.html>; see also Joanne Rodrigues-Craig, *A Dream Deferred? Price Transparency in the American Healthcare System*, HEALTH CARE BLOG (Apr. 21, 2020), <https://the-healthcareblog.com/blog/2020/04/21/a-dream-deferred-price-transparency-in-the-american-healthcare-system/> (calculating hospital chargemaster rates in California for most common services to be at least 10 times the Medicare reimbursement rates, and lab work up to 100 times the Medicare rate).

discounts from the listed charges and are reimbursed on the basis of the discounted rates. The only patients actually paying the stated charges are the uninsured, a small fraction of medical bill payors.<sup>14</sup>

On January 1, 2021, a new rule promulgated by the Centers for Medicaid and Medicare Services (“CMS”) took effect, requiring prominent publication on a hospital’s website of standard charges for all items and services—gross charges, discounted cash prices, and negotiated charges—and lists of “shoppable” health services that can be scheduled in advance.<sup>15</sup> By including disclosure of more than the chargemaster rate, hospitals and health systems should be revealing, at least implicitly, that their chargemaster rate is a rate that is deliberately overinflated and bears little to no relation to the actual cost of care or the rate paid by the vast majority of patients and insurance providers. The new rule is unlikely to create more choice among patients who need emergent care or who have few medical providers from which to choose in their region, but publication could elucidate the practice of unreasonable and unconscionable billing.

This Article will evaluate the pattern that has emerged in hospital billing litigation in which state courts initially avoided applying the common law doctrine of unconscionability. Part II specifically addresses how the rising costs of healthcare have a longstanding impact on the financial stability and health of patient consumers. Part III examines the current practice of expecting patient consumers to negotiate billing with medical care providers after services have been rendered. Part IV discusses the failure of deception-related claims, such as racketeering, against major hospitals for their billing practices, noting the impact of public access to chargemaster rates. Finally, Part V identifies the potential for procedural and substantive unconscionability claims to ameliorate lack of transparency and exorbitant healthcare pricing, and the need for medical professionals to serve as fiduciaries to patients.

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14. *Law v. Griffith*, 930 N.E.2d 126, 133 (Mass. 2010).

15. 45 C.F.R. §§ 180.50, 180.60 (2019); *see also Hospital Price Transparency*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/hospital-price-transparency/hospitals> (last updated Sept. 30, 2020, 1:42 PM).

## II. THE IMPACT OF RISING HEALTHCARE COSTS ON THE PATIENT CONSUMER

High chargemaster rates bring about consistent increases in health insurance premiums,<sup>16</sup> and yet most hospitals prior to the COVID-19 pandemic managed to make a profit even with “discounted rates” for the insured.<sup>17</sup> The employer and consumer keep paying more for healthcare, and, in turn, health insurance companies, health systems, and hospitals usually keep making more money for the same services.<sup>18</sup> When demand falls, health systems may suffer but insurance companies are protected, as seen by the fact that health insurance companies doubled their profits during the COVID-19 crisis due to the reduction in claims submitted for elective care.<sup>19</sup> If this were about buying a car or laptop computer, it might be prudent to suggest that consumers force market corrections by opting out of a bad deal; but this

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16. *Health Insurance: Premiums and Increases*, NAT’L CONF. OF STATE LEGISLATURES (Dec. 4, 2018), <https://www.ncsl.org/research/health/health-insurance-premiums.aspx> (addressing rising health insurance premiums since 2017).

17. See David Belk, *Hospital Financial Analysis*, TRUE COST OF HEALTHCARE, [https://truecostofhealthcare.org/hospital\\_financial\\_analysis/](https://truecostofhealthcare.org/hospital_financial_analysis/) (last visited May 16, 2021) (determining that hospital profit margins average around 8% in recent years, despite the fact that they are paid an average of less than 30% of what they bill). *But see Hospitals and Health Systems Continue to Face Unprecedented Financial Challenges due to COVID-19*, AM. HOSP. ASS’N (June 2020), <https://www.aha.org/system/files/media/file/2020/06/aha-covid19-financial-impact-report.pdf> (describing hospital financial losses related to lack of patient volume in non-emergent procedures in the first months of the pandemic and the cost of acquiring necessary equipment and supplies to treat COVID-19 patients).

18. See generally *How Does the U.S. Healthcare System Compare to Other Countries?*, PETER G. PETERSON FOUND. (July 14, 2020) (“[T]he United States spends about \$940 per person on administrative costs—four times more than the average of other wealthy countries and significantly more than we spend on preventive or long-term healthcare.”).

19. Carolina F. Plott et al., *Unexpected Health Insurance Profits and the COVID-19 Crisis*, J. AM. MED. ASS’N HEALTH F. (Aug. 27, 2020), <https://jamanetwork.com/channels/health-forum/fullarticle/2770148> (noting that insurance providers are required to rebate excess revenues back to the employers and individuals paying premiums).

is about access to healthcare, which most of the world considers a fundamental human right.<sup>20</sup>

The enactment of the ACA reduced the number of uninsured down from over 13% to approximately 8.5% of the U.S. population.<sup>21</sup> Nevertheless, medical debt continues to be the type of debt owed in more than half of bankruptcy cases, including debt accrued from medical expenses or illness-related work loss.<sup>22</sup> Rising healthcare costs, lack of disability insurance, policies restricting Medicaid access, and stagnant wages may have counteracted many of the benefits of the ACA.<sup>23</sup> Prior to the COVID-19 pandemic, twenty-nine million people, disproportionately racial minorities, still lacked health insurance coverage.<sup>24</sup> In 2020, due to the negative employment and economic

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20. See generally Benjamin Mason Meier & Lance Gable, *Advancing the Human Right to Health: Eleanor Kinney's Seminal Contributions to the Development and Implementation of Human Rights for Public Health*, 17 IND. HEALTH L. REV. 21, 22–23 (2020) (discussing the refusal of the United States to enter into international treaties that provide for a human right to healthcare).

21. Phil Galewitz, *Breaking a 10-Year Streak, The Number of Uninsured Americans Rises*, KHN, KAISER FAM. FOUND. (Sept. 10, 2019), <https://khn.org/news/number-of-americans-without-insurance-rises-in-2018/#:~:text=The%20Census%20found%20that%208.5,%2D09%2C%20Census%20officials%20said> (analyzing census data which indicated that 13.3% were uninsured in 2013, and 8.5% in 2018).

22. See *id.*; Sara S. Greene et al., *Cracking the Code: An Empirical Analysis of Consumer Bankruptcy Outcomes*, 101 MINN. L. REV. 1031, 1064 (2017); David U. Himmelstein et al., Editorial, *Medical Bankruptcy: Still Common Despite the Affordable Care Act*, 109(3) AM. J. PUB. HEALTH 431, 431 (Mar. 2019).

23. See Rachel Garfield et al., Issue Brief, *The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid*, KAISER FAM. FOUND. 2 (Jan. 2020), <http://files.kff.org/attachment/Issue-Brief-The-Coverage-Gap-Uninsured-Poor-Adults-in-States-that-Do-Not-Expand-Medicaid> (calculating two million more Americans would have qualified for Medicaid under the ACA if all states had expanded Medicaid coverage); Himmelstein et al., *supra* note 22, at 433 (discussing CONSUMER FIN. PROTECTION BUREAU, CONSUMER CREDIT REPORTS: A STUDY OF MEDICAL & NON-MEDICAL COLLECTIONS (2014)).

24. See Buchmueller & Levy, *supra* note 8 (studying the shifting rates of persons who are uninsured or covered by Medicaid and identifying continued racial and citizenship disparities since the enactment of the ACA); DAVID KENDALL ET AL., COST CAPS AND COVERAGE FOR ALL: HOW TO MAKE HEALTH CARE UNIVERSALLY AFFORDABLE (Feb. 19, 2019), [https://papers.ssrn.com/sol3/Delivery.cfm/SSRN\\_ID3356722\\_code924991.pdf?abstractid=3356722&mirid=1](https://papers.ssrn.com/sol3/Delivery.cfm/SSRN_ID3356722_code924991.pdf?abstractid=3356722&mirid=1).



impacts of the pandemic, millions have become uninsured,<sup>25</sup> although, the CARES Act reimbursed hospitals for the cost of care to uninsured COVID-19 patients so that the patients themselves purportedly would not be billed.<sup>26</sup>

Although coverage of all factors in this complex debate on the cause of rising healthcare costs is beyond the scope of this Article's focus, financial incentive is a dominant theme. Some attribute the problem of high cost and low access in the American healthcare system to excessive, inefficient, and wasteful medical care practices in the United States, which could be remediated by a more uniform and "robust public health infrastructure."<sup>27</sup> Others suggest the influence of a larger aging population and the promotion and cost of advanced medical technology.<sup>28</sup> The fee-for-service payment structure, rather than a bundled system of payment, is often cited as an incentive for healthcare providers to conduct testing and treatment, "whether or not it is needed, wanted, or successful."<sup>29</sup> CMS has asserted that such schemes violate the provision of the federal Anti-Kickback Act, which requires that

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25. See *Hospitals and Health Systems*, *supra* note 17, at 5–6 (fifteen million new uninsured); Lindsey Copeland, *Analysis Shows Millions More Uninsured Due to COVID-19 Pandemic*, MEDICARE RTS. CTR. (Aug. 6, 2020), <https://www.medicare-rights.org/medicare-watch/2020/08/06/analysis-shows-millions-more-uninsured-due-to-the-covid-19-pandemic> (twenty-one million new unemployed between February and May 2020).

26. See Blake Farmer, *Hospital Bills for Uninsured Patients Are Covered, but No One Tells Them*, KHN (Oct. 29, 2020), <https://khn.org/news/hospital-bills-for-uninsured-covid-patients-are-covered-but-no-one-tells-them/>; *Hospitals and Health Systems*, *supra* note 17, at 5–6. *But see* Bob Curley, *Surprise Medical Bills Rising During COVID-19: What To Do If You Get One*, HEALTHLINE (Dec. 2, 2020), <https://www.healthline.com/health-news/surprise-medical-bills-rising-during-covid-19-what-to-do-if-you-get-one>.

27. Sanne Magnan et al., *Healthier People: Setting Targets for Life Expectancy and Health Care Expenditures*, 110 AM. J. PUB. HEALTH 1733, 1734 (2020).

28. BERNSTEIN RSCH., HEALTH-CARE COST CONTAINMENT: A BITTER PILL FOR THE PHARMACEUTICAL INDUSTRY 24–25 (1993).

29. KENDALL ET AL., *supra* note 24, at 5; *e.g.*, *United States ex rel. Graziosi v. Accretive Health, Inc.*, No. 13-cv-1194, 2018 WL 4503366 (N.D. Ill. 2018) (addressing claims under the federal False Claims Act that defendant hospitals had a scheme to recommend hospital admission for Medicare patients despite the physician's assessment that it was unneeded and outpatient care would suffice); *United States ex rel. Graziosi v. R1 RCM, Inc.*, No. 13-cv-1194, 2020 WL 7025082 (N.D. Ill. Nov. 30, 2020) (continuing litigation on False Claims Act).

hospitals seeking Medicare reimbursement “assure that services . . . ordered or provided . . . to beneficiaries and recipients will be provided economically and only when, and to the extent, medically necessary.”<sup>30</sup>

Legal advocates for uninsured patient consumers who are presented with a bill at the highest chargemaster rate have argued vociferously that if the vast majority of hospital bills are routinely negotiated down to a lower cost, it is fraudulent or at least negligent misrepresentation to conceal the customary negotiated rate from consumers.<sup>31</sup> However, a series of state and federal judicial opinions have rejected this argument, despite the public policy of transparency promoted by the ACA and the rise of consumer protection policies.<sup>32</sup> With some exceptions, courts have also continued to hold that hospitals should set their own prices, however high, deferring to legislative authority to implement price controls.<sup>33</sup> Payday lenders made the same argument to a court with respect to transparent but exorbitant interest rates in states that failed to enact usury laws, yet courts have been willing to apply the doctrine of unconscionability to protect the vulnerable borrower.<sup>34</sup>

Even those with insurance face payment challenges. As one advocacy group noted, one in ten employees has a health insurance plan with a \$3,000 deductible.<sup>35</sup> In 2019, substantial numbers of underinsured were identified among persons relying on the health insurance exchanges (44%), Medicaid (26%), Medicare (24%), and employer-

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30. ACA, 42 U.S.C. § 1320c-5(a).

31. See *infra* Part IV. See generally Leah Snyder Batchis, Comment, *Can Lawsuits Help the Uninsured Access Affordable Hospital Care?: Potential Theories for Uninsured Patient Plaintiffs*, 78 TEMP. L. REV. 493 (2005).

32. E.g., *Centura Health Corp. v. French*, No. 19CA0023, 2020 WL 2759685 (Colo. Ct. App. May 28, 2020); *Holland v. Trinity Health Care Corp.*, 791 N.W.2d 724 (2010); *Banner Health v. Med. Sav. Ins. Co.*, 163 P.3d 1096 (Ariz. Ct. App. 2007), *rev. denied* (Jan. 8, 2008).

33. See, e.g., *Banner Health*, 163 P.3d at 1103 (“We do not believe it is within the province of the courts, on this record, to declare billings based on the filed rates to be unenforceable.”). *But see* *Leslie v. Quest Diagnostics, Inc.*, No. 17-1590 (ES) (MAH), 2019 WL 4668140 (D.N.J. Sept. 25, 2019) (holding that healthcare pricing is a proper matter for the court in the context of breach of contract and unfair business practices).

