Using the Common Law of Contracts to Police Abusive Terms in Hospital Admissions Agreements: Balancing Freedom of Contract with Fairness

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ABSTRACT

Standard hospital admissions contracts ("HACs") often contain provisions that are shockingly unfair, but are easily overlooked or misunderstood by patients. Hospitals rely on the common law of contracts, especially the doctrine of freedom of contract, to claim that these provisions should be enforced. Many courts have accepted the freedom of contract argument and enforced some or all of these provisions. This Article suggests that courts are in error to enforce these harsh provisions against patients.

This Article focuses on four harsh provisions commonly found in HACs. First is the payment provision which is opaque, misleading, and designed to allow hospitals to price gouge self-pay patients by charging an exorbitant price. Second is the pernicious pre-dispute binding arbitration clause, which provides that patients waive their constitutional right to sue in court when they have been the victim of medical negligence. Third is the independent contractor provision that requires patients to acknowledge that the doctors treating the patient are independent contractors and thus prevents the patient from suing the hospital in the event of medical professional negligence. The fourth is the overly broad assignment of benefits provision that requires patients to assign not just health insurance benefits, but all other insurance benefits that may cover the patient's losses related to an accident, including medical expenses and the proceeds of any claim the patient may have against any person that caused the patient's injuries. This provision allows hospitals to exploit patients who have been the victim of an accident by charging, even for insured patients, the hospital's exorbitant list price for the care provided. Moreover, because the hospital uses this provision to take a grossly excessive fee, there is less money available to reimburse the patient for other losses resulting from the accident.

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The gross unfairness of these provisions, the latent dangers they create for patients, and standardized nature of HACs provide more than enough justification for courts to use existing common law doctrines to refuse enforcement of these harsh provisions. In particular, common law contract requirements of mutual assent and capacity to contract, as well as doctrines concerning contracts of adhesion and unconscionable contracts can and should be used to limit or eliminate the enforceability of these provisions.

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Of all the judicial maladies
the worst by far, if you please,
is the overconfident jurist
who can't see the forest for the trees.[1]

INTRODUCTION

Some of the most common provisions in hospital admissions contracts ("HACs") are shockingly unfair when enforced against patients.[2] Hospitals rely on the common law of contracts, especially the doctrine of freedom of contract, to claim that these provisions

1. Anonymous.
2. *See infra* Part I.

should be enforced.[3] Courts often feel, incorrectly, that unless there is some applicable statutory relief for patients, the court is bound by the common law of contracts to enforce these harsh provisions.[4] However, as discussed here, given the gross unfairness of these provisions and the hollowness of the claim of freedom of contract in these situations, the common law of contracts does not support the enforcement of these harsh provisions.[5] Specifically, the common law doctrines requiring mutual assent and capacity to contract and those restricting the enforcement of contracts of adhesion and unconscionable contracts can and should be used to limit or eliminate the enforceability of these provisions.[6]

Contract law is the law of voluntary agreement.[7] The most important hallmark of a contract is the free and knowing agreement between the parties, which is often referred to as mutual assent.[8] In the case of HACs, it is mutual assent that is lacking in one way or another.[9] Unfortunately, various common law doctrines related to

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3. *See, e.g.*, Dennis v. PHC-Martinsville, Inc., 93 Va. Cir. 111 (Va. Cir. Ct. 2016). Memorial Hospital of Martinsville and Henry County ("the hospital") sought to collect from Glenn M. Dennis the amount that the hospital said Dennis was contractually obligated to pay for services during a brief hospitalization in May of 2014. *Id.* at 111. The trial court held that no contract was formed based on the patient signing the HAC because mutual assent was lacking. *Id.* at 118. However, the Supreme Court of Virginia reversed, finding that mutual assent was present because the patient signed the HAC. *See* PHC-Martinsville, Inc. v. Dennis, No. 161019, 2017 WL 4053898, at *2–4 (Va. Sept. 14, 2017).

4. *See, e.g.*, DiCarlo v. St. Mary's Hosp., No. 05-1665, 2006 U.S. Dist. LEXIS 49000, at *12–13 (D.N.J. July 19, 2006).

> This case, and other similar cases being brought throughout the country, arise[s] out of the anomalies which exist in the American system of providing health care. A court could not possibly determine what a "reasonable charge" for hospital services would be without wading into the entire structure of providing hospital care and the means of dealing with hospital solvency. These are subjects with which state and federal executives, legislatures, and regulatory agencies are wrestling and which are governed by numerous legislative acts and regulatory bodies. For a court to presume to address these problems would be rushing in where angels fear to tread. What Plaintiff is asking the Court to do here is, put simply, to solve the problems of the American health care system, problems that the political branches of both the federal and state governments and the efforts of the private sector have, thus far, been unable to resolve. Like other similar suits filed in other federal courts, this action *see*ks judicial intervention in a political morass.

Id.

5. *See infra* Part III.

6. *See id.*

7. RESTATEMENT (SECOND) OF CONTRACTS §§ 1, 4 (AM. L. INST. 1981) (discussing freedom of contract and the philosophical foundation of contract law, respectively).

8. *Id*. § 17 (noting that the formation of a contract requires a bargaining in which there is a manifestation of mutual assent).

9. *See infra* Section III.A.

the objective theory of contracts, such as objective intent, the duty to read, and presumptions concerning knowing agreement based on the presence of a person's signature on a contract, which are reasonable and useful when applied in the proper context of negotiated as opposed to adhesive contracts, are too often misapplied in the HAC context.[10] Applying these doctrines unthinkingly to HACs makes a mockery of true freedom of contract and leads to unjust and damaging consequences for patients.[11] However, as discussed below, the proper application of objective intent to HACs results in the unenforceability of these harsh and unexpected provisions.[12]

This Article focuses on four provisions commonly found in HACs that are grossly unfair when enforced against patients. The first is the payment provision which is opaque, misleading, and designed to allow hospitals to price gouge self-pay patients by charging an exorbitant price.[13] The second is the pernicious pre-dispute binding arbitration clause, which provides that patients waive their constitutional right to sue in court when they have been the victim of medical negligence.[14] The third is the independent contractor provision that requires patients to acknowledge that the doctors treating the patient are independent contractors and thus prevents the patient from suing the hospital in the event of medical professional negligence.[15]

Finally, the fourth provision is the overly broad assignment of benefits provision requiring patients to assign not just health insurance benefits, but all other insurance benefits that may cover the patient's losses related to an accident, including medical expenses and the proceeds of any claim the patient may have against any person that caused the patient's injuries.[16] As discussed below, the

10. *See* George A. Nation III, *Contracting for Healthcare: Price Terms in Hospital Admission Agreements*, 124 DICK. L. REV. 91, 112–20 (2019) [hereinafter Nation, *Contracting for Healthcare*] (discussing the objective intent in the context of adhesive contracts).

11. *See, e.g.*, PHC-Martinsville, Inc. v. Dennis, No. 161019, 2017 WL 4053898 (Va. Sept. 14, 2017). The patient signed the HAC but did not read it because he was "too anxious" to read or focus because he was in the emergency department believing he was suffering a heart attack and that if he did not receive treatment soon, he would die. *Id.* at *1. The Supreme Court of Virginia held that the patient's signature nonetheless established mutual assent and, as a result, the patient was liable to pay the hospital's grossly excessive list price of $111,115.37 for the same care that the hospital would otherwise accept $20,000 or $23,000 for (from Medicare and in-network commercial insurers, respectively). *Id.* at *3; *see* Dennis v. PHC-Martinsville, Inc., 93 Va. Cir. 111, 119–20 (Va. Cir. Ct. 2016).

12. *See infra* Section III.A.

13. *See infra* Section I.A.

14. *See infra* Section I.B.

15. *See infra* Section I.C.

16. *See infra* Section I.D.

assignment provision allows hospitals to exploit patients who have been the victim of an accident by charging the hospital's exorbitant list price for the care provided.[17] Moreover, because the hospital uses this provision to take a grossly excessive fee, there is less money available to reimburse the patient for other losses (property damage, lost wages, future medical expenses, pain and suffering) resulting from the accident.[18]

This Article begins with a discussion of the four unfair provisions mentioned above.[19] Next is a discussion of the contract law doctrines that can be used to limit or eliminate the enforceability of those provisions.[20] An analysis of how courts can apply these doctrines to HACs follows.[21] Finally, the Article concludes.

I. PERNICIOUS PROVISIONS INCLUDED IN HACS

A. Price Terms

The author has written elsewhere about the unfairness of the price terms included in HACs, and does not wish to repeat that work here.[22] However, this Article does provide a brief review the price terms included in HACs. The biggest problem with price terms in HACs is that they are based on hospitals' shockingly excessive list prices, which are set at unreasonably high levels that are, on average, about 500 percent of the Medicare price.[23] It is important to note that hospitals voluntarily agree to accept Medicare prices as full payment when they sign a provider agreement with Centers for Medicare and Medicaid Services (CMS) to become a Medicare participating hospital, something that they are not required to do.[24] Thus, by analogy

17. *See infra* Section I.D.
18. *See infra* Section I.D.
19. *See infra* Part I.
20. *See infra* Part II.
21. *See infra* Part III.
22. *See* Nation, *Contracting for Healthcare*, *supra* note 10, at 108 ("[T]he misapplication of contract law principles in cases involving hospitals and self-pay patients has effectively resulted in hospitals price gouging self-pay patients.").
23. *See, e.g.*, Steven I. Weissman, *Remedies for an Epidemic of Medical Provider Price Gouging*, 90 FLA. BAR J. 22, 24 (2016) ("Average charge master pricing at Florida hospitals is a minimum of 500 percent of Medicare allowable amounts. . . ."). *See also* Press Release, Nat'l Nurses United, New Study – Hospitals Hike Charges by Up to 18 Times Cost (Nov. 16, 2020), https://tinyurl.com/ypjm27ns [https://perma.cc/C2LB-MFVA] ("[H]ospitals jack up charges by as much as 18 times over their costs. . . . Overall, the 100 most expensive U.S. hospitals charge from $1,129 to $1,808 for every $100 of their costs. Nationally, U.S. hospitals average $417 for every $100 of their costs, a markup that has more than doubled over the past 20 years.").
24. *See Conditions for Coverage (CfCs) & Conditions for Participations (CoPs)*, U.S. CNTRS. FOR MEDICARE & MEDICAID SERVS. (Jan. 1, 2021, 7:02 PM), https://tinyurl.com/bde5s425 [https://perma.cc/7QT4-T8B7] ("CMS develops Conditions of

to the logic of objective intent, it seems reasonable to assume that hospitals find Medicare prices acceptable and that any difference between the Medicare price and the price charged to other patients is all additional profit for the hospital.[25] To say that many or most hospitals are greedy—notwithstanding their not-for-profit charitable tax-exempt status—would be an understatement.[26]

Hospital list prices are unilaterally determined by the hospital and contained in a computer file called a Charge Description Master or "CDM."[27] The CDM typically includes a price for every good and service the hospital provides, arranged by billing code.[28] The hospital calculates its list price on an *à la carte* basis, not a by-procedure basis, by using the CDM to determine a separate charge for each good and service provided to the patient.[29] Taking numbers from an actual case, for example, the court determined that one patient was billed $111,115.37 based on the hospital CDM price.[30] By contrast, the hospital would have charged an in-network commercial insurer $23,389, and Medicare would have paid the hospital, again, for the same care, about $20,000.[31] In other words, Medicare, in this case, paid, and the hospital voluntarily accepted, a little less than 18 percent of the "list" price as full payment.[32]

Participation (CoPs) and Conditions for Coverage (CfCs) that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs."). Also, a hospital may terminate its participation at any time. *See* MEDICARE GEN. INFO., ELIGIBILITY, & ENTITLEMENT MANUAL Ch. 5, § 10.6.1 (U.S. CNTRS. FOR MEDICARE & MEDICAID SERVS. 2018), https://tinyurl.com/27t8c83u [https://perma.cc/Y73G-923Z] ("A provider may terminate its agreement . . . by filing with the Secretary a written notice of its intention to terminate the agreement.").