34. See, e.g., *State ex rel. King v. B&B Inv. Grp., Inc.*, 329 P.3d 658, 670 (N.M. 2014).

35. KENDALL ET AL., *supra* note 24, at 2.

based coverage (24%).<sup>36</sup> The health insurance system is also complicated and there is evidence that many patient consumers fail to fully understand distinctions between medical bills, insurance bills, and the explanation-of-benefits statement.<sup>37</sup> The Consumer Financial Protection Bureau (“CFPB”) reported that among all types of consumers who reported debt collection concerns, medical collections complaints are much more likely to relate to the existence, amount, or information pertaining to the debt than non-medical collections complaints.<sup>38</sup> Even with ACA mandates to improve the transparency of health insurance plan options, such as cost-sharing amounts of co-pays or deductibles, the patient consumer still has substantial sums that may be owed.<sup>39</sup>

For the average patient consumer, the highest costs of healthcare include hospital charges, then physician fees, followed by pharmaceutical drug costs.<sup>40</sup> The 1980s saw many new and now widely prescribed drugs emerge in the market for conditions such as ulcers, heart failure, and anxiety and depression.<sup>41</sup> Employers have balked at the high prices of drug benefits, particularly for retirees, especially given that Medicare did not traditionally cover drug costs.<sup>42</sup> In 1993, an industry earnings analysis predicted that revenue growth in the pharmaceutical industry would slow from 14% in 1987 to about 5% a year by 1997, and that price increases would cease due to government intervention.<sup>43</sup> The prediction did not bear out. Between 2000 and 2018, the thirty-five

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36. *Id.* at 2–3 (“A standard definition of underinsurance sets 10% as the maximum for out-of-pocket costs for most people and 5% for people with incomes under 200% of the poverty level.”).

37. Rukavina, *supra* note 3, at 969.

38. CONSUMER FIN. PROTECTION BUREAU, *supra* note 23, at 6–7.

39. *See* ACA, 42 U.S.C. § 18031(e)(3)(C) (“The Exchange shall require health plans seeking certification as qualified health plans to permit individuals to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the individual’s plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual.”).

40. BERNSTEIN RSCH., *supra* note 28, at 31.

41. *Id.* at 93.

42. *Id.* at 31–32.

43. *Id.* at 11.

major pharmaceutical companies made a combined gross profit of \$8.6 trillion.<sup>44</sup>

Healthcare costs have been increasing for decades in the United States,<sup>45</sup> and reform continues to be debated widely.<sup>46</sup> Employers pushed for managed healthcare reform in the 1980s and 1990s in an effort to control costs.<sup>47</sup> Income tax deductions for healthcare expenses alleviate the costs for consumers, but only 30% of Americans itemize, mostly on the basis of mortgage interest deductions, charitable donations, and healthcare spending—an option primarily for wealthier Americans.<sup>48</sup> In addition to varied state legislation, the federal government acted to reduce costs by adopting preventative health care measures under the ACA, such as mandatory coverage of annual physicals and vaccinations.<sup>49</sup> Both have worked toward greater cost efficiency, but against a swell of lobbying to retain exorbitant healthcare costs. According to medical policy researchers, “[b]efore COVID-19, medical care cost was growing at 4.6% a year and was responsible for

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44. Rosie McCall, *Big Pharma Companies Earn More Profits Than Most Other Industries, Study Suggests*, NEWSWEEK (Mar. 4, 2020, 6:01 AM), <https://www.newsweek.com/big-pharma-companies-profits-industries-study-1490407#:~:text=Big%20pharmaceutical%20companies%20appear%20to,according%20to%20a%20new%20study.&text=Their%20calculations%20found%20that%20in,gross%20profit%20of%20%248.6%20trillion>.

45. BERNSTEIN RSCH., *supra* note 28, at 21 (stating that healthcare costs doubled from 6% of the national product in 1965 to about 12% by 1990).

46. See Joe J. Dilulio, *Health Care Reform: A Consensus on Values, but an Administrative Road to Nowhere*, BROOKINGS (July 16, 2019), <https://www.brookings.edu/blog/fixgov/2019/07/16/healthcare-reform-a-consensus-on-values-but-an-administrative-road-to-nowhere/> (briefly outlining the ongoing debate and history of challenges to administering state and federal health care reform).

47. See generally Vicki Lawrence MacDougall, *The “Shared Risk” of Potential Tort Liability of Health Maintenance Organizations and the Defense of ERISA Preemption*, 32 VAL. U.L. REV. 855, 859 (1998).

48. *Briefing Book, Key Elements of the U.S. Tax System*, TAX POL’Y CTR., <https://www.taxpolicycenter.org/briefing-book/what-are-itemized-deductions-and-who-claims-them#:~:text=In%20re-cent%20years%2C%20about%2030,and%20medical%20and%20dental%20ex-penses> (last updated May 2020).

49. See *Preventive Services Covered Under the Affordable Care Act*, NAT’L CONF. OF STATE LEGISLATURES (June 30, 2014), <https://www.ncsl.org/research/health/american-health-benefit-exchanges-b.aspx>.

17.7% of the nation's gross domestic product."<sup>50</sup> Physician reimbursement for face-to-face office outpatient visits for primary and chronic care are set to receive "a historic increase" in 2021 due to the significant rise in the number of Medicare patients, with a reported 10,000 new beneficiaries enrolled every day.<sup>51</sup> The financial incentive to physicians has also influenced a shift to more lucrative specialty areas of practice. In 1965, at least 42% of physicians were general practitioners.<sup>52</sup> Today, that number has been reduced to only 33%.<sup>53</sup>

The persistent lack of access to affordable care has a health impact. In a large survey of persons who filed for bankruptcy between 2013 to 2016, many reported that, in the two years prior to bankruptcy, they had opted out of receiving needed medical care or drug prescriptions, likely due to cost.<sup>54</sup> Collecting the debt can involve aggressive third-party contractors. For example, the Minnesota Attorney General successfully obtained a \$2.5 million fine and banned Accretive Healthcare, Inc. from engaging in hospital debt collection in the state due to its allegedly abusive and intimidating collection practices against patients.<sup>55</sup> The Federal Trade Commission settled charges

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50. Magnan et al., *supra* note 27, at 1734; *see also* NHE Fact Sheet, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet> (last updated Dec. 16, 2020, 4:15 PM) (listing the national health expenditure for 2018 at 17.7% of GDP, projected to increase to 19.7% by 2028).

51. Press Release, Ctrs. for Medicare & Medicaid Servs., *Trump Administration Finalizes Permanent Expansion of Medicare Telehealth Services and Improved Payment for Time Doctors Spend with Patients* (Dec. 1, 2020), <https://www.cms.gov/newsroom/press-releases/trump-administration-finalizes-permanent-expansion-medicare-telehealth-services-and-improved-payment>; *see also* Jacqueline LaPointe, *CMS Finalizes 2021 Physician Fee Schedule, Including E/M Changes*, REVCYCLE INTEL. (Dec. 2, 2020), <https://revcycleintelligence.com/news/cms-finalizes-2021-physician-fee-schedule-including-e-m-changes> (discussing the finalization by CMS of a reimbursement rate increase in the 2021 Medicare Physician Fee Schedule).

52. BERNSTEIN RSCH., *supra* note 28, at 95.

53. James E. Dalen et al., *Where Have the Generalists Gone? They Became Specialists, Then Subspecialists*, 130 AM. J. MED. 766, 767 (July 2017), <https://www.amjmed.com/action/showPdf?pii=S0002-9343%2817%2930134-1>.

54. *See* Himmelstein et al., *supra* note 22, at 432.

55. *See* Ameet Sachdev, *Chicago-Based Accretive Health Banned from Doing Business in Minnesota for 2 Years*, CHI. TRIB. (July 31, 2012); *see also* Anger v. Accretive Health, Inc., No. 2:14-cv-12864, 2015 WL 5063269 (E.D. Mich. Oct. 11,

against Accretive for a privacy breach but declined to take enforcement action regarding its debt collection practices, noting that “the practice of attempting to collect payment for prior debts from consumers while they are seeking treatment in an emergency room or other medical facility raises serious concerns.”<sup>56</sup> The public policy and consumer protection concerns are legion.

Even consumer reporting agencies recognize that the reporting of uncollected medical billing debts is problematic.<sup>57</sup> For example, medical billing errors and delays in billing may interfere with systematic reporting of data to consumer reporting agencies.<sup>58</sup> Also, the CFPB reported in 2014 that approximately 22% of medical debtors have no other type of debt reported to collections, indicating a type of consumer who would ordinarily pay bills on time.<sup>59</sup> Some state consumer protection laws prevent hospitals from reporting medical debt to agencies too quickly, such as the Illinois Fair Patient Billing Act.<sup>60</sup> The Illinois patient consumer must, in turn, “act reasonably and cooperate in good faith with the hospital” in order to receive the benefits of the Act’s

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2017) (applying the FDCPA, 15 U.S.C. § 1692, and the Michigan Occupational Code, MICH. COM. LAWS SERV. § 339.916(2) (LexisNexis 2021)).

56. *Accretive Health Settles FTC Charges That It Failed to Adequately Protect Consumers’ Personal Information*, FED. TRADE COMM’N (Dec. 31, 2013), <https://www.ftc.gov/news-events/press-releases/2013/12/accretive-health-settles-ftc-charges-it-failed-adequately-protect>.

57. *See Allison V. Bishop, Does Medical Debt Really Go Away After Seven Years?*, OPPLOANS.BLOG (Jan. 11, 2021), <https://www.opploans.com/blog/does-medical-debt-go-away-after-seven-years/> (asserting, as a financial advisor, “[u]nless your medical debt goes into collections, you probably won’t see it on your credit report, as medical practices aren’t typically in the habit of reporting to the credit bureaus”); Rukavina, *supra* note 3, at 974–75 (stating that credit reporting agencies have testified before Congress suggesting that medical debt information should be screened out when making determinations as to credit-worthiness, such as in rental applications and credit score calculations).

58. *See Rukavina, supra* note 3, at 970 (noting that, by 2003, medical bill collections had become the most frequently reported type of collection account on consumer reports).

59. CONSUMER FIN. PROTECTION BUREAU, *supra* note 23, at 7.

60. *See* 210 ILL. COMP. STAT. ANN. 88/30 (West 2020) (permitting collection actions by hospitals only after the patient has had an opportunity to determine the accuracy of the bill and to pursue reasonable payment plan options or apply for Medicaid or other government sponsored health insurance programs).

protections.<sup>61</sup> One stated method of mutual cooperation in the Act is to provide sufficient time and notice for the patient consumer to negotiate with a hospital to determine a more reasonable fee for service.<sup>62</sup>

### III. THE PRACTICE OF NEGOTIATING MEDICAL BILLS

Although they may be unaware of this, patients facing high out-of-pocket costs of medical care are expected to negotiate the price down. As one retired insurance broker commented, “It is true that a stubborn patient can sometimes reduce their debt through negotiation . . . but no one has to negotiate with the fire department. Americans are used to posted prices, not haggling, and especially not haggling in medicine.”<sup>63</sup> For the now tens of millions of uninsured,<sup>64</sup> negotiation of bills can be accomplished directly with the provider or health system, or through arbitration if a dispute cannot be resolved.<sup>65</sup> Judicial intervention, discussed at length below,<sup>66</sup> is a last resort.

Before addressing the process of negotiating medical bills, it bears mention that medical providers generally do not have to accept patients for treatment. Principle VI of the American Medical Association Code of Medical Ethics states: “A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.”<sup>67</sup> Physicians cannot refuse to care for patients on the basis of invidious discrimination, such as on the basis of race, sexual orientation, or gender identity, nor can they refuse to treat on the basis of infectious disease status.<sup>68</sup> However, a physician’s

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61. *Id.* § 88/45(a).

62. *See id.* § 88/5.

63. Bob Hertz, *A Full-Scale Assault on Medical Debt, Part 2*, HEALTH CARE BLOG (Mar. 9, 2020), <https://thehealthcareblog.com/blog/2020/03/09/a-full-scale-assault-on-medical-debt-part-2/>.

64. *See* sources cited *supra* note 25.

65. *See* *Buckeye Check Cashing, Inc. v. Cardegna*, 546 U.S. 440, 449 (2006) (holding that if the patient consumer seeks to void the contract as usurious or unconscionable, the arbitrator must decide the matter, not a court of law).

66. *See infra* Parts IV and V.

67. CODE OF MEDICAL ETHICS Principle VI (AM. MED. ASS’N 2020).

68. *See* Am. Med. Ass’n, Ethics Op. 10.05(2), at 422 (2015) (referring to Op. 9.12 “Patient-Physician Relationship: Respect for Law and Human Rights” and Op. 2.23 “HIV Testing”).

stated obligation to “care for the poor” is underwhelming, as it “may vary with circumstances such as community characteristics, geographic location, the nature of the physician’s practice and specialty, and other conditions.”<sup>69</sup> Although medical codes of ethics do not carry a mandate on which a cause of action may be based,<sup>70</sup> they do shed light on professional attitudes toward the economic plight of the patient consumer.

Under the Emergency Medical Treatment and Active Labor Act of 1986 (“EMTALA”), hospitals receiving Medicare funding that have an emergency department must screen patients for emergency medical needs and may not discharge them unless their emergency conditions have been stabilized,<sup>71</sup> regardless of the patient’s ability to pay.<sup>72</sup> This includes required emergency medical treatment for persons unable to pay because they are uninsured or ineligible to be insured due to citizenship status.<sup>73</sup> Hospital administrators have long contested the affordability of EMTALA for healthcare systems, suggesting that it would result in emergency room closures due to unpaid bills for emergency care.<sup>74</sup> However, the federal government has provided periodic funding to hospitals to compensate for services to undocumented

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69. Am. Med. Ass’n, Ethics Op. 9.065, at 359 (2015).

70. See *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 282 (3d Cir. 2001).

71. Emergency Medical Treatment and Active Labor Act, 42 U.S.C. §§ 1395cc and 1395dd [hereinafter EMTALA].

72. See *id.* § 1395dd(h); see also *Kizzire v. Baptist Health Sys., Inc.*, 441 F.3d 1306, 1310 (11th Cir. 2006).

73. See generally Tristan Dollinger, *America’s Unraveling Safety Net: EMTALA’s Effect on Emergency Departments, Problems and Solutions*, 98 MARQ. L. REV. 1759 (2015); Laura D. Hermer, *The Scapegoat: EMTALA and Emergency Room Overcrowding*, 14 J.L. & POL’Y 695 (2006).

74. See *EMTALA Fact Sheet*, AM. COLL. OF EMERGENCY PHYSICIANS, <https://www.acep.org/life-as-a-physician/ethics—legal/emtala/emtala-fact-sheet/> (last visited Apr. 12, 2021) (“The burden of uncompensated care is growing, closing many emergency departments, decreasing resources for everyone and threatening the ability of emergency departments to care for all patients.”).



patients,<sup>75</sup> as it has now done for emergency treatment of COVID-19 patients.<sup>76</sup>

Whether EMTALA requires hospitals to accept COVID-19-infected patients from other facilities that have run out of room or lack adequate medical equipment has been a matter of serious concern since the early days of the pandemic, testing the legal mandate to assess all patients.<sup>77</sup> By December 2020, the Secretary of Health and Human Services declared that EMTALA waivers for the part of the Act related to location of assessment would become available (e.g., testing for COVID-19 off-site), but all other requirements of the Act remained in place.<sup>78</sup>

Evidence before the pandemic suggests a trend in hospital closures, from twenty-eight closures in 2015, to forty-seven closures in 2019, impacting mostly small and rural facilities in Medicaid non-expansion states where decreases in patient volume is associated with a declining population.<sup>79</sup> And yet, early in 2020, ten health systems had

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75. See Medicare Modernization Act of 2003, Pub. L. No. 108-173 § 1011, 117 Stat. 2066, 2432–35; CMS, *Emergency Health Services for Undocumented Aliens*, CMS (May 9, 2005), <https://www.cms.gov/newsroom/fact-sheets/emergency-health-services-undocumented-aliens> (summarizing the provision of millions of dollars in appropriated congressional funding to states between 2005–2008 under the Medicare Modernization Act). *But see Section 1011: Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens*, CTRS. FOR MEDICARE & MEDICAID SERVS. (May 2013), [http://www.obc.med.miami.edu/documents/Section\\_1011\\_Fact\\_Sheet.pdf](http://www.obc.med.miami.edu/documents/Section_1011_Fact_Sheet.pdf) (listing as of May 2013 the 28 states that had already run out of annual hospital reimbursement funds under section 1011).

76. See *supra* note 26.

77. See Memorandum from Dir., Quality Safety & Oversight Grp., Ctrs. for EMTALA Requirements and Implications Related to Coronavirus Disease, to State Survey Agency Dirs., Ref. QSO-20-15 Hospital/CAH/EMTALA (Mar. 9, 2020), <https://www.cms.gov/files/document/qso-20-15-emtala-requirements-and-coronavirus-0311-updated-003pdf.pdf-1> (providing guidance that the EMTALA requirements remain in place, informed by the directions of the CDC and public health directives).

78. *COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers*, CTRS. FOR MEDICARE & MEDICAID SERVS. 1, 43 (Dec. 1, 2020), <https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf> (waiving enforcement of section 1867(a) of EMTALA only).

79. Rich Daly, *47 Hospitals Have Closed in 2019*, MedPAC Reports, HEALTHCARE FIN. MGMT. ASS'N (Dec. 10, 2019), <https://www.hfma.org/topics/news/2019/12/47-hospitals-have-closed-in-2019—medpac->

plans to open new hospitals, and most healthcare systems remain financially robust.<sup>80</sup> One medical professor from Northwestern University defended turning away uninsured patients to ensure profits:

[C]onscience urges that [the physician] treat all patients, no matter what, but a convergence of health system factors such as rising medical liability premiums, stagnant reimbursement from commercial insurers, escalating overhead, and personal moral beliefs can make following one's conscience costly . . . . Arguably, since it does not bear the medical student's financial burden, society should remain silent on the issue of whether physicians have the right to refuse patients.<sup>81</sup>

The sentiment rings hollow when faced with the reality that patient consumer medical debt is associated with most bankruptcies in the United States.<sup>82</sup> Also, allowing the medical profession to turn away uninsured and underinsured patients with chronic, non-emergent health conditions, such as diabetes, hypertension, or mental illness, is unshamedly and impliedly stating that refusal to treat “the main cause of death and disability in the world”<sup>83</sup> acceptably puts profit over people and society. One might not say the same for the right to refuse a patient seeking an elective surgery who cannot afford it.<sup>84</sup>

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reports.html#:~:text=Additionally%2C%20more%20than%20600%20rural,and%2063.3%25%20for%20all%20hospitals.

80. Alia Paavola, *10 Health Systems Opening New Hospitals*, BECKER'S HOSP. REV. (Jan. 3, 2020), <https://www.beckershospitalreview.com/capital/9-health-systems-opening-new-hospitals.html>. For the current number of hospitals in the United States by type (e.g., federal, state, not-for-profit, profit), see *Fast Facts on U.S. Hospitals, 2021*, AM. HOSP. ASS'N, (Jan. 2021), <https://www.aha.org/statistics/fast-facts-us-hospitals>.

81. June M. McKoy, *Obligation to Provide Services: A Physician-Public Defender Comparison*, AMA J. ETHICS (2006), <https://journalofethics.ama-assn.org/article/obligation-provide-services-physician-public-defender-comparison/2006-05>.

Note that the author also makes a highly dubious comparison to public defenders.

82. See *supra* Part II.

83. JoAnne Epping-Jordan et al., *The Challenge of Chronic Conditions: WHO Responds*, 323 BRIT. MED. J. 947, 947 (Oct. 27, 2001), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1121495/pdf/947.pdf>.

84. See *Americans Spent More Than \$16.5 Billion on Cosmetic Plastic Surgery in 2018*, AM. SOC'Y OF PLASTIC SURGEONS (Apr. 10, 2019),

When medical providers do accept patients for treatment, they may or may not be able to screen patients for ability to pay before services are rendered. Non-emergent routine care is more likely to involve a sharing of cost of services and methods of payment in advance of care, but emergency treatment or complex medical services may only involve a signature of responsibility for all charges.<sup>85</sup> Consumer patients receiving an expensive medical bill after services are complete would find it daunting to negotiate with the provider if unable to pay.<sup>86</sup> The opportunistic or savvy consumer may negotiate for a lower price, but the less able and less savvy patient consumer may be in trouble.<sup>87</sup> As discussed above in Part II, if the patient attempts to negotiate with the provider, but still cannot pay, the patient will risk the hospital's debt collection practices.

The patient who fails in negotiation is not without a potential legal remedy. While the price term in contracts is generally enforced, courts contemplate that some bargains are overly harsh and one-sided and may apply the doctrine of unconscionability.<sup>88</sup> The primary question is whether the price billed is reasonable. This is a deceptively difficult determination given that the chargemaster rate is asserted by the hospital but bears little relation to actual costs of care, is not the

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<https://www.plasticsurgery.org/news/press-releases/americans-spent-more-than-16-billion-on-cosmetic-plastic-surgery-in-2018> (finding that specialists providing elective cosmetic surgeries have captured a \$16.5 billion market, allowing, for example, a plastic surgeon to charge on average \$6,253 for a tummy tuck, not including the cost of anesthesia, operating room facilities and other related expenses).

85. See sources cited *supra* note 3.

86. See Jason Scott Johnson, *The Return of Bargain: An Economic Theory of How Standard-Form Contracts Enable Cooperative Negotiation Between Businesses and Consumers*, 104 MICH. L. REV. 857, 865–66 (2006) (describing the rise of hospital financial counselors to assist patients with affordable payment plans in order to avoid the formal debt collection process).

87. See Thomas L. Hafemeister & Joshua Hinckley Porter, *Don't Let Go of the Rope: Reducing Readmissions by Recognizing Hospitals' Fiduciary Duties to Their Discharged Patients*, 62 AM. U.L. REV. 513, 562–63 (2013) (“In some cases, hospital patients are essentially a captive audience with no means to personally gauge the validity of the advice they are given, minimal opportunity to seek input from other experts due to time or financial limitations, and insufficient physical or mental capacity to simply walk away and seek care elsewhere.”).

88. See *infra* Part V (discussing substantive unconscionability as it relates to pricing).

customary rate for most patients, and provides a rate structure that is quite detailed and difficult for most patients to understand.

As guidance, the American Medical Association (“AMA”) has put forth that “the patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives.”<sup>89</sup> Its Code of Medical Ethics lists five factors that inform the reasonableness of a fee: (1) difficulty and/or uniqueness of services; (2) “the fee customarily *charged* in the locality for similar physician services”; (3) amount of charges; (4) quality of performance; and (5) experience, reputation, and ability of the physician.<sup>90</sup> The average patient-consumer expected to negotiate a bill would be hard pressed to assert these factors without the expertise of a physician or an advocate familiar with billing practices.

Modern consumer protection statutes recognize this imbalance in knowledge and negotiation skills between business and consumer, but inconsistently consider the level of sophistication, or lack thereof, required of the consumer. For example, the Federal Trade Commission Act requires that a business provide prominent disclosures and avoid unfair and deceptive practices, eliminating the element of undue reliance on the part of the consumer in matters of deception and fraud.<sup>91</sup> However, in hospital billing claims involving the Fair Debt Collection Practices Act (“FDCPA”), which prohibits using “unfair or unconscionable means” to collect a debt,<sup>92</sup> most courts employ the least sophisticated consumer test.<sup>93</sup> The Tenth Circuit held that “the test is how

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89. Am. Med. Ass’n, Ethics Op. 10.01(1), at 399 (2015).

90. Am. Med. Ass’n, Ethics Op. 6.05, at 208 (2015) (emphasis added).

91. *E.g.*, Federal Trade Commission Act, 15 U.S.C. § 45(a)(4)(A) (“[T]he term ‘unfair or deceptive acts or practices’ includes such acts or practices involving foreign commerce that— (i) cause or are likely to cause reasonably foreseeable injury within the United States; or (ii) involve material conduct occurring within the United States.”)

92. 15 U.S.C. § 1692f.

93. *See* *Fouts v. Express Recovery Servs., Inc.*, 602 Fed. Appx. 417, 421 (10th Cir. 2015); *LeBlanc v. Unifund CCR Partners*, 601 F.3d 1185, 1201 (11th Cir. 2010); *see also* *Clomon v. Jackson*, 988 F.2d 1314, 1318 (2d Cir. 1993) (applying the least sophisticated consumer test for actions under section 1692e of the FDCPA, which prohibits “false, deceptive, or misleading practice[s]”). *But see* *Sheriff v. Gillie*, 136 S. Ct. 1594, 1602 n.6 (2016) (declining to resolve “whether a potentially false or misleading statement should be viewed from the perspective of ‘the least sophisticated consumer’”).

the least sophisticated consumer—one not having the astuteness of a ‘Philadelphia lawyer’ or even the sophistication of the average, everyday, common consumer—understands the notice he or she receives.”<sup>94</sup> The Seventh Circuit further requires that an FDCPA claim be evaluated “through the objective lens of an unsophisticated consumer who, while ‘uninformed, naïve, or trusting,’ possesses at least ‘reasonable intelligence, and is capable of making basic logical deductions and inferences.’”<sup>95</sup>

This is quite a different standard from the “reasonable consumer.” For example, the Illinois Fair Patient Billing Act will only enforce protections of consumers from unfair debt collection practices in medical billing cases if a consumer acts:

reasonably and cooperate[s] in good faith with the hospital by providing the hospital with all of the reasonably requested financial and other relevant information and documentation needed to determine the patient’s eligibility under the hospital’s financial assistance policy and reasonable payment plan options to qualified patients within 30 days of a request for such information.<sup>96</sup>

This is a negotiation process that occurs after the service is rendered. Even with additional disclosures and reasonable familiarity with the chargemaster rate, the medical provider, especially within a larger health system, is usually the more sophisticated party in the transaction. Also, whether consumers know how unfair the pricing system is does not change the fact that the pricing system is unfair.

In the context of medical billing disputes, the opportunity for the consumer to negotiate meaningfully should be enhanced by the new hospital transparency rule promulgated by CMS.<sup>97</sup> The stated purpose of the rule is as follows:

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94. Russell v. Equifax A.R.S., 74 F.3d 30, 34 (2d Cir. 1996).

95. Steffek v. Client Services, Inc., 948 F.3d 761, 765 (7th Cir. 2020) (holding that dunning letters sent by a debt collector, but failing to identify the holder of the debt, violated the FDCPA whether the consumer was sophisticated or unsophisticated).

96. 210 ILL. COMP. STAT. ANN. 88/45(a) (West 2020).

97. 45 C.F.R. §§ 180.50 and 180.60 (2019); see also *Hospital Price Transparency*, *supra* note 15.

By disclosing hospital standard charges, we believe the public (including patients, employers, clinicians, and other third parties) will have the information necessary to make more informed decisions about their care. We believe the impact of these final policies will help to increase market competition, and ultimately drive down the cost of health care services, making them more affordable for all patients.<sup>98</sup>

This rule has been a long time coming. In 1978, physician George Markle IV advocated for such an approach, appealing to his medical colleagues in a commentary published in the *Journal of American Medicine*:

But how can we become prudent, honest fiduciaries? We can all lay down our cards on the table. The laboratories should publish a list of their fees for all the physicians to see, and so should the radiologists. We should be given the prices of drugs in the hospitals and the charges for pulmonary and physical therapies. The local pharmacists should publish their charges, and, last but not least, we clinicians should publish our various fees for the local profession.<sup>99</sup>

But neither Dr. Markle nor the new CMS rule addresses how to determine a reasonable fee within the profession or as ascertained by the patient consumer. Critics question, in particular, whether publication of the chargemaster rate truly gives consumer patients more choice and ability to negotiate. In 2019, Secretary of Health and Human Services, Alex Azar asserted that it will: “Today’s transparency announcement may be a more significant change to American healthcare markets than any other single thing we’ve done, by shining light on the costs of our shadowy system and finally putting the American patient in

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98. Medicare and Medicaid Programs: Price Transparency Requirements for Hospitals to Make Standard Charges Public, 84 Fed. Reg. 65,524 (Nov. 27, 2019) (Summary).

99. Markle, *supra* note 1, at 1630.

control.”<sup>100</sup> This can only be true if patients are well informed and if they have options for care in their region.

Hospitals routinely require that patients agree to pay for “all charges” without a cost estimate. In other areas of healthcare, providing advance notice of cost to the patient consumer may only consist of a warning that health insurance may not cover all costs. For example, if a patient is in a clinical drug trial, federal regulations require that part of the informed consent process, “when appropriate,” is that the subject should be made aware of “added costs.”<sup>101</sup> The regulatory scheme provides no definition of the term “costs,” but the Food and Drug Administration (“FDA”) has recommended that a trial subject should be informed that insurance may not cover costs when services are provided through a clinical trial.<sup>102</sup> Moreover, the FDA suggested the consumer should pay even more to determine the cost on their own: “[b]ecause these issues may be complex, it may be appropriate to refer the subject to a knowledgeable financial counselor or reimbursement specialist to explain the costs and the insurance and reimbursement issues prior to signing the consent form.”<sup>103</sup> So much for protection of the least sophisticated consumer.