25. *See* Michael K. Beard & Dylan H. Marsh, *Arbitrary Healthcare Pricing and the Misuse of Hospital Lien Statutes by Healthcare Providers*, 38 AM. J. TRIAL ADVOC. 255, 276 (2014) ("It *see*ms obvious that private hospitals will not routinely accept unreasonably low reimbursement rates.").

26. *See* George A. Nation III, *Hospitals Use the Pernicious Chargemaster Pricing System to Take Advantage of Accident Victims: Stopping Abusive Hospital Billing*, 66 DRAKE L. REV. 645, 653 (2018) [hereinafter Nation, *Accident*] ("However, if a hospital—regardless of whether it is a for-profit or a tax-exempt, nonprofit "charity"—*see*s the opportunity to grab its exorbitant chargemaster prices, the hospital goes for it aggressively and relentlessly.").

27. *See* George A. Nation III, *Hospital Chargemaster Insanity: Heeling the Healers*, 43 PEPP. L. REV. 745, 747–48 (2016) [hereinafter Nation, *Chargemaster*] (explaining chargemasters and "noting that today chargemaster prices are insanely high, often running 10 times the amount that hospitals routinely accept as full payment from insurers").

28. Nation, *Accident*, *supra* note 26, at 658.

29. Nation, *Chargemaster*, *supra* note 27, at 777.

30. *See* Dennis v. PHC-Martinsville, Inc., 93 Va. Cir. 111, 119–20 (Va. Cir. Ct. 2016).

31. *Id.*

32. *Id.* That is, $20,000/$115,111.37 = 0.1737.

There is no question that the CDM-based list price is exorbitant, and it is also no surprise that hospitals recover this price from less than five percent of their patients.[33] However, hospitals charge their grossly excessive list prices to many more than five percent of their patients, most of whom, while they cannot pay the full charge, nonetheless have their financial lives ruined by the hospital's relentless but ultimately unsuccessful effort to recover this exorbitant amount.[34] On average, from all payers (government health insurers, commercial health insurers, and self-pay patients), hospitals collect less than a third of their list price, meaning that the average discount from the list price across all of these payers is about 70 percent.[35]

Hospitals purposely set their list prices at grossly excessive levels to threaten commercial health insurers in negotiations over in-network reimbursements.[36] Specifically, if the health insurer does not agree to the reimbursement levels demanded by the hospital, then the hospital will refuse to include the insurer in its network and threaten to balance bill any of the insurer's customers that are treated at the hospital at the hospital's excessive list prices.[37] If the

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33. *See* Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alts., Inc., 832 A.2d 501, 506 (Pa. Super. Ct. 2003) ("[N]inety-four percent of the time, the Hospital received less than eighty percent of the Hospital's published rates.").

34. *See* George A. Nation III, *Determining the Fair and Reasonable Value of Medical Services: The Affordable Care Act, Government Insurers, Private Insurers and Uninsured Patients*, 65 BAYLOR L. REV. 425, 446–49 (2013) (discussing price discrimination by hospitals based on the entity paying the hospital and noting that out-of-network and uninsured patients are charged at CDM prices).

> In the case of hospitals, it *see*ms unlikely that charging the uninsured and other self-pay patients much higher prices furthers any ethical or charitable goal; quite the opposite, it *see*ms unethical and uncharitable. Nor does this practice likely result in increased profit, as most uninsured patients do not in fact pay the billed charges, even though they are liable for them and often driven into bankruptcy because of these exorbitant charges.

Id. at 448.

35. Today, on average, hospital chargemaster prices exceed payments by more than a factor of three. Michael Batty & Benedic Ippolito, *Mystery of the Chargemaster: Examining the Role of Hospital List Prices in What Patients Actually Pay*, 36 HEALTH AFFS. 689, 689 (2017). In other words, hospitals in the U.S. billed over three times what they received in payments for all the services they provided in 2015. *Id. See also* Emily Gee, *The High Price of Hospital Care*, CTR. FOR AM. PROGRESS (June 26, 2019), https://tinyurl.com/ymnpc7fs [https://perma.cc/9SA3-DLV8] ("Across all payers, hospitals receive reimbursement averaging about 134 percent of what Medicare pays, according to CAP analysis detailed in this report.").

36. *See* Nation, *Contracting for Healthcare*, *supra* note 10, at 94 ("CDM rates are used by hospitals primarily as a cudgel to threaten commercial health insurance companies with exorbitant prices unless they agree to the reimbursement rates demanded by the hospital.").

37. *See* George A. Nation III, *Healthcare and the Balance-Billing Problem: The Solution Is the Common Law of Contracts and Strengthening the Free Market for Healthcare,* 61 VILL. L. REV. 153, 154–55, 163 (2016) (noting that the hospital's

insurer's customers receive an enormous balance bill from the hospital, they will be upset, and this will make it more difficult for the health insurer to sell health insurance.[38] As discussed elsewhere, this is one of the primary reasons (the other is the consolidation of health systems which has eliminated hospital competition in many markets) that commercial health insurance companies in the United States pay excessive reimbursements and that health insurance premiums are so high.[39]

The HAC typically provides that patients understand their responsibility for any charges not covered by their insurance company.[40] This part of the provision is not the problem. It is certainly

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"bargaining power is increased by the fact that if the insurance company fails to agree to the reimbursement rates desired by the hospital, then all of the insurance company's customers" will be "balance billed" at exorbitant "chargemaster rates").

38. *Id.* at 163.