State legislatures have begun to intervene. The Illinois Fair Patient Billing Act adds consumer protections to existing common law, statutory, and constitutional claims, providing patients with more opportunities to become self-informed when negotiating hospital bills.<sup>104</sup> Public enforcement is granted to the Illinois State Attorney General,

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100. Press Release, U.S. Dept. of Health & Hum. Servs., Trump Administration Announces Historic Price Transparency Requirements to Increase Competition and Lower Healthcare Costs for All Americans (Nov. 15, 2019), <https://www.hhs.gov/about/news/2019/11/15/trump-administration-announces-historic-price-transparency-and-lower-healthcare-costs-for-all-americans.html>.

101. Food and Drugs, 21 C.F.R. § 50.25(b)(3) (2020).

102. U.S. FOOD & DRUG ADMIN., INFORMATION SHEET, INFORMED CONSENT: DRAFT GUIDANCE FOR IRBs, CLINICAL INVESTIGATORS, AND SPONSORS, FDA-2006-D-0031 (July 2014), <https://www.fda.gov/regulatory-information/search-fda-guidance-documents/informed-consent#additionalcosts>.

103. *Id.*

104. Fair Patient Billing Act of 2007, 210 ILL. COMP. STAT. ANN. 88/60 (West 2020) (“Nothing in this Act shall be construed as relieving or reducing any hospital of any other obligation under the Illinois Constitution . . . or under any other statute or the common law including, without limitation, obligations of hospitals to furnish financial assistance or community benefits.”).

including the request for injunctive relief and civil monetary penalties of up to \$500 to \$1000 for individual violations.<sup>105</sup> From a consumer protection standpoint, in the equitable and remedial spirit of common law unconscionability, perhaps the most impactful provision the Illinois legislature adopted was section thirty-five:

*Collection limitations.* The hospital shall not pursue legal action for non-payment of a hospital bill against uninsured patients who have clearly demonstrated that they have neither sufficient income nor assets to meet their financial obligations provided the patient has complied with Section 45 of this Act.<sup>106</sup>

Also, numerous states have enacted laws against unexpected or surprise medical bills, such as those for out-of-network services when the patient deliberately sought services from an in-network provider, including four states with laws effective as of 2020.<sup>107</sup> At the federal level, there were over a dozen congressional bills to address and curtail surprise medical billing in the 2019–2020 session.<sup>108</sup> Finally, at least twenty-five states prohibit, to a degree, the practice of balance billing, in which a medical provider, usually a hospital, that receives less from the health insurance company than it wishes then bills the patient directly for the remainder rather than negotiating with the insurance company for the covered treatment.<sup>109</sup>

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105. *See id.* § 88/55.

106. *Id.* § 88/35.

107. Zina Gontscharow, *Four States Start 2020 with New Surprise Billing Laws*, AM.'S ESSENTIAL HOSPS. (Jan. 22, 2020), <https://essentialhospitals.org/policy/four-states-start-2020-new-surprise-billing-laws/#:~:text=Four%20states%20%E2%80%94%20Colorado%2C%20New%20Mexico,billing%2C%20or%20surprise%20medical%20bills> (Colorado, New Mexico, Texas, and Washington).

108. *E.g.*, No Surprises Act, H.R. 3630, 116th Cong. (2019); No Surprise Bills for New Moms Act, H.R. 8330, 116th Cong. (2019); Protecting Patients from Surprise Medical Bills Act, S. 1266, 116th Cong. (2019); *see also* Jack Hoadley et al., *Unpacking the No Surprises Act: An Opportunity to Protect Millions*, HEALTH AFFS. (Dec. 18, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20201217.247010/full/>.

109. Jack Hoadley et al., *State Efforts to Protect Consumers from Balance Billing*, COMMONWEALTH FUND (Jan. 18, 2019), <https://www.commonwealth-fund.org/blog/2019/state-efforts-protect-consumers-balance-billing> (finding that among the twenty-one states with protections against balance billing, only nine



As usual, states vary in their general willingness to adopt specific consumer protection provisions, particularly in areas potentially involving federal preemption.<sup>110</sup> Some state consumer protection laws may exclude professional services.<sup>111</sup> On the other hand, a few state legislatures have exhibited a willingness to place statutory caps on healthcare costs, such as Maryland,<sup>112</sup> and all but thirteen states have expanded Medicaid coverage pursuant to the ACA.<sup>113</sup> Whether it is a prohibition on surprise billing or a cap on costs, enforcing reasonable pricing through statutory mandate precludes the patient consumer from having to negotiate bills in the first (and last) place. Until more legislatures are willing to enact robust, healthcare-specific consumer protection laws, patient consumers will continue to try to protect themselves through common law claims against unfair and deceptive practices.

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(California, Connecticut, Florida, Illinois, Maryland, Oregon, New Hampshire, New Jersey, and New York) were rigorous enough to be protective).

110. See, e.g., 12 U.S.C. § 5551 (providing a declaration by the CFPB that if state authority provides greater protection than federal consumer protections under the Dodd-Frank Wall Street Reform and Consumer Protection Act, then the state statute is not in conflict).

111. E.g., *Leslie v. Quest Diagnostics, Inc.*, No. 17-1590, 2019 WL 4668140, at \*8 (D.N.J. 2019) (holding that plaintiffs' claims under the New Jersey and North Carolina consumer protection statutes for unfair medical billing were foreclosed by the "learned professional rule," a rule which recognizes that professional services are already covered by statutes other than the general unfair and deceptive trade practices acts); see also Jeffrey T. LaRosa & Eric A. Inglis, *Recent Appellate Opinion Calls "Learned Professional" Jurisprudence into Question*, LAW.COM (Jan. 10, 2020, 10:30 AM), <https://www.law.com/njlawjournal/2020/01/10/recent-appellate-opinion-calls-learned-professional-jurisprudence-into-question/?slreturn=20201119102853>.

112. See generally Chris L. Peterson & Dale N. Schumacher, *How Maryland's Total Cost of Care Model Has Helped Hospitals Manage the COVID-19 Stress Test*, HEALTH AFFS. (Oct. 7, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20201005.677034/full/>.

113. See *Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAM. FOUND. (Feb. 12, 2021), <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>

#### IV. THE IMPACT OF BILLING TRANSPARENCY ON RICO AND OTHER DECEPTION CLAIMS

A contract reflects the liberal ideals of autonomy of choice and trust between persons in a negotiated agreement.<sup>114</sup> Individuals and society benefit when individuals are incentivized to mutually cooperate. Deception, however, is antithetical to the utilitarian justification of the process of contract formation, because “the process of contract formation is morally legitimate if the parties come to their agreement freely and with (relatively) full information.”<sup>115</sup> Normally, consistent lack of information should deter a consumer from entering a bargain, but sadly there may be little choice if there is a need for medical care. As shown below, in hospital billing litigation, significant variation in price offered by the same hospital for the same services has not met the elements of fraud. It may be unreasonable, but it is not deceptive, according to the courts.

Several Federal Racketeer Influenced and Corrupt Organizations Act (“RICO”) claims have been filed by patients in class actions against hospitals for failure to disclose negotiated or discounted rate structures.<sup>116</sup> Historically, racketeering cases focused on those within a criminal enterprise who were otherwise beyond reach of the law, such as mob bosses who never directly participated in numbers rackets or illegal trading. However, the United States Supreme Court interpreted RICO’s civil provision to include claims against otherwise “legitimate” businesses.<sup>117</sup> As a private cause of action or through public

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114. CHARLES FRIED, *CONTRACT AS PROMISE: A THEORY OF CONTRACTUAL OBLIGATION* 7–8 (1981).

115. ALAN WERTHEIMER, *EXPLOITATION* 38–39 (1996).

116. Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. §§ 1961–68 (originally enacted under the Organized Crime Control Act of 1970, Pub. L. 91-452, 84 Stat. 922) [hereinafter RICO]; e.g., *Brown v. Knoxville HMA Holdings, L.L.C.*, 447 F. Supp. 3d 639 (M.D. Tenn. 2020); *Bowden v. Med. Ctr., Inc.*, 845 S.E.2d 555 (Ga. 2020).

117. *Compare H.J., Inc. v. Northwestern Bell Telephone Co.*, 492 U.S. 229, 245 (1989) (addressing an alleged bribery scheme by a telephone company with utility commissioners to achieve unreasonable rate hikes), with Press Release, U.S. Dept. of Just., 40 Charged in Largest Federal Racketeering Conspiracy in South Carolina History (Dec. 10, 2020), <https://www.justice.gov/opa/pr/40-charged-largest-federal-racketeering-conspiracy-south-carolina-history> (according to the U.S. Attorney, “[n]either

enforcement, a RICO claim requires proof that a person has been injured in business or property through violation of the criminal provisions of the Act.<sup>118</sup> The criminal provision states in part:

It shall be unlawful for any person employed by or associated with any enterprise engaged in, or the activities of which affect, interstate or foreign commerce, to conduct or participate, directly or indirectly, in the conduct of such enterprise's affairs through a pattern of racketeering activity or collection of unlawful debt.<sup>119</sup>

Racketeering includes fraudulent activity.<sup>120</sup> Therefore, when misrepresentation is alleged, hospitals and health systems may be targeted as enterprises allegedly engaged in racketeering or the collection of unlawful debt. So far, in the hospital cases discussed below, the defendant hospitals have prevailed, because the public disclosure of the hospital chargemaster rate is deemed neither fraudulent nor deceptive—it is an open and lawful scheme of arguably excessive rates.

In short, the healthcare system is not hiding its ability to charge very high, but inconsistently applied, prices. For example, in *Brown v. Knoxville HMA Holdings, L.L.C.*, the Middle District Court of Tennessee addressed a class action of patient consumer claims that the hospital's collection practices sought to collect the full, unadjusted costs of medical services (the chargemaster rate) rather than the typical discounted rate.<sup>121</sup> The class was comprised of insured patients who had been injured in automobile accidents and the hospital sought payment in the form of hospital liens against the third-party tortfeasors who caused the accidents, not from the patients.<sup>122</sup> As in many consumer protection actions, the claims were numerous and varied: violations of

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pandemic nor prison walls will provide refuge for the full force of the federal government” when criminally charging prisoners for drug trafficking).

118. 18 U.S.C. § 1964 (providing for public enforcement by the Attorney General under section (b) and permitting a private cause of action under section (c)).

119. 18 U.S.C. § 1962(c).

120. *E.g.*, *Bridge v. Phoenix Bond & Indem. Co.*, 553 U.S. 639 (2008) (“The term ‘racketeering activity’ is defined to include a host of so-called predicate acts, including ‘any act which is indictable under . . . section 1341 (relating to mail fraud).’”).

121. 447 F. Supp. 3d at 642.

122. *Id.*

both the federal RICO and FDCPA, and state law claims for violation of the Tennessee Consumer Protection Act and for tortious interference with business relationships, fraud, breach of contract, unjust enrichment, and declaratory judgment.<sup>123</sup>

The problem for the plaintiffs in *Brown* was similar to that of the plaintiffs in a similar hospital lien case decided by the Supreme Court of Georgia, *Bowden v. Medical Center, Inc.*<sup>124</sup> The conduct of the defendant hospital and its contracted debt collection service was open and did not appear to be misleading.<sup>125</sup> The chargemaster rates are charged to every patient, regardless of the fact that many or most patient consumers and insurance providers find a way to negotiate for a lower rate for the same medical services.<sup>126</sup>

In contrast, a deceptive act of racketeering sufficient to survive a motion to dismiss under RICO was shown in a federal claim in Florida, where plaintiffs alleged that a hospital owner purposefully inflated the amount charged for services in order to increase Medicare reimbursements.<sup>127</sup> The United States Supreme Court has also held that claims that a hospital and health insurer schemed to gain discounts on service costs that were not disclosed or passed on to insurance policy beneficiaries could support a RICO claim.<sup>128</sup> These latter two examples demonstrate the need to prove scienter.

A patient consumer cannot easily exert a common law fraud or negligent misrepresentation claim against a medical provider for billing practices for similar reasons. For example, in Georgia, the essential elements of a claim of negligent misrepresentation are: “(1) the defendant’s negligent supply of false information to foreseeable persons, known or unknown; (2) such persons’ reasonable reliance upon that false information; and (3) economic injury proximately resulting from

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123. *See id.*

124. 845 S.E.2d at 555 (addressing a state RICO claim pursuant to Ga. Stat. § 16-14-3(5)(A)).

125. *Id.* at 565–66.

126. *See id.* at 557 n.2.

127. State of Florida, Off. of Att’y Gen. v. Tenet Healthcare Corp., 420 F. Supp. 2d 1288 (S.D. Fla. 2005).

128. *Humana Inc. v. Forsyth*, 525 U.S. 299, 309, 311 (1999) (specifically holding that the RICO claim survived a preemption challenge based on the McCarran-Ferguson Act and did not violate state public policy in Nevada, where RICO advances the state’s interest in combating insurance fraud).

such reliance.”<sup>129</sup> The primary distinction between fraud and negligent misrepresentation is that fraud requires the element of scienter—knowledge of the falsity of the information disclosed.<sup>130</sup> A purchaser or other consumer is expected to exercise due diligence before entering the transaction; thus, “a failure to obtain and supply information [by the vendor] does not state a claim for negligent misrepresentation.”<sup>131</sup> In contrast to determinations of unconscionability as a matter of law,<sup>132</sup> both justifiable reliance and due diligence on the part of the consumer are generally matters of fact for the jury to decide in a claim for fraud or negligent misrepresentation.<sup>133</sup>

Hospitals, in addition to individual medical providers, may be liable for deceptive acts. For example, California permits a common law fraud claim in tort against a corporation. This would require proof that the defendant knowingly engaged in misrepresentation, including “false representation, concealment, or nondisclosure,” to wrongfully induce reliance, and that the plaintiff actually relied upon the misrepresentation, resulting in damages.<sup>134</sup> With respect to corporate fraud, a corporation breaches its statutory duty to shareholders, to whom it owes a fiduciary duty, when it furnishes an annual report that is misleading.<sup>135</sup> The Supreme Court of California identified important public policy reasons to remedy corporate fraud:

A corporation’s financial report invites shareholders to read and rely on it. Some undoubtedly will do so. The possibility that a shareholder will commit perjury and falsely claim to have read and relied on the report does not differ in kind from the many other credibility issues

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129. *Trico Env’t Servs., Inc. v. Knight Petroleum Co.*, 849 S.E.2d 538, 543–44 (Ga. Ct. App. 2020) (internal citation omitted).

130. *See id.* at 544.

131. *Id.* (quoting *Futch v. Lowndes County*, 676 S.E.2d 892, 896 (Ga. Ct. App. 2009)).

132. *See Wisconsin Auto Title Loans, Inc. v. Jones*, 714 N.W.2d 155, 163 (Wis. 2006).

133. *Saks Mgmt. & Assocs., L.L.C. v. Sung Gen. Contracting, Inc.*, 849 S.E.2d 19, 27 (Ga. Ct. App. 2020).

134. *E.g., Small v. Fritz Cos., Inc.*, 65 P.3d 1255, 1258 (Cal. 2003).

135. *Id.* at 1262.

routinely resolved by triers of fact in civil litigation. It cannot justify a blanket rule of nonliability.

...

There are, moreover, strong countervailing policy arguments in favor of allowing a holder's cause of action. "California . . . has a legitimate and compelling interest in preserving a business climate free of fraud and deceptive practices."<sup>136</sup>

This statement of public policy properly recognizes that a business ordinarily has the power of information in a consumer transaction, but again focuses on intentional acts of deception.

However, a patient consumer may not be able to evaluate the risks and costs of medical care in advance to the same degree as a purchaser of other high cost products or services, such as real estate<sup>137</sup> or construction services.<sup>138</sup> Due diligence is nearly impossible for a patient consumer who has not been provided with an estimate of charges or an accurate rate structure. For this reason, plaintiffs unable to negotiate on healthcare billing matters may then resort to unconscionability claims, addressing not only lack of transparency but unreasonable pricing, as well. After conducting an in depth review of published charge-master rates, one health tech data scientist summed up the problem as follows: "While greater price transparency in healthcare can improve consumers' ability to shop around, it will not solve the central problem of affordability."<sup>139</sup>

#### V. UNCONSCIONABILITY CLAIMS IN AN AGE OF CONSUMER PROTECTION

The common law doctrine of unconscionability is longstanding, but it serves as an exception to core tenets of the law of contract. As

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136. *Id.* at 1264.

137. *See* *Trico Env't Servs., Inc. v. Knight Petroleum Co.*, 849 S.E.2d 538, 544 (Ga. Ct. App. 2020) (acknowledging the "equal opportunity" for a vendor and purchaser of real property to determine the location of a sewer line).

138. *Saks Mgmt.*, 849 S.E.2d at 23 (addressing reliance on a contractual promise to complete construction services by a date certain).

139. *Rodrigues-Craig*, *supra* note 13.

Professor Charles Fried lyrically stated, if society is to avoid “a jungle of unrestrained self-interest . . . there must exist a ground for mutual confidence deeper than and independent of the social utility it permits.”<sup>140</sup> That is, to ensure effective transactions, good will and common ideals are not enough—contracts between persons must be enforceable. Legal exceptions to this basic principle do permit the forgiveness of contract obligations, often debated as an issue of public morality. For example, the 1960s transformation of bankruptcy law and the 1990s effort to tie a work requirement to welfare benefits demonstrated the public tension between providing needed assistance and encouraging a lack of fidelity to enforceability of contract.<sup>141</sup> Nevertheless, when the bargain is simply too skewed in favor of one party and what is bargained for is key, the exceptions to contract enforcement remain undeniably vital.

This is the case with healthcare services today. Even if the courts employ the doctrine of unconscionability in only the exceptional case, it will contribute to a needed market correction alongside other approaches by the legislative branch.<sup>142</sup> Moreover, to bolster the court’s reach in unconscionability claims, the fiduciary relationship of the medical provider and health system to the patient consumer should be expanded to include the business side of the transaction, reinforcing a duty to set a reasonable price and to ensure transparency in billing. While the reluctance of state courts to employ the unconscionability doctrine in hospital billing cases will be laid out below, the concluding words of the Federal District Court of New Jersey should be kept in mind:

While the Court recognizes the Third Circuit’s reluctance to wade into the morass of the costs of health care in the United States . . . , the Court reads Plaintiffs’ claims here not as a generalized challenge to public policy issues of affordability of health care better left to the legislature,

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140. FRIED, *supra* note 114, at 17.

141. DAVID A. SKEEL, JR., *DEBT’S DOMINION: A HISTORY OF BANKRUPTCY LAW IN AMERICA* 191 (2001).

142. See Frank P. Darr, *Unconscionability and Price Fairness*, 30 *HOUS. L. REV.* 1819, 1823 (1994).

but rather as claims sounding in unfair business practices and breach of contract[.]<sup>143</sup>

A. *The Doctrine of Unconscionability Applied to Transparency and Price*

The doctrine of unconscionability as a common law defense stands as an exception to freedom of contract and the obligations of parties who choose to sign binding documents.<sup>144</sup> Whether facts found by the trial court render a contractual provision unconscionable is reviewed *de novo* as a question of law.<sup>145</sup> Since its origin, unconscionability has been “an equitable doctrine, rooted in public policy, which allows courts to render unenforceable an agreement that is unreasonably favorable to one party while precluding a meaningful choice of the other party.”<sup>146</sup> Unconscionability does not arise simply because the parties are unequal in bargaining position,<sup>147</sup> but rather “[t]he principle is one of the prevention of oppression and unfair surprise.”<sup>148</sup>

Granted, the law of contract is founded in concepts of liberty and freedom, where limitations such as the unconscionability doctrine are the exception and not the norm:

The right of competent persons to make contracts and thus privately to acquire rights and obligations is a basic part of our general liberty. This ability to enter and enforce contracts is universally thought not only to reflect and promote liberty, but as well to promote the production of wealth. Thus, the right to make and enforce contracts is elemental in our legal order. But not every

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143. *Leslie v. Quest Diagnostics, Inc.*, 2019 WL 4668140, at \*8 (D.N.J. 2019).

144. *James v. Nat'l Fin., L.L.C.*, 132 A.3d 799, 812 (Del. Ch. 2016); *see also* RESTATEMENT (SECOND) OF CONTRACTS § 208 cmt. B (AM. L. INST. 1981) (citing *U.S. v. Hume*, 132 U.S. 406, 411 (1889)). For a succinct history of the development of the doctrine of unconscionability and its early common law roots, see *Ryan v. Weiner*, 610 A.2d 1377, 1381 (Del. Ch. 1992).

145. *See Wisconsin Auto Title Loans, Inc. v. Jones*, 714 N.W.2d 155, 163 (2006).

146. *State ex rel. King v. B&B Inv. Grp., Inc.*, 329 P.3d 658, 670 (N.M. 2014).

147. RESTATEMENT (SECOND) OF CONTRACTS § 208 cmt. d (AM. L. INST. 1981).

148. *State ex rel. King*, 329 P.3d at 673 (emphasis and citation omitted).



writing purporting to contain a promise or every document purporting to make a transfer will be given legal effect.<sup>149</sup>

Early American courts in the 1800s were reluctant to provide equitable relief to avoid contract enforcement where public policy was more concerned with affirming agreed upon terms and “the rugged individual’s” ability to enter confidently into a free market.<sup>150</sup> Only certain individuals even had that right throughout early American history, where persons subject to enslavement, married women, and many others had few, if any, contract rights.<sup>151</sup>

By the end of the nineteenth century, the unprecedented wealth among the industrialists of the new corporate structures, and the complexity and rise of middle men, further diminished individual freedom of contract.<sup>152</sup> For a limited number of contracts involving fiduciary relationships, contracts *uberrimae fidei*, the courts continued to protect an obligation of good faith and a requirement to disclose facts affecting the contract.<sup>153</sup> In this Gilded Age, standardized contracts, lack of choice, lack of understanding, monopolies, and harsh terms, all accompanied unemployment, housing, and health concerns for those suffering under disparate conditions.<sup>154</sup> It is no surprise that our current economic climate in the Digital/Information Age has been compared to the excesses and division of wealth in the Industrial Age.<sup>155</sup>

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149. Ryan v. Weiner, 610 A.2d 1377, 1380 (Del. Ch. 1992) (providing examples of fraudulent misrepresentation, lack of legal capacity, or the existence of duress as justifiable legal limitations on the enforceability of contracts).

150. KEVIN M. TEEVEN, A HISTORY OF THE ANGLO-AMERICAN COMMON LAW OF CONTRACT 186 (1990).

151. See generally David P. Weber, *Restricting the Freedom of Contract: A Fundamental Prohibition*, 16 YALE HUM. RTS & DEV. L.J. 51 (2013); Rebecca E. Zietlow, *Slavery, Liberty, and the Right to Contract*, 19 NEV. L.J. 447 (2018).

152. TEEVEN, *supra* note 150, at 291.

153. WILLIAM R. ANSON, PRINCIPLES OF THE LAW OF CONTRACTS § 233, at 267 (Thomas H. Patterson ed., Callaghan & Co. 1939) (1887).

154. TEEVEN, *supra* note 150, at 294–95.

155. E.g., Tom Wheeler, *Who Makes the Rules in the New Gilded Age? Lessons from the Industrial Age Inform the Information Age*, BROOKINGS (Dec. 12, 2018), <https://www.brookings.edu/research/who-makes-the-rules-in-the-new-gilded-age/>; David Huyssen, *We Won't Get Out of the Second Gilded Age the Way We Got Out of the First*, VOX (Apr. 1, 2019, 8:30 AM) <https://www.vox.com/first-person/2019/4/1/18286084/gilded-age-income-inequality-robber-baron>.

In addition to its common law roots, unconscionability appears in the Uniform Commercial Code (“UCC”), which states that a court may refuse to enforce a contract for the sale of goods if it finds as a matter of law that “any clause of the contract” is unconscionable, or “it may so limit the application of any unconscionable clause as to avoid any unconscionable result.”<sup>156</sup> The drafting of an unconscionability provision in the UCC in the 1940s appears to have been a response to mass standardized transactions, placing what had been a matter of equity directly into the common law.<sup>157</sup> Karl Llewellyn, one of its drafters, described it as “perhaps the most valuable section in the entire Code.”<sup>158</sup>

Today, a number of state consumer protection statutes specifically include unconscionability as a basis of a claim.<sup>159</sup> For example, in 2015, North Dakota added an element of unconscionability as a prohibited business practice, in addition to its existing prohibition against deceptive business practices.<sup>160</sup> The precepts of the common law doctrine are very much alive in the modern age of consumer protection.

Although in contract disputes it serves as a claim of last resort, its impact could be significant. If a court should uphold an unconscionability claim, potential remedies generally include voiding the contract, excising the unconscionable clause or term, or limiting the offending

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156. U.C.C. § 2-302(1) (AM. LAW INST. & UNIF. LAW COMM’N 1977).

157. See E. ALLAN FARNSWORTH, FARNSWORTH ON CONTRACTS, § 4.28, at 577 (3d ed. 2004); TEEVEN, *supra* note 150, at 317.

158. FARNSWORTH, *supra* note 157, at 578. For a critical review of the adoption of the provision, see Arthur Allen Leff, *Unconscionability and the Code—The Emperor’s New Clause*, 115 U. PA. L. REV. 485, 558 (1967) (arguing that section 2-302 has “no reality referent, and all of its explanatory material ranges between the irrelevant and the misleading”).

159. See NAT’L CONSUMER L. CTR., CONSUMER PROTECTION IN THE STATES: A 50-STATE EVALUATION OF UNFAIR AND DECEPTIVE PRACTICES LAWS 1 (2018), <https://www.nclc.org/images/pdf/udap/udap-report.pdf>.

160. N.D. CENT. CODE § 51-15-02 (2019) (unfair trade practices law) (“The act, use, or employment by any person of any act or practice, in connection with the sale or advertisement of any merchandise, which is unconscionable or which causes or is likely to cause substantial injury to a person which is not reasonably avoidable by the injured person and not outweighed by countervailing benefits to consumers or to competition, is declared to be an unlawful practice.”). This added provision was enacted in 2015. See 2015 N.D. Laws 350.

clause.<sup>161</sup> There is also a risk of disincentivizing medical providers from providing non-emergent care to the uninsured, to whom they have no obligation to treat,<sup>162</sup> should unconscionability claims prevail more regularly. For example, if an uninsured patient consumer cannot pay for medical care, a court could find that the contract for services was unconscionable if the provider did not believe there was a reasonable probability that the patient could perform the contract but proceeded to send the bill to debt collection.<sup>163</sup> But perhaps this is as it should be, for charitable care should be charitably given.

To better support patients faced with exorbitant and misleading chagemaster rates, unconscionability can serve as an important common law doctrine that would address both the need for transparency and fairness in pricing. As such, the doctrine presents as both a procedural and substantive issue.<sup>164</sup> Procedural unconscionability reflects the lack of autonomy and informed consent that interferes with the transactional process.<sup>165</sup> Substantive unconscionability has deeper common law roots, in both Roman law and medieval concepts of a “just price.”<sup>166</sup> Neither requires the scienter of wrongdoing that accompanies a RICO claim for fraud or negligent misrepresentation. Thus, the doctrine of unconscionability bears greater resemblance to modern consumer protection statutes than to other common law claims.

That no one factor will create *per se* unconscionability in a contract lends itself to varied interpretation. However, the presence of an adhesion or adhesive contract is a strong consideration for procedural unconscionability. In the arbitration unconscionability arena, more courts are finding that consumers who are asked to “flip through and sign” forms without explanation are not given a meaningful

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161. See Susan Landrum, *Much Ado About Nothing?: What the Numbers Tell Us About How State Courts Apply the Unconscionability Doctrine to Arbitration Agreements*, 97 MARQ. L. REV. 751, 764 (2014).

162. See *supra* notes 67–69 and accompanying text.

163. See *Gulfc0 of Louisiana, Inc. v. Brantley*, 430 S.W.3d 7, 13 (Ark. 2013) (affirming a finding that a mortgage lender’s action in foreclosure was unconscionable when it knew that borrowers were incapable of making mortgage payments).