39. *See* George A. Nation III, *Reference-Based Price Health Plans: A Necessary Approach to Exorbitant Healthcare Prices*, 91 UMKC L. REV. 585, 605 (2023).

> These statistics beg the question: why are hospitals able to negotiate such high reimbursements from commercial insurers? As noted, this problem is the result of a combination of the pernicious chargemaster-based pricing, billing, and payment system and the consolidation among hospitals that has resulted in large market dominating health systems that use their excessive market power to extract exorbitant payments.

Id.

40. *See, e.g.*, *Pre-Registration General Admission Information,* GEORGE WASHINGTON UNIV. HOSP. (Apr. 2019), https://tinyurl.com/4ex35mf4 [https://perma.cc/MT4F-R7KS]. This form contains the following "Financial Agreement":

> I understand that all estimates of charges given to me represent the approximate cost and are not guaranteed. I have the right to request an itemized statement and an explanation of the billing. I understand that I, as the patient or appropriate guarantor, am obligated to pay the account of the hospital/provider/physician in accordance with the regular rates and terms of the "Hospital"/Provider/Physician for the healthcare services the patient receives within 30 days of service, or if insured, within 30 days of either insurance benefits payment or denial. Should the account be referred to an attorney or collection agency for collection, I will pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the maximum legal rate. If payment is received from more than one source causing overpayment for this or any other period of hospitalization, I authorize application of the overpayment to any unpaid hospital bill for which the patient is legally responsible. I certify that the information I have provided is true and accurate to the best of my knowledge. I understand that the information that I submit is subject to verification, including credit agency scoring, and subject to review by federal and/or state agencies and others as required. I authorize my employer to release to the "Hospital" proof of my income. I understand that if any information I have given proves to be untrue, the "Hospital" will re-evaluate my financial status and take whatever action becomes appropriate and/or necessary. . . . Courtesy in Filing Insurance Claims: I understand that as a courtesy, the hospital will file insurance claims for hospital services. I waive any rights of action against the hospital and it's [sic] employees for omissions in

not unfair to expect patients to pay for the medical services they receive through their insurance or personally. The issue is how much they are expected to pay.[41]

The payment provision goes on and states that the patient further understands that they are obligated to pay the account of the hospital in accordance with the "regular rates," "normal charges," "standard terms of the hospital," "charges listed in the hospital's charge description master," or similar terms. Regardless of the exact language used, HACs never contain a real dollar and cents price. As a result, the patient, even if they read the HAC,[42] would have no idea how much they are promising to pay the hospital for the healthcare they will receive.[43]

In some circumstances, there is no excuse for the hospital's failure to include a real dollars and cents price. For example, hospitals can readily determine the cost of imaging treatments, blood tests, and other services.[44] However, in other contexts, it may simply not be possible to know how much medical care the patient is going to need at the time the patient signs the HAC.[45] But this is no excuse for price gouging patients by forcing them to agree to pay the innocuous-sounding but grossly excessive "regular rates" or "normal charges" in accordance with the "standard terms of the hospital" or "charges listed in the hospital's charge description master."[46]

The CDM is a price list created unilaterally by the hospital and maintained solely by the hospital.[47] The hospital can change any price at any time in the CDM.[48] As noted above, the CDM is primarily a tool used in negotiations with commercial health insurance companies.[49] Furthermore, for insured and in-network patients, the CDM

> submitting insurance claims. I understand that I remain liable to the hospital for charges for services and goods for which I am legally responsible.

Id.

41. *See* Nation, *Contracting for Healthcare*, *supra* note 10, at 124–26. These provisions are designed to charge the patient the grossly excessive CDM-based list price. *See id.*

42. *See, e.g.*, Mitch Lipka, *Make a Stand with Hospital Paperwork*, REUTERS (July 31, 2012, 12:01 PM), https://tinyurl.com/3ye8zcd3 [https://perma.cc/8DF2-PE4A] ("99 out of 100 people will sign the documents without regard to what they say. . . .").

43. *See Pre-Registration General Admission Information*, *supra* note 40.

44. *See* Nation, *Accident*, *supra* note 26, at 693–95 (discussing the differences between emergency care and scheduled care from a price perspective).

45. *Id*. at 690–93.

46. *Id.*

47. *See* Nation, *Contracting for Healthcare*, *supra* note 10, at 129–33 (discussing problems with CDM prices).

48. *Id.*

49. *See supra* Section I.A.

price is usually irrelevant.[50] For such patients, the hospital's contract with the patient's insurer will determine how much the hospital will be paid for the care provided to the patient. The patient's obligation will be determined by the contract between the patient and the insurance company, which will determine the amount the patient must pay as coinsurance, copayment, or deductible.[51]

However, in the case of self-pay patients, the contract between the patient and the hospital will determine the patient's financial obligation to the hospital.[52] Self-pay patients include uninsured patients, patients who are insured but receive care out-of-network, patients who choose not to use their health insurance, and patients who have so-called high deductible health plans. The self-pay category also includes in-network patients—for example, third-party liability ("TPL") patients—with respect to which the hospital has decided not to submit their claims to their health insurer in hopes of recovering a financial windfall from third parties who are liable to pay for the medical expenses incurred by the patient.[53]

For self-pay patients, the price provision in the HAC, if enforced, is grossly unfair because the price is exorbitant; it is purposely set at many times the fair and reasonable value of the care received.[54] This price gouging of self-pay patients needs to stop, and as discussed below, the common law provides the tools to do so.

B. Pre-Dispute Binding Arbitration

An arbitration clause in an HAC provides that the patient agrees to resolve any dispute that may arise with the hospital or its doctors through mandatory binding arbitration.[55] The arbitration requirement means that the patient must waive their constitutional right to access the court system in order to resolve any dispute the patient may have with the hospital or doctors.[56]

Often the arbitration clause also limits the selection of the arbitrator by, for example, allowing the hospital to select the arbitrator

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50. *See* Nation, *Contracting for Healthcare, supra* note 10, at 99–101.

51. *Id.*

52. *Id.*

53. *See infra* notes 127–148 and accompanying text (discussing TPL patients).

54. *See* Nation, *Contracting for Healthcare, supra* note 10, at 129–33 (discussing problems with CDM prices).

55. *See* Brittany Risher Englert, *Watch Out for This Legal Clause in Healthcare Forms*, ZOCDOC (Mar. 23, 2021), https://tinyurl.com/5n7frn9t [https://perma.cc/FA6V-FZXU] ("It's not clear how many providers make patients sign binding arbitration clauses, but experts say they're increasingly common.").

56. *Id.* ("Often, your only two choices will be signing the clause and seeking treatment elsewhere.").

or requiring that the arbitrator be a medical doctor.[57] It may also require that the arbitrator be a member of the same medical association as the doctor being sued.[58] In addition, the clause may prescribe certain rules of evidence or limit the amount of non-economic damages the patient may recover.[59] In other words, the arbitration clause stacks the deck in favor of the hospital and against the patient.

Some arbitration clauses provide that unless the patient agrees to arbitration, the hospital and doctors will refuse to treat the patient.[60] Such a restriction would not be enforceable in the case of a patient who is suffering an emergency as defined in the Emergency Medical Treatment and Active Labor Act.[61] In that case, if the patient refuses to sign the HAC, the hospital still has a statutory duty to evaluate and provide stabilizing treatment to the patient.[62] If the patient still refuses to sign the HAC, many hospitals claim that the patient can be refused further treatment once stabilized.[63]

There are several reasons that hospitals prefer arbitration. First, doctors and hospitals are less likely to be found liable in arbitration than in a trial; even if they are found liable, the damages awarded in arbitration are usually less than those that would be awarded in a court proceeding.[64] In addition, there is no judicial oversight or right to appeal, even if the arbitrator commits an error, when disputes are resolved through binding arbitration.[65] Also, the arbitrator is not required to consider the law or legal precedent in reaching their decision.[66] Arbitration proceedings are private, with neither judge nor

57. *Id.*

58. *Id.* For example, the clause may require the arbiter to be board certified in the same specialty as the doctor being sued.

59. *Id*. For example, the clause may provide that any expert appearing at the arbitration proceeding must be a member of the American Association of Orthopedic Surgeons or that non-economic damages are limited to no more than $250,000.

60. *Id.*

61. 42 U.S.C. § 1395dd (2023).

62. *Id.*

63. *Id*.

64. *See* Englert, *supra* note 55.

65. Harris v. Sandro, 96 Cal. App. 4th 1310, 1313–14, 1316 (Cal. Ct. App. 2002) (ruling that an arbitration award in a real estate contract dispute will not be reversed on appeal, even if it contains significant legal or factual errors which result in substantial injustice). The Federal Arbitration Act significantly limits the ability to appeal arbitration awards. *See* 9 U.S.C. § 16. An arbitration decision can be appealed only if the arbitration provision agreed to by the parties specifically allows for appeals or is silent on the issue. *Id.* If the contract provides for no appeal on any issue, then there can be no appeal and the courts uphold these agreements. *Id.*

66. *See* Charles L. Knapp, *Taking Contracts Private: The Quiet Revolution in Contract Law*, 71 FORDHAM L. REV. 761, 785 (2002). Arbiters, unlike common law judges, "neither follow the law, nor contribute to it." *Id. See also* David Horton, *Arbitration as Delegation*, 86 N.Y.U. L. REV. 437, 490 (2011) ("[A]rbitrators need not follow precedent and thus can flout controlling law.").

jury; thus, even if the hospital or doctor is found negligent, this may be kept from public knowledge.[67]

Arbitration clauses often limit discovery, impose compressed time frames within which the patient must bring suit, and prohibit patients from participating in class action lawsuits.[68] Additionally, arbitration is often more expensive for patients than suing in court[69]—but conversely less expensive for hospitals and doctors.[70] Finally, as noted previously, issues of fairness and impartiality easily arise concerning the selection of the arbitrator since the hospital has complete and unilateral control over the arbitration provision.[71] All of these factors redound to the benefit of the hospital and to the detriment of the patient.

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67. *See* Englert, *supra* note 55.

68. *See* Horton, *supra* note 66, at 439 ("Businesses do not merely use these provisions to funnel cases away from the courts; rather, they seize the opportunity to redefine the parameters of the dispute resolution process—from the scope of discovery, to the right to bring a class action, to the payment of fees and costs.").

69. *See* Englert, *supra* note 55; *see also Arbitration More Expensive Than Court? So Costly That Many Victims of Consumer Fraud, Employment Discrimination Give Up*, PUBLIC CITIZEN (May 1, 2002), https://tinyurl.com/4e8wzewn [https://perma.cc/8UQE-2SGF] ("Arbitration, although widely billed as a low-cost alternative to court, is actually far more expensive for consumers and employees who *see*k redress for discrimination, fraud and malpractice, a new Public Citizen report reveals. In fact, arbitration costs are so high that many people drop their complaints because they can't afford to pursue them, Public Citizen found.")

70. *Arbitration*, NAT'L ASS'N OF CONSUMER ADVOCS., https://tinyurl.com/mrc5v4db [https://perma.cc/CXP2-EVJY] (last visited June 29, 2023).

> One of the alleged benefits of arbitration is that it costs less than litigation, but frequently this is not true for consumers and employees. Forced arbitration frequently costs more than taking a case to court and can cost thousands of dollars. Individuals often have to pay a large fee simply to initiate the arbitration process. If they are able to get an in-person hearing, individuals sometimes have to travel thousands of miles on their own dime to attend the arbitration. In the end, the loser (usually the individual) often pays the company's legal fees.

Id.