164. FARNSWORTH, *supra* note 157, at 583.

165. WERTHEIMER, *supra* note 115, at 41.

166. *Id.* (explaining the Roman law principle of *laesio ultra dimidium vel enormis*, which allowed a contract to be set aside if a party received less than half the market value of what was exchanged).

opportunity to understand the terms of the arbitration provision in a contract before signing.<sup>167</sup> Many patient consumers likely complete medical billing paperwork in a similar manner. Adhesion contracts are generally enforceable, however, and have been described by the courts as “indispensable facts of modern life,”<sup>168</sup> if only to a point.

The significance of the impact on the weaker party matters in the analysis. For example, a contract is more likely to be adhesive if it relates to an oppressive employment contract, where an employee must agree to all terms to retain his or her position.<sup>169</sup> Similarly, a medical patient has much to lose in terms of personal health, economic pressures, and the potential impact of disability on employment if the patient opts out of medical care. The problem is a lack of meaningful choice.<sup>170</sup>

More numerous than hospital billing cases, arbitration clause cases provide a typical example of how state courts have addressed the doctrine of unconscionability in recent years.<sup>171</sup> For example, in *Wisconsin Auto Title Loans, Inc. v. Jones*, the Supreme Court of Wisconsin held that an arbitration provision was invalid based on both procedural and substantive unconscionability.<sup>172</sup> Procedurally, the Court identified the imbalance between the parties in the negotiating process:

Wisconsin Auto Title Loans was in the business of providing loans with automobile titles as collateral and was experienced in drafting such loan agreements;

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167. *Swain v. LaserAway Med. Grp., Inc.*, 270 Cal. Rptr. 3d 786, 792 (2020); see also *Baltazar v. Forever 21, Inc.*, 367 P.3d 6, 12 (Cal. 2016) (exemplifying an adhesion contract as a standardized contract on a prolix pre-printed form, offered by the party with superior bargaining power “on a take-it or-leave-it basis”).

168. *OTO, L.L.C. v. Kho*, 447 P.3d 680, 702 (Cal. 2019) (Chin, J., dissenting) (quoting *Gentry v. Superior Court*, 165 P.3d 556, 469 (Cal. 2007)).

169. *Id.* at 691 (majority opinion) (describing an employment contract as “a paragon of prolixity, only slightly more than a page long but written in an extremely small font”).

170. *Cf. Song fi, Inc. v. Google, Inc.*, 72 F. Supp. 3d 53, 62–63 (D.D.C. 2015) (holding that plaintiffs’ lack of bargaining power did not render the contract for video-hosting services procedurally unconscionable where the terms were clear and plaintiffs had a meaningful choice to opt not to contract).

171. See, e.g., Landrum, *supra* note 161; Charles L. Knapp, *Blowing the Whistle on Mandatory Arbitration: Unconscionability as a Signaling Device*, 46 SAN DIEGO L. REV. 609 (2009).

172. 714 N.W.2d 155, 176 (Wis. 2006) (applying WIS. STAT. § 425.107 (2006)).

Wisconsin Auto Title Loans was in a position of substantially greater bargaining power than the borrower; the borrower was indigent and in need of cash; and the loan agreement was an adhesion contract presented to the borrower on a take-it-or-leave-it basis.<sup>173</sup>

As a substantive matter of unconscionability, the Court was concerned with the “broad, one-sided, unfair” term in the loan agreement which subjected the borrower to an arbitration restriction but allowed Wisconsin Auto Title Loans “full access to the courts, free of arbitration.”<sup>174</sup>

In addition to its analysis of the common law unconscionability doctrine, the court also took into account that the Wisconsin Legislature had laid out several related factors in its consumer protection statute:

- (a) That the practice unfairly takes advantage of the lack of knowledge, ability, experience or capacity of customers;
- (b) That those engaging in the practice know of the inability of customers to receive benefits properly anticipated from the goods or services involved;
- (c) That there exists a gross disparity between the price of goods or services and their value as measured by the price at which similar goods or services are readily obtainable by other customers, or by other tests of true value;
- (d) That the practice may enable merchants to take advantage of the inability of customers reasonably to protect their interests by reason of physical or mental infirmities, illiteracy or inability to understand the language of the agreement, ignorance or lack of education or similar factors;
- (e) That the terms of the transaction require customers to waive legal rights;
- (f) That the terms of the transaction require customers to unreasonably jeopardize money or property beyond the

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173. *Id.* at 178.

174. *Id.* at 160.

money or property immediately at issue in the transaction;

(g) That the natural effect of the practice would reasonably cause or aid in causing customers to misunderstand the true nature of the transaction or their rights and duties thereunder;

(h) That the writing purporting to evidence the obligation of the customer in the transaction contains terms or provisions or authorizes practices prohibited by law; and

(i) Definitions of unconscionability in statutes, regulations, rulings and decisions of legislative, administrative or judicial bodies.<sup>175</sup>

The State of Delaware more broadly defines the vulnerability factors seen in (a) and (d) above in addressing unconscionability: “exploitation of the underprivileged, unsophisticated, uneducated and the illiterate.”<sup>176</sup> Clearly, this interpretation is more akin to protection of the least sophisticated consumer standard than the reasonable consumer standard.<sup>177</sup>

To support a claim for unconscionability, many jurisdictions require a showing of both procedural and substantive unconscionability. The State of California, for example, requires this, but not in equal measure:

[T]he more substantively oppressive the contract term, the less evidence of procedural unconscionability is required to conclude that the term is unenforceable. Conversely, the more deceptive or coercive the bargaining tactics employed, the less substantive unfairness is required. . . . The ultimate issue in every case is whether the terms of the contract are sufficiently unfair, in view

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175. See WIS. STAT. ANN. § 425.107(3) (2020); *Id.* at 164 n.15.

176. *James v. Nat'l Fin., L.L.C.*, 132 A.3d 799, 815 (Del. Ch. 2016) (internal citation omitted).

177. See *supra* note 92 and accompanying text, discussing statutory expectations of consumer due diligence.

of all relevant circumstances, that a court should withhold enforcement.<sup>178</sup>

Scholars have debated whether early interpretations of unconscionability in equity court would have required not only unfair practices generally, but also some kind of wrongdoing in the bargaining process, such as an abuse of fiduciary relationship.<sup>179</sup> However, today there appears to be cohesion of analysis in state courts in requiring either substantive or procedural unconscionability, or both.<sup>180</sup> Indeed, commentary in the *Restatement (Second) of Contracts* makes the astute point that inadequacy of consideration and gross disparity in the values exchanged might inherently indicate defects in the bargaining process.<sup>181</sup>

Between the two forms, contemporary courts are more likely to find procedural unconscionability rather than substantive, “such as arm’s-length transactions or ‘standard form’ contracts, which are allegedly unconscionable not because there is an abuse of bargaining, but because there is no bargaining at all.”<sup>182</sup> For example, the California Supreme Court has held that an airplane travel insurance policy was unconscionable in part because the method of sale did not permit the purchaser to read the contract prior to signing.<sup>183</sup> Regarding substantive unconscionability claims, courts are more likely to find substantive

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178. *OTO, L.L.C. v. Kho*, 447 P.3d 680, 690 (Cal. 2019) (internal quotation marks and punctuation omitted); *see also Nat’l Fin.*, 132 A.3d at 815 (explaining that the requirement of both substantive and procedural unconscionability is a “unitary” analysis, rather than a two-prong test, where “if more of one is present, then less of the other is required”).

179. *Compare TEEVEN*, *supra* note 150, at 185 (assuming that unfairness in pricing was not a concern where bargains “set the price”), *and WERTHEIMER*, *supra* note 115, at 43, *and ANSON*, *supra* note 153, at 301 n. 40 (relating, in this 1887 treatise, the doctrine of unconscionability in equity to that of undue influence), *with Baxter v. Wales*, 12 Mass. 365, 367 (1815) (holding that a contract price for the letting of cows was usurious, without evidence of fraud).

180. *See* RESTATEMENT (SECOND) OF CONTRACTS § 208 cmt. a (AM. L. INST. 1981) (“The determination that a contract or term is or is not unconscionable is made in the light of its setting, purpose and effect.”).

181. *Id.* § 208 cmt. c.

182. *See Ryan v. Weiner*, 610 A.2d 1377, 1381 (Del. Ch. 1992) (citing JOSEPH STORY, COMMENTARIES ON EQUITY JURISPRUDENCE, §§ 244–46 (1835)); *WERTHEIMER*, *supra* note 115, at 43.

183. *Steven v. Fid. & Cas. Co.*, 377 P.2d 284, 298 (Cal. 1962).

unconscionability in matters of disproportionate contract terms, such as a one-sided arbitration clause, than for an exorbitant price charged when consumer products allow for negotiation in pricing.<sup>184</sup> But unconscionability based solely on substantive unconscionability, such as plainly oppressive pricing, is still considered a valid basis under the *Restatement (Second) of Contracts* and applied as such by the courts.<sup>185</sup> The requirement is not about “a simple, old-fashioned bad bargain” but with terms “so one-sided as to shock the conscience.”<sup>186</sup> This may include “fine-print terms, unreasonably or unexpectedly harsh terms regarding price or other central aspects of the transaction, and terms that undermine the nondrafting party’s reasonable expectations.”<sup>187</sup>

But courts applying state law in the last decade have faltered in applying the doctrine of unconscionability to hospital billing cases, due in large part to their trust of the hospital’s given chargemaster rate. Several hospital billing cases since 2004 have addressed the issue of procedural unconscionability or breach of contract for a missing and definite price term, as well as substantive unconscionability for an exorbitant bill for medical care. Although some courts expressed sympathy for uninsured patients billed the chargemaster rate, many more declined to question the validity of a hospital’s chargemaster rate despite repeated legal claims and the outcry of consumer advocates.<sup>188</sup>

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184. See Darr, *supra* note 142, at 1823 (“[A] challenge based on a high price is difficult to conceive within the traditional contract rules.”); WERTHEIMER, *supra* note 115, at 56 (“[T]here is often more explicit bargaining over price than over terms.”). *But see* FARNSWORTH, *supra* note 157, at 596 n.61 (noting that equity cases involving unconscionability prior to the UCC’s adoption “usually involved some judgment as to the inadequacy of the price”).

185. See FARNSWORTH, *supra* note 157, at 588 (referring to RESTATEMENT (SECOND) OF CONTRACTS § 208 cmt. c (AM. L. INST. 1981)); ANSON, *supra* note 153 § 269, at 301.

186. OTO, L.L.C. v. Kho, 447 P.3d 680, 693 (Cal. 2019).

187. *Id.*

188. See, e.g., DiCarlo v. St. Mary Hosp., 530 F.3d 255, 264 (3d Cir. 2008); Banner Health v. Med. Sav. Ins. Co., 163 P.3d 1096 (Ariz. Ct. App. 2007), *rev. denied*, 2008 Ariz. LEXIS 12 (Ariz. Jan. 8, 2008); Centura Health Corp. v. French, No. 19CA0023, 2020 WL 2759685 (Colo. Ct. App. May 28, 2020); Allen v. Clarian Health Partners, Inc., 980 N.E.2d 306 (Ind. 2012); Holland v. Trinity Health Care Corp., 791 N.W.2d 724 (2010); Limberg v. Sanford Med. Ctr. Fargo, 881 N.W.2d 658 (N.D. 2016); Pitell v. King County Pub. Hosp. Dist. No. 2, 423 P.3d 900 (Wash. Ct. App. 2018).



For example, the Supreme Court of Indiana held that “[i]n the context of contracts providing for health care services, . . . precision concerning price is ‘close to impossible,’ [thus,] a hospital’s chargemaster rates serve as the basis for its pricing, and they are unique because they are set by each hospital.”<sup>189</sup> Similarly, in 2020, the Colorado Court of Appeals reversed the decision of the trial court, where the jury had questioned the reasonableness of the chargemaster rate, agreeing instead with the defendant hospital that “most jurisdictions hold that a hospital-patient agreement requiring a patient to pay ‘all charges’ (or similar language) unambiguously refers to a hospital’s chargemaster rates.”<sup>190</sup>

Patient advocates would disagree. As one put bluntly:

A hospital’s chargemaster is an archaic fiction, a way previously used to allocate the joint and common costs of the hospital to particular services. It does not serve as the basis for how much a hospital is paid by Medicare. It does not serve as the basis for how much a hospital is paid by Medicaid. It does not serve as the basis for how much a hospital is paid by private insurers.<sup>191</sup>

With respect to transparency and procedural unconscionability, the CEO of the Health Care Cost Institute, has also criticized the accuracy of public disclosure of chargemaster rates, concluding: “You have to start somewhere on transparency, but these charges are not indicative of what anyone really pays for hospital services other than Saudi Arabian kings[.]”<sup>192</sup> In support of substantive unconscionability claims, one researcher found that hospital chargemaster rates in California for the most common services were at least 10 times the Medicare reimbursement rates, and laboratory work was charged up to 100 times the Medicare rate.<sup>193</sup>

A point of contention is how to determine what is a customary and reasonable fee for medical services. In *Bowden v. Medical Center, Inc.*, the Supreme Court of Georgia held that the average cost of other

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189. *Allen*, 980 N.E.2d at 310.

190. *Centura Health Corp.*, 2020 WL 2759685 at ¶ 21.

191. *Levy*, *supra* note 13.

192. *Meyer*, *supra* note 10.

193. *Rodrigues-Craig*, *supra* note 13.

patients' bills for similar services is not dispositive in defining a reasonable cost of care.<sup>194</sup> "[T]here is no 'one size fits all' answer to the question of what may or may not constitute a reasonable charge for each individual patient in the purported class here."<sup>195</sup> While standards may vary depending on the nature of the claim, a variety of claims have considered reasonableness in the context of the chargemaster rate.

In the hospital lien cases in which a hospital seeks reimbursement as a third-party in a tort action, even *Bowden* acknowledged that the chargemaster rate was not misleading as a starting point, while contemplating that it could be reduced if "ultimately" found unreasonable at trial.<sup>196</sup> To reach this decision, the Supreme Court of Georgia in *Bowden* overruled two lower court decisions which gave weight to criticism of the chargemaster rate to the extent that they would have allowed the fraud, negligent misrepresentation, and state RICO claims to survive a motion to dismiss.<sup>197</sup> One was *Clouthier v. Medical Center of Central Georgia*, where the court noted that there was evidence in the pleading that the hospital typically accepted as full payment only 29% of the full chargemaster rate.<sup>198</sup>

When reviewing rulings on discovery motions, several jurisdictions have readily granted discovery on the average discounted rate given to those with public and private insurance in order to support a claim that the chargemaster rate billed was excessive and unreasonable.<sup>199</sup> The Supreme Court of Texas was unusual in acknowledging the basis of the critics' concerns as it allowed discovery on the average rate of actual payment:

Commentators lament the increasingly arbitrary nature of chargemaster prices, noting that, over time, they have "lost any direct connection to costs or to the amount the hospital actually expect[s] to receive in exchange for its

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194. 845 S.E.2d 555, 562 (Ga. 2020).