71. *See* Englert, *supra* note 55. Most contracts identify either the arbitration service that will be used or how it will be selected. *Id.*

> If the designated arbitration service doesn't *see*m reputable, carefully consider whether or not to sign your name. The same advice applies if the clause either doesn't specify who chooses the arbitrator or says something like, "The arbitrator will be unilaterally selected by the drafter of the agreement." . . . "If the arbitrator is a person to whom the provider regularly sends business, one might argue the arbitrator has an unconscious incentive, or bias, to rule in that party's favor, in order to keep getting the business," [law professor Ramona L.] Lampley says. If you suspect bias, you can ask the provider to explain who the designated arbitrator is and what sort of relationship they have.

Id.

When HACs contain a pre-dispute arbitration clause, arbitration becomes mandatory for patients, the arbitrator's decision becomes binding, and the results become inaccessible to the public.[72] Hospitals want patients to forfeit their right to go to court because hospitals enjoy the advantage in arbitration, thus enabling them to evade accountability.[73]

There is nothing *per se* wrong with voluntary agreements that mandate binding arbitration to resolve disputes. In fact, federal and state legislation often exhibit a preference for the enforceability of arbitration agreements that have been voluntarily entered into.[74] However, pre-dispute binding arbitration agreements contained in HACs, whether they are required to receive care or not, are neither knowingly nor voluntarily entered into.[75]

When presented on a take it or leave it basis, in a hospital setting and under tension-laden and anxiety-provoking circumstances, HACs leave patients with no choice but to sign in order to receive needed medical care.[76] Even when the HAC is written so that agreeing to arbitration is technically optional, patients typically cannot fully understand what they are surrendering unless advised by counsel.[77] As a result, it is blatantly unfair to enforce arbitration agreements in the HAC context.[78]

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72. *See id*.

73. *See id*.

74. *See* Horton, *supra* note 66, at 439 (discussing the Federal Arbitration Act).

75. *See infra* Section III.A (discussing the context in which HACs are entered into by patients).

76. *See* Englert, *supra* note 55 (noting that often the arbitration provision is written in such a way that even if patients read the HAC, most would not realize that it requires them to give up their constitutional right to sue the hospital and doctors in court if they act negligently and harm the patient).

77. *See infra* Section III.A (discussing the context in which HACs are entered into by patients).

78. Because of this, some states and organizations place limits in the use of pre-dispute binding arbitration clauses in the healthcare context. For example, Texas, Georgia, Arkansas, Colorado, and the American Arbitration Association impose such limits. *See* Catherine Greaves, *Arbitration Agreements in the Healthcare Context*, CATARACT & REFRACTIVE SURGERY TODAY (July 2003), https://tinyurl.com/y59t9n83 [https://perma.cc/QR2E-3TAX] (last visited July 13, 2023). Specifically, "[t]he American Arbitration Association will not administer an arbitration involving an individual patient unless the agreement to arbitration was made after the dispute arose." *Id.* Further:

> Texas law states that no physician may request or require a patient to sign an agreement to arbitrate a healthcare liability claim unless (1) specific language is included within the agreement and (2) an attorney has reviewed and signed the agreement along with the patient. Failure to comply with these requirements is considered a violation of the state's Medical Practices Act. Other states, including Georgia and Arkansas, do not allow arbitration agreements to cover future medical malpractice or personal injury claims. Colorado permits patients a 90-day rescission period.

Id.

C. Independent Contractor Agreement

The independent contractor provision states that the patient acknowledges and agrees that all of the doctors treating the patient are independent contractors and not employees of the hospital.[79] The classification of doctors as independent contractors allows the hospital to avoid liability for the negligent acts of any doctors treating the patient.[80] The common law of torts includes the doctrine of *respondeat superior*, which provides for the liability of employers for damages caused by the negligent acts of employees that occur within the scope of the employee's employment.[81]

For purposes of the doctrine of *respondeat superior*, the law distinguishes between an employee and an independent contractor.[82] In general, the doctrine of *respondeat superior* cannot be used to impose liability on an employer for the negligent acts of an independent contractor.[83] However, an exception to this rule, as discussed below, applies if the person injured by the independent contractor's

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79. *See, e.g., Pre-Registration General Admission Information, supra* note 40. This sample HAC contains a clause entitled "Physician Providers Are Not Hospital Employees":

> I acknowledge and agree that the "Hospital" is not responsible for the judgment or conduct of any Physician who treats or provides a professional service to me, but rather each Physician is an independent contractor who is not the agent, servant, or employee of the hospital. The "Hospital" or affiliate agency is not liable for any acts or omission made by any Physician or in following the order of the Physician.

See id. Interestingly, this same HAC went on to directly contradict the preceding provision in a financial responsibility clause entitled "Physicians Bill Separately":

> *Some physicians are employees of the hospital* and some are independent contractors, not agents or employees of the hospital. I understand that each professional group or individual practitioner who renders professional services to the patient, including, but not limited to the Radiologist, Pathologist, Emergency Physician, Anesthesiologist and Cardiologist, may bill and collect for his/her professional services separate from the hospital's billing and collections. I agree to pay for any physician services performed on the patient's behalf and billed to the patient unless the physician has entered into agreement with the patient's insurance company to accept payment in full or unless otherwise provided by law. This professional billing is subject to the authorizations granted by me in this consent agreement.

Id. (emphasis added).

80. *Id.*

81. *See* Russell G. Thornton, *Responsibility for the Acts of Others*, 23 BAYLOR UNIV. MED. CTR. PROC. 313, 313 (2010) ("*Respondeat superior* embodies the general rule that an employer is responsible for the negligent acts or omissions of its employees. Under *respondeat superior* an employer is liable for the negligent act or omission of any employee acting within the course and scope of his employment.).

82. *Id.*

83. *See, e.g.*, Franklin v. Santa Barbara Cottage Hosp., 297 Cal. Rptr. 3d 850, 861 (Cal. Ct. App. 2022) (holding that a hospital cannot be held liable for the acts of an independent contractor working at the hospital).

negligence reasonably believed, based on the employer's conduct, that the independent contractor was an employee.[84] In that case, liability may be imposed on the employer even in the case of an independent contractor.[85]

Legally the distinction between an employee and an independent contractor is based on the level of control that the employer exercises over the worker; in this context, this means the level of control the hospital exercises over the patient's doctors.[86] A high level of control defines an employee, while a lower level of control equates to an independent contractor.[87]

For example, some of the factors a court considers to determine whether the hospital exercises sufficient control over doctors to render them employees are: (1) whether the hospital or doctor determines the doctor's work hours at the hospital, (2) who determines the patients that the doctor will treat, (3) whether the doctor receives a fixed salary (which would indicate employee status) or receives a fee for each service performed, (4) who determines the fee charged for the doctor's services performed in the hospital, and (5) whether the hospital has the power to discipline or fire the doctor.[88]

The more that the hospital makes these determinations, the more likely the doctor is to be an employee.[89] If a doctor is considered an employee and commits medical malpractice in the course of surgery, that negligent act would be considered to have occurred within the scope of the doctor's employment, and the hospital would, along with the doctor, be liable for any damages incurred by the patient.[90]

However, as noted, a hospital may be liable for negligent acts committed by a doctor who is an independent contractor if the hospital has led the patient to reasonably believe that the doctor is an employee of the hospital.[91] This is referred to as ostensible agency,

84. *See generally* Thornton, *supra* note 81.

85. *Id.*

86. *Id.*

87. *Id.*

88. *Id*. *See also* Rhett Fraser, *The Hospital Says My Doctor Isn't an Employee—Can I Still Sue the Hospital?*, HUEGLI FRASER PC (Aug. 4, 2021), https://tinyurl.com/45cufhcf [https://perma.cc/MDJ6-6RE6] (listing factors).

89. *See generally* Thornton, *supra* note 81.

90. *Id.*

91. *Id.* This doctrine is sometimes referred to as ostensible agency or agency by estoppel. *See, e.g.*, Ermoian v. Desert Hosp., 61 Cal. Rptr. 3d 754, 788 (Cal. Ct. App. 2007). Ostensible agency is present when "the principal [hospital] intentionally, or by want of ordinary care, causes a third person [patient] to believe another to be his agent who is not really employed by him." CAL. CIV. CODE § 2300 (West 2023). To prove ostensible agency, a plaintiff must establish the following elements: representation by the principal that an agency relationship existed between the parties, justifiable reliance on those representations by a third party, and change of position or injury resulting from such reliance. *See Ermoian*, 61 Cal. Rptr. 3d at 502.

apparent agency, or agency by estoppel and requires that the patient show that the conduct of the hospital would have caused a reasonable person to believe that the doctor was an employee of the hospital and that the patient relied on that belief to their detriment.[92]

For example, a patient would typically argue that because the doctors treating the patient work at the hospital and possess the ability to admit patients, and also because some of the doctors treating the patient—like the anesthesiologist, radiologist, or assistant surgeons—may be unknown to the patient, the patient had reasonably assumed that all of the doctors treating the patient were employees of the hospital.[93] In addition, a patient would argue that he or she had relied on the hospital to exercise its control over the doctors to ensure that the doctors were not negligent.[94] The patient would allege that they had relied on this representation to their detriment because they have been injured by the doctor's negligence.[95]

Thus, if the doctors treating the patient are considered employees of the hospital, or if the patient reasonably believes that their doctors are employees of the hospital, then the hospital, in addition to the doctor, may be liable for negligent acts committed by the

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See also Mejia v. Cmty. Hosp. of San Bernardino, 99 Cal. App. 4th 1448, 1454 (Cal. Ct. App. 2002) ("[H]ospitals are generally deemed to have held themselves out as the provider of services unless they gave the patient contrary notice, and the patient is generally presumed to have looked to the hospital for care unless he or she was treated by his or her personal physician.").

92. *See generally* Thornton, *supra* note 81.

93. *See, e.g.*, Arthur v. Saint Peters Hosp., 405 A.2d 443, 447 (N.J. Super. Ct. 1979).

> [G]enerally people who seek medical help through the emergency room facilities of modern-day hospitals are unaware of the status of the various professionals working there. Absent a situation where the patient is directed by his own physician or where the patient makes an independent selection as to which physicians he will use while there, it is the reputation of the hospital itself upon which he would rely. Also, unless the patient is in some manner put on notice of the independent status of the professionals with whom it might be expected to come into contact, it would be natural for him to assume that these people are employees of the hospital.

Id. See also Brown v. Coastal Emergency Servs., 354 S.E.2d 632, 637 (Ga. Ct. App. 1987).

> Such appearances [referring to the absence of patient knowledge that ER physicians are typically not actual agents of the hospital] speak much louder than the words of whatever private contractual arrangements the physicians and the hospital may have entered into, unbeknownst to the public, in an attempt to insulate the hospital from liability for the negligence, if any, of the physicians.

Id.

94. *Brown*, 354 S.E.2d at 637.

95. *Id*.

doctor.[96] If enforced, the independent contractor provision's purpose and effect is to prevent the patient from raising this argument because the patient and the hospital have agreed in the HAC that the doctors working in the hospital are independent contractors.[97] In addition, the patient cannot have relied on any implied representation made by the hospital's actions suggesting that the doctor was an employee when the patient has expressly agreed that the doctors are not employees of the hospital.[98]

The independent contractor provision of the HAC is often treated by courts (erroneously—as discussed below) as important evidence for determining whether the hospital has liability for the negligent acts of the doctors working in the hospital.[99]

For example, in *Franklin v. Santa Barbara Cottage Hospital*,[100] the court upheld summary judgment in favor of the hospital based on the independent contractor provision in the HAC.[101] When a hospital's motion for summary judgment is upheld, it means that the patient never gets a chance to argue to a judge or jury that the hospital should be held liable for the injuries sustained by the patient.[102] The case against the hospital is dismissed before the trial even begins.[103]

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96. *See supra* notes 90–95 and accompanying text.