195. *Id.* at 563.

196. *Id.* at 565.

197. *Id.* (overruling *Clouthier v. Med. Ctr. of Cent. Ga., Inc.*, 833 S.E.2d 584 (Ga. Ct. App. 2019) and *Aguila v. Kennestone Hosp., Inc.*, 836 S.E.2d (Ga. Ct. App. 2019)).

198. 833 S.E.2d at 589.

199. *E.g.*, *Taylor v. Kilmer*, No. 18 CV 7403, 2020 WL 606781 (N.D. Ill. 2020); *Parkview Hosp., Inc. v. Frost*, 52 N.E.3d 804 (Ind. Ct. App. 2016); *In re N. Cypress Med. Ctr. Operating Co.*, 559 S.W.3d 128 (Tex. 2018).

goods and services.” Yet hospitals have incentive to continue raising chargemaster prices because of the positive correlation between those prices and hospital revenue.<sup>200</sup>

In one of the earlier cases, the Southern District of Florida in *Colomar v. Mercy Hospital, Inc.* also permitted evidence that the chargemaster rate may be unreasonable, laying out three factors in the analysis: “(1) an analysis of the relevant market for hospital services (including the rates charged by other similarly situated hospitals for similar services); (2) the usual and customary rate Mercy charges and receives for its hospital services; and (3) Mercy’s internal cost structure.”<sup>201</sup>

Judicial determination of reasonableness of the chargemaster rate may also be influenced by whether the contract is express or implied. In denying a motion to dismiss plaintiff’s breach of implied contract claim for missing the essential element of price for laboratory testing services, the Western District of New Jersey held in *Leslie v. Quest Diagnostis, Inc.* that plaintiffs should be able to present evidence of the unreasonableness of the chargemaster rate, for no reference was ever made to any standard rate.<sup>202</sup> The court distinguished the implied contract from written agreements where the patient agrees to pay “all charges” at the facility’s regular rates or its usual and customary terms, which it deemed served as an implied reference to the chargemaster rate.<sup>203</sup> Therefore, “Plaintiffs sufficiently allege that Quest’s chargemaster prices are unreasonable based on Quest’s internal cost structure, the usual and customary rates charged, and payments received for these services by both Quest and other laboratory testing services.”<sup>204</sup> What is remarkable is that in *Leslie* the inflating of charges billed was equivalent to that found in some of the worst usury cases for payday and

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200. *N. Cypress Med. Ctr.*, 559 S.W.3d at 132 (internal citations omitted).

201. *Colomar v. Mercy Hosp., Inc.*, 461 F. Supp. 2d 1265, 1269 (S.D. Fla. 2006).

202. No. CV-17-1590 (ES)(MAH), 2019 WL 4668140, at \*17–18 (D.N.J. 2019).

203. *Id.* at \*6.

204. *Id.* at \*7.

short term predatory lenders, for which courts have upheld substantive unconscionability claims.<sup>205</sup>

In *State ex rel. King v. B&B Investment Group, Inc.*, the Supreme Court of New Mexico reviewed a lower court decision which had determined that exorbitant interest rates in short term lending were not substantively unconscionable, in part because the legislature had not capped the rates or expressly indicated high rates were against public policy.<sup>206</sup> The Supreme Court of New Mexico held otherwise, explaining that “[r]uling on substantive unconscionability is an inherent equitable power of the court, and does not require prior legislative action.”<sup>207</sup> Importantly, the court referred to the state’s consumer protection statute, the Unfair Practices Act (“UPA”),<sup>208</sup> and likened the UPA’s prohibition and deterrent effect against unfair practices to that of unconscionability.<sup>209</sup>

The UPA is a law that prohibits the economic exploitation of others. The language of the UPA evinces a legislative recognition that, under certain conditions, the market is truly not free, leaving it for courts to determine when the market is not free, and empowering courts to stop and preclude those who prey on the desperation of others from being rewarded with windfall profits.<sup>210</sup>

Moreover, while the lower court had suggested that the plaintiff mother’s significant need for the loan to pay for groceries for her children should be considered, the Supreme Court of New Mexico dispatched with this by stating that “desperation” should not be a measure of the loan’s value.<sup>211</sup> Rather, it is the terms of the loan that determine unconscionability, not the use to which the loan is put.<sup>212</sup> This makes

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205. See *State ex rel. King v. B&B Invest. Grp., Inc.*, 329 P.3d 658, 670 (N.M. 2014) (holding that interest rates of 1,500 percent for fringe financial products such as payday and other short-term loans to be unconscionable, illegal and against public policy).

206. *Id.*

207. *Id.*

208. N.M. STAT. ANN. § 57-12-1 (2020).

209. *B&B Invest. Grp., Inc.*, 329 P.3d at 670.

210. *Id.* at 671.

211. *Id.*

212. *Id.*

good sense. A patient hospitalized with COVID-19 in dire need of critical care should not pay more for services because she is desperate for them or unable to take the time to negotiate.

That the ubiquity of a practice may make a one-sided transaction seem normative is problematic for patient consumers within the healthcare industry. Nevertheless, when a state court considers the ancient common law principles of equity and the entire modern schema of consumer protection laws, no industry or service provider should be exempt from having to deal fairly with consumers. To explain in human terms why this is so important, the Supreme Court of New Mexico stated:

The Legislature did not repeal all statutes protecting consumers from usurious practices: far from it, the Legislature empowered the Attorney General and private citizens to fight unconscionable practices through the UPA; it ratified the court's inherent equitable power to invalidate a contract on unconscionability grounds under the UCC; it maintained a prohibition on excessive charges and set a reasonable default interest rate of 15 percent under the Money Act; and it set a de facto interest rate cap on substantively identical types of loans with the 2007 amendments to the Small Loan Act. Contrary to Defendants' contention that the repeal of the interest rate cap demonstrates a public policy in favor of unlimited interest rates, the statutes when viewed as a whole demonstrate a public policy that is consumer-protective and anti-usurious as it always has been. A contrary public policy that permitted excessive charges, usurious interest rates, or exploitation of naive borrowers would be inequitable, particularly in New Mexico where a greater percentage of people are struggling in poverty, and where more households are unbanked and underbanked than almost anywhere in the nation.<sup>213</sup>

The enactment of consumer protection statutes has not usurped the role of the court in determining unconscionability. It has strengthened the court's traditional equitable role in reviewing these claims.

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213. *Id.* at 674.

Indeed, that role has always been important as long as there have been businesses and professions seeking to take unfair advantage of the consumer.

An early review of pricing unconscionability cases 25 years ago revealed that the court could serve an important role in both market efficiency and consumer protection:

In some cases, . . . market enforcement may be ineffective due to the lack of market mechanisms to assure that the gouger is policed. In those cases, the courts may serve as a market surrogate and police prices in conformity with existing notions of price fairness. . . . Indeed, the close correlation between price unconscionability and judicial enforcement of pricing norms in the successful price unconscionability cases suggests an implicitly recognized need for judicial enforcement.<sup>214</sup>

Of course, consumers also wish to take advantage of businesses and other parties at times. In an interesting series of state cases assessing the collateral source rule, patients have been promoting the chargemaster rate in order to increase the assessment of medical damages, not against hospitals, but against defendant tortfeasors who allegedly caused their injuries.<sup>215</sup> Under the common law collateral source rule, the value of reasonable medical expenses that an injured plaintiff would be entitled to recover in compensatory damages may not be reduced by insurance payments or other compensation received from third parties.<sup>216</sup> Such efforts by consumers to take advantage of hospital rate structures cannot compare in weight to the power that hospitals and health systems have over individual patients when generating and negotiating bills for treatment.

### *B. A Fiduciary Duty Within the Business of Health Care*

As discussed above, when parties are presumed to be capable of mutual understanding and assent to the terms of a contract,

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214. Darr, *supra* note 142, at 1823.

215. See, e.g., *Weston v. AKHappytime, L.L.C.*, 445 P.3d 1015 (Alaska 2019); *Verci v. High*, 161 N.E.3d (Ill. App. Ct. 2019); *Law v. Griffith*, 930 N.E.2d 126 (Mass. 2010).

216. *Griffith*, 930 N.E.2d at 131.

unconscionability is an exception allowing a significantly disadvantaged party to evade enforcement of the contract's terms.<sup>217</sup> However, if medical professionals were held to be in a fiduciary relationship with patient consumers, it would facilitate a judicial finding of unconscionability. Historically, courts have been more likely to find a contract to be unconscionable if there was a violation of fiduciary duty between the parties, as opposed to a contract involving a typical arm's-length commercial transaction.<sup>218</sup>

"Fiduciary relationship" is a legal term of art, focusing on relationships of inequality, where "complete trust has been placed by one party in the hands of another who has the relevant knowledge, resources, power, or moral authority to control the subject matter at issue."<sup>219</sup> Moreover, if a breach of fiduciary duty is found, additional remedies may be available in equity, such as punitive damages and restitution.<sup>220</sup> As the court held in *Moore v. Regents of the University of California*, plaintiffs may recover for breach of fiduciary duty if they can show that they would not have consented to the medical services had they known of a defendant physician's "personal interests unrelated to the patient's health, whether research or economic, that may affect his medical judgment."<sup>221</sup>

Many jurisdictions hold that physicians have a limited fiduciary relationship with patients, but the scope of the relationship is not settled.<sup>222</sup> Because they take the venerable ethical oath to "first, do no

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217. See *Davis v. M.L.G. Corp.*, 712 P.2d 985, 993 (Colo. 1986) (Lohr, J., concurring) ("Certainly, these [unconscionability claims] are not typical modes of analysis to be utilized in resolving most if not all contract disputes, and they should not be used, as the majority uses them here, as the starting point for analyzing any such dispute.").

218. WERTHEIMER, *supra* note 115, at 54 (citing the research of Daniel T. Ostas, *Predicting Unconscionability Decisions: An Economic Model and an Empirical Test*, 29 AM. BUS. L.J. 535 (1992)).

219. *In re Estate of Karmey*, 658 N.W.2d 796, 799 n.3 (Mich. 2003).

220. Furrow, *supra* note 4, at 441.

221. 793 P.2d 479, 485 (Cal. 1990).

222. See Hafemeister & Porter, *supra* note 87, at 548 (advocating for a physician-patient fiduciary relationship, but asserting that it did not historically exist); Joseph M. Healey, Jr. & Kara L. Dowling, *Controlling Conflicts of Interest in Doctor-Patient Relationship*, 42 MERCER L. REV. 989, 1002 (1991) (recommending an expansion of the physician-patient fiduciary relationship to recognize the duty of loyalty a physician owes to dependent patients).

harm,” translated from the Greek *primum non nocere*,<sup>223</sup> some jurisdictions have recognized that at least a limited fiduciary duty to the patient arises, such as a duty of confidentiality or a duty to disclose emergent medical needs observed by the physician during treatment.<sup>224</sup> However, in those jurisdictions that do not recognize such a fiduciary duty to the patient with respect to medical care, the rationale is that the relationship does not involve property,<sup>225</sup> in contrast to traditional fiduciaries such as financial advisors, trustees, executors, and attorneys. Of course, the services of attorneys do not always involve property, such as representing clients in child custody matters, but the fiduciary relationship is upheld, nonetheless.

Few courts have directly considered whether a medical provider or hospital should stand in a fiduciary relationship with respect to billing and the costs of care. The Michigan Court of Appeals refused to establish such a fiduciary relationship, asserting that the limited scope of a physician or hospital’s fiduciary duty is related to medical care only.<sup>226</sup> However, for the consumer, the cost of healthcare is equivalent if not more than that charged by other professionals who are subject to fiduciary duties. If medical ethics were broadened to ensure loyalty and fairness to the patient financially, there would be a number of existing models to follow.

Subject to the American Bar Association’s Model Rules of Professional Conduct, attorneys as fiduciaries are responsible for the conduct of non-legal staff, such as accountants and billing managers.<sup>227</sup> In the attorney-client relationship, not all services directly involve property, such as criminal defense or child custody and adoption, and yet

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223. See Schmerling, *supra* note 5.

224. See generally Maxwell J. Mehlman, *Why Physicians Are Fiduciaries for Their Patients*, 12 IND. HEALTH L. REV. 1 (2015); Hafemeister & Porter, *supra* note 87.

225. See Hafemeister & Porter, *supra* note 87, at 1188 n.110; E. Haavi Morreim, *Conflicts of Interest: Profits and Problems in Physician Referrals*, 262 J. AM. MED. ASS’N 390, 390–94 (1989) (explaining that some, but not all, courts and commentators regard physicians as having full fiduciary status).

226. *Holland v. Trinity Health Care Corp.*, 791 N.W.2d 724 (Mich. Ct. App. 2010).

227. *E.g.*, MODEL RULES OF PROF’L CONDUCT r. 5.3 cmt. 1 (AM. BAR ASS’N 2020) (requiring adoption by attorneys of measures that give “reasonable assurance that nonlawyers in the firm and nonlawyers outside the firm who work on firm matters act in a way compatible with the professional obligations of the lawyer”).



the relationship is clearly fiduciary.<sup>228</sup> Comment 11 to ABA Model Rule 1.6(b)(5) states: “A lawyer entitled to a fee for services rendered is permitted by paragraph (b)(5) to prove the services rendered in an action to collect it. This aspect of the rule expresses the principle that the beneficiary of a fiduciary relationship may not exploit it to the detriment of the fiduciary.”<sup>229</sup>

The Rules of Professional Conduct for attorneys also require that fees charged to clients be reasonable and that the basis and rate of the fee be communicated in writing to the client “before or within a reasonable time after commencing the representation.”<sup>230</sup> A trial court is bound to assess the reasonableness of attorney fees, considering hourly rates, type of practice, length of service, results obtained, experience of the legal practitioner, and the customary rates in the geographic area.<sup>231</sup> The United States Supreme Court has adopted the “lodestar” method of calculating reasonable attorney fees, in which the starting point for determining the amount of a reasonable fee is the number of hours reasonably expended on the litigation, multiplied by a reasonable hourly rate.<sup>232</sup> “Thus, a court is not bound by the prevailing attorney’s proposed hourly rate or by the bill submitted. The fee itself must be reasonable.”<sup>233</sup> Similarly, a court should not be bound by the hospital’s proposed chargemaster rate without further evaluation. If the American Bar Association can acknowledge the risk of financial exploitation of clients by attorneys, the American Medical Association can acknowledge the same risk of financial exploitation of patients by physicians.