97. *See supra* notes 79–85 and accompanying text.

98. *See* Franklin v. Santa Barbara Cottage Hosp., 297 Cal. Rptr. 3d. 850, 859-60 (Cal. Ct. App. 2022).

99. *Id*; *see also* Schroeder v. Nw. Cmty. Hosp., 862 N.E.2d 1011, 1015 (Ill. App. Ct. 2007). The hospital filed a Motion for Summary Judgment on the grounds that the co-defendant doctors were neither its actual nor apparent agents. *Id.* at 1014. In support, Northwest attached three separate universal consent forms signed by the patient or his wife, which contained a disclosure statement that read:

> Your care will be managed by your personal physician or other physicians who are not employed by Northwest Community Hospital or Northwest Community Day Surgery Center, but have privileges to care for patients and this facility. Your physician's care is supported by a variety of individuals employed by Northwest Community Hospital or Northwest Community Day Surgery Center, including nurses, technicians and ancillary staff. Your physician may also decide to call in consultants who practice in other specialties and may be involved in your care. Like your physician, those consultants have privileges to care for patients at this facility, but are not employed by Northwest Community Hospital or Northwest Community Day Surgery Center.

Id. at 1015. The consent form also contained language that provided that the patient's signature was an acknowledgment that he or she had read and understood the terms of the consent. *Id*.

100. Franklin v. Santa Barbara Cottage Hosp., 297 Cal. Rptr. 3d 850 (Cal. Ct. App. 2022).

101. *See id.* at 859–60.

102. *Id.* at 857.

103. *Id.*

This is exactly what hospitals are trying to accomplish by putting the independent contractor language in the HAC.[104]

Essentially, the hospital is using contract law in order to avoid tort liability.[105] However, the problem with the independent contractor clause, as with all of the provisions in the HAC, is that the patient is not knowingly and freely agreeing to it.[106] The court in *Franklin* granted the hospital's motion for summary judgment based on a key piece of evidence: The patient executed admissions paperwork (HAC) formally recognizing the independent contractor status of doctors working in the hospital.[107]

The court noted that, at the ER, Franklin "signed a three-page consent form authorizing the surgery. . . . [One section] stated, 'All physicians and surgeons providing services to me . . . are not employees or agents of the hospital. . . .'"[108] The court also noted that Rosa Pinedo, who worked as a patient financial counselor at the hospital and served as the witness for Franklin's signature of the HAC in the ER, testified that while she did not remember him specifically, she informs all patients before they sign the forms "[t]hat the physician that is treating the patient is not a Cottage Hospital employee; they are independent contractors that have privileges here at the hospital."[109] One important issue is whether such a statement by the admitting

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104. *Id.*

105. Exculpatory clauses included in contracts for medical care are often considered unenforceable as being against public policy. *See generally* Tunkl v. Regents of University of California, 383 P.2d 441 (Cal. 1963). The California Supreme Court noted that liability waivers will not be enforced when a contract exhibits some or all of the following characteristics:

> [(1) The contract] concerns a business of a type generally thought suitable for public regulation. [(2)] The party *see*king exculpation is engaged in performing a service of great importance to the public, which is often a matter of practical necessity for some members of the public. [(3)] The party holds himself out as willing to perform this service for any member of the public who *see*ks it. . . . [(4)] As a result of the essential nature of the service, in the economic setting of the transaction, the party invoking exculpation possesses a decisive advantage of bargaining strength against any member of the public who *see*ks his services. [(5)] In exercising a superior bargaining power the party confronts the public with a standardized adhesion contract of exculpation, and makes no provision whereby a purchaser may pay additional reasonable fees and obtain protection against negligence. [(6)] Finally, as a result of the transaction, the person or property of the purchaser is placed under the control of the seller, subject to the risk of carelessness by the seller or his agents.

Id. at 446–47 (footnotes omitted). An independent contractor clause is in many ways similar to an exculpatory clause.

106. *See infra* Section III.A.

107. *Franklin*, 297 Cal. Rptr. 3d at 860.

108. *Id.* at 856.

109. *Id.*

personnel, even if made to the patient, or a similar statement in the HAC is meaningful to most patients. It is certainly doubtful.[110]

Franklin claimed that he did not recall any details surrounding the consent form (HAC) he signed because he was "was in so much pain and anxious to get the surgery approved."[111] The nurses who treated Franklin noted that although it appeared that he was in pain, he was also "alert" and "oriented to person, place, and time."[112] In addition, his medical records showed that he reported that his pain level was at two out of ten shortly before he signed the consent forms.[113]

Finally, the court noted that Franklin stated under oath, "[b]efore retaining counsel to bring this suit, I had never thought about and had no information regarding what the legal relationship was between Dr. Park and [the hospital.]"[114] Clearly, this is evidence that Franklin, like most patients, did not understand the legal significance of what he was told or what he signed regarding independent contractors and the hospital's status. Rather, Franklin, like most patients, likely never thought about the distinction between employees and independent contractors and the legal niceties associated with that distinction. He—like most patients—never questioned the obvious appearance that the doctors working at the hospital are employees of the hospital.

According to the court, however, Franklin's statement showed that he did not rely on or believe that there was an employee/employer relationship between Dr. Park and the hospital.[115] Therefore, he could not be injured by such a reliance because it did not exist, and thus the hospital could not be held liable for Franklin's injuries.[116]

The court here couldn't see the forest for the trees, perhaps willfully so, because Franklin's statement fails to show that he did not rely on an employer/employee relationship. Rather, it is much more likely that he relied on the fact that the hospital was in charge of the doctors and that if something went wrong both the doctors and the hospital would be responsible. He may not have been able to articulate that in legal terms, but nonetheless, that is what he thought and what most patients would think. The fact that the patient did not think specifically in terms of employers, employees, and