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228. See *Ingeneri v. Ingeneri (In re Ingeneri)*, 321 B.R. 601, 604–05 (Bankr. D. Me 2005) (“When client property is entrusted to an attorney the attorney-client relationship, which would otherwise be a fiduciary relationship based upon special knowledge, skills, and expectations, becomes, in addition to that, a technical trust relationship.”).

229. ABA Comm. on Ethics & Prof’l Responsibility, Formal Op. 16-476 n.12 (2016) (Confidentiality Issues when Moving to Withdraw for Nonpayment of Fees in Civil Litigation).

230. MODEL RULES OF PROF’L CONDUCT r. 1.5(a)–(b) (AM. BAR ASS’N 2020).

231. See, e.g., *Tupelo Redevelopment Agency v. Gray Corp., Inc.*, 972 So. 2d 495, 520 (Miss. 2007) (applying Mississippi’s Rules of Professional Conduct rule 1.5(a)).

232. See *Murphy v. Smith*, 138 S. Ct. 784, 789 (2018).

233. *Delta Airlines, Inc. v. August*, 450 U.S. 346, 365 (1981) (Powell, J., concurring).

However, it makes good sense that if a professional is a fiduciary based on the type of service provided that the same professional should be a fiduciary with respect to the fees charged for that service. Wertheimer suggests that a professional context lends itself to a fiduciary relationship of loyalty and trust to the party served, “where the quality of the professional’s service is one that the consumer cannot easily or successfully monitor or in cases where it is predictable that strong emotions, such as fear or grief, will distort one’s judgment.”<sup>234</sup> This easily describes the position of the patient consumer about to sign an agreement for payment of hospital services. Medical services are given the imprimatur of professional licensure and status in part because those who need services are so vulnerable.

The medical profession should not ignore its potential detrimental impact on patients who have little say in the medical billing contract, but they can under their ethical code, just as they can refuse to treat most patients if they wish.<sup>235</sup> The American Medical Association Code of Medical Ethics provides that “[t]he health and well-being of patients depends on a collaborative effort between patient and physician in a mutually respectful alliance.”<sup>236</sup> Among the enumerated principles respecting patient rights, only the following expressly mentions financial transparency:

To receive information from their physicians and to have [an] opportunity to discuss the benefits, risks, and costs of appropriate treatment alternatives, including the risks, benefits and costs of forgoing treatment. Patients should be able to expect that their physicians will provide guidance about what they consider the optimal course of action for the patient based on the physician’s objective professional judgment.<sup>237</sup>

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234. WERTHEIMER, *supra* note 115, at 274.

235. See Maxwell J. Mehlman, *The Oregon Medicaid Program: Is It Just?*, 1 HEALTH MATRIX 175, 178 (1991).

236. Am. Med. Ass’n, Ethics Op. Ethics Op. 1.1.3 (2017).

237. *Id.* at 1.1.3(b).

However, the Code of Medical Ethics also addresses access to healthcare, frequently an issue of cost, but only as an “ethical responsibility” rather than a right.<sup>238</sup>

Hospital and healthcare system administration is big business and must contend with the profit culture of the corporate world.<sup>239</sup> Harvard Business School Professor Joshua Margolis has posited: “If companies are instruments that advance social welfare when leaders focus on economic returns, and medicine is based on a commitment to patients and their health, can both be honored in how leaders run health-related businesses? Yes.”<sup>240</sup> He aptly suggests that a tailored fiduciary duty with respect to healthcare administration and patient costs could guide these powerful entities toward a more constructive approach to the tension between care and cost.<sup>241</sup>

Rigorous protection for indigent members of society already exists in the legal profession. For example, recent attention to the scope of procedural due process rights regarding a trial court’s levy of fines and financial payment conditions against criminal defendants who have no ability to pay them has resulted in successful constitutional claims, as well as arguments of professional ethics violations.<sup>242</sup> In *People v. Kopp*, a decision currently under review, the California Court of Appeals held that a defendant was permitted to contest payment of restitution and punitive fees pursuant to federal and state excessive fines

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238. See *id.* at 11.1.4 (“As professionals, physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care regardless of their economic means.”).

239. See *Lewis v. Physicians Ins. Co.*, 627 N.W.2d 484, 493 (Wis. 2001) (“In essence, hospitals have become big business, competing with each other for health care dollars.”).

240. Joshua D. Margolis, *Professionalism, Fiduciary Duty, and Health-Related Business Leadership*, 313 J. AM. MED. ASS’N 1819, 1819 (2015).

241. See *id.*

242. See David L. Hudson Jr., *Penalizing Poverty*, ABA J. 32, 33 (2020); David L. Hudson Jr., *Judges Must Consider Defendants’ Ability to Pay Fines and Fees, Ethics Opinion Says*, ABA J. (Mar. 24, 2020, 12:16 PM), <https://www.abajournal.com/news/article/ethics-opinion-490-judges-must-consider-defendants-ability-to-pay-fines-fees>; see also *Turner v. Rogers*, 564 U.S. 431, 435 (2011) (evaluating procedural fairness in matters of civil debt payment in criminal cases).

clauses.<sup>243</sup> Irrespective of any constitutional requirement, the court explained the underlying policy for its decision to require an ability-to-pay hearing for non-punitive fees, such as court facilities and operations fees: “These assessments are not punitive in nature, and, we agree that ‘imposing unpayable fines on indigent defendants is not only unfair, it serves no rational purpose, fails to further the legislative intent, and may be counterproductive.’”<sup>244</sup> Newly adopted Formal Opinion 490 to the Model Code of Judicial Conduct encourages judges to perform the duties of office fairly and impartially, including offering more transparency, advance notice, and a meaningful opportunity for litigants to be heard on ability-to-pay inquiries and hearings in both civil and criminal court.<sup>245</sup> Further, the rise in court fees and aggressive collection practices in the courts was identified as a response to budget cuts in the judicial system and an effort to inspire personal responsibility among litigants, but the Opinion put forth that the importance of these state interests is diminished when the litigant is “indigent or otherwise unable to pay.”<sup>246</sup>

This raises the question whether hospitals should send the unpaid medical bills of uninsured and underinsured patients to collections as a matter of course. But patient consumers lack the constitutional protections of the criminal defendant, and, of course, the comparative role of government financing of the legal and medical professions to support services to those without the ability to pay is a key related issue, but beyond the scope of this discussion. A critical care patient, even with health insurance, needs consumer protection from the first moment he or she seeks a diagnosis, including with respect to the financial costs of care. As one advocate convincingly stated:

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243. 38 Cal. App. 5th 47, 95 (2019), *cert. granted*, 451 P.3d 776 (Cal. 2019) (applying the Eighth Amendment of the U.S. Constitution and Article I, section 17, of the California Constitution).

244. *Id.*

245. ABA Comm. on Ethics & Prof'l Responsibility, Formal Op. 490 (2020) (Ethical Obligations of Judges in Collecting Legal Financial Obligations and Other Debts) (focusing on “the contempt power to collect unpaid civil debt by jailing or threatening to jail individuals without inquiry into their ability to pay, or using the contempt power to punish failure to appear at judgment debtor examinations by incarceration where bail on the warrant for contempt of court is set without inquiry into ability to pay and bail is automatically applied to satisfy the civil judgment.”).

246. *Id.*

Many [patients] are uncertain about the most prudent course of treatment and rely heavily on the suggestions and guidance of their primary-care provider or medical team. Such a highly charged, emotional setting is not one in which most people are prepared to make decisions about credit or financial services. There are few circumstances under which people feel more vulnerable than when they are being treated for illness or injury.<sup>247</sup>

A fiduciary duty that encompasses billing practices would help protect consumers by ensuring that medical professionals are bound by a duty of loyalty, which would also help physicians avoid the pitfalls of potential conflicts of interest in a lucrative profession.<sup>248</sup> For example, a recent study demonstrated that medical research professors at academic institutions experience inevitable conflicts of interest when they serve on pharmaceutical corporate boards, owing a fiduciary responsibility “to shareholders to promote the financial success of the company, which may conflict or compete with institutional oversight responsibilities and individual clinic and research practices.”<sup>249</sup> The annual compensation for such board members is substantial, with reported compensation in 2013 at \$309,500 (Eli Lilly), \$472,770 (Valeant Pharmaceutical), and \$557,172 (Allergan).<sup>250</sup> The Physician Payments Sunshine Act of 2014 may be yet another example of “open and unashamed” practices,<sup>251</sup> with little impact on healthcare costs for consumers.

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247. Rukavina, *supra* note 3, at 981–82.

248. Thomas L. Hafemeister & Joshua Hinckley Porter, *Don't Let Go of the Rope: Reducing Readmissions by Recognizing Hospitals' Fiduciary Duties to Their Discharged Patients*, 62 AM. U.L. REV. 513, 548 (2013) (“Fiduciary duties benefit patients and society as a whole because they both induce better medical judgment and empower physicians ‘to fully exercise their training and skills and . . . minimize financial incentives that might otherwise lead them to diminish and perhaps even abdicate their role in medical decision making.’”) (internal citations omitted).

249. See Timothy S. Anderson et al., *Academic Medical Center Leadership on Pharmaceutical Company Boards of Directors*, 311 J. AM. MED. ASS'N 1353 (2014).

250. *Id.* at 1353–54.

251. See Elizabeth Richardson, Health Policy Brief, *The Physician Payments Sunshine Act*, HEALTH AFFS. (Oct. 2, 2014),

As with other areas of consumer protection, consumers themselves would need to remain diligent as to care and costs, if they could,<sup>252</sup> particularly if greater transparency of costs is provided. In 1978, a physician penned a short letter to the editor of the Journal of the American Medical Association, responding to a published article titled *We Physicians Are Fiduciary Failures*:

Indeed, if we are to discharge our fiduciary relationship to the patient honorably, we should consider only that individual's physical, mental, and financial well-being rather than that of some third party. . . . [However, patients and their families] want no stone left unturned, the cost be damned, especially since someone else is paying the charges. Somehow the public seems to feel very cost conscious when insurance premiums are being discussed, but not when the discussion shifts to benefits.<sup>253</sup>

A fiduciary duty to the consumer patient does not relieve the patient, or any single entity in the complex transaction of healthcare services, of responsibility for an efficient and effective system. Nevertheless, physicians and health systems should bear a greater responsibility than the consumer as reflected in the balance of power in a fiduciary relationship. This is also the nature of the doctrine of unconscionability in contract law and modern consumer protection law where there is a risk of unduly harsh terms in a relatively one-sided transaction, of obvious concern in matters of financial exploitation by healthcare professionals with patient consumers who may be relatively unsophisticated, and also ill or in recovery.

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[https://www.healthaffairs.org/doi/10.1377/hpb20141002.272302/full/#:~:text=The%20Physician%20Payments%20Sunshine%20Act%20\(PPSA\)%2D%2Dalso%20known%20as,to%20physicians%20or%20teaching%20hospitals](https://www.healthaffairs.org/doi/10.1377/hpb20141002.272302/full/#:~:text=The%20Physician%20Payments%20Sunshine%20Act%20(PPSA)%2D%2Dalso%20known%20as,to%20physicians%20or%20teaching%20hospitals) (explaining that the Act is a component of the ACA, requiring public disclosure of payments by medical product manufacturers to physicians and teaching hospitals).

252. See *supra* notes 92–96 and accompanying text.

253. M.J. Wizenberg, Letter to the Editor, *Fiduciary Responsibility*, 240 J. AM. MED. ASS'N 1140, 1140 (1978) (responding to Markle, *supra* note 1).

## VI. CONCLUSION

Until basic, affordable universal healthcare is a reality in the United States, opaque and highly variable pricing of healthcare services will leave many Americans facing medical bills that could be the basis of a claim for unconscionability. That many state and federal courts in recent years have been unwilling to apply the doctrine of unconscionability in hospital billing cases is contrary to the historic equitable role of the courts, and contrary to the revival of tenets of unconscionability already emerging in modern consumer law. The judiciary need not wait for legislative price caps and mandated price disclosures when common law remedies in unconscionability remain at hand precisely for egregious cases, already enforced in other contexts against predatory lenders even in states, such as New Mexico, without usury statutes.

The courts should also consider application of fiduciary status to a hospital and health care provider's relationship to the patient with respect to billing and the costs of care, as they already do in other professions, such as the legal profession. This would facilitate the court's finding of unconscionability for exorbitant and inconsistent pricing of needed medical care, as is widely apparent in various published charge-master rates. Instead, the courts have treated the provider-patient relationship similar to relationships involving standard consumer transactions, in which the buyer should expect to have to negotiate on the price. But the average patient consumer does not perceive that a medical bill is a mere inflated sticker price meant to be negotiated down as if it were a used car. Patients are asked and expected to trust their healthcare providers, a principle repeatedly stated in the AMA Code of Medical Ethics.<sup>254</sup> To earn such trust, health systems need the courts to serve as an additional consumer watchdog.

Although CMS has implemented a new hospital billing transparency rule, and there is an incipient trend in statutory protections against unfair medical billing practices, patient consumers have yet to see any significant positive impact. The most obvious indicator of this is that medical debt persists as the most common type of debt in bankruptcy proceedings today.<sup>255</sup> Transparency alone will not alleviate

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254. See *supra* notes 89–90.

255. See Himmelstein et al., *supra* note 22, at 431, 433 (revealing, in 2019, research that demonstrates that even after the ACA was enacted, “medical costs continue to outpace incomes, 29 million remain uninsured, and many of those with health

most concerns if courts fail to question whether the published and transparent chargemaster rate is deliberately inflated, bearing little relation to the actual cost of care.

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insurance face unpredictable and unaffordable out-of-pocket costs as copayments and deductibles ratchet up”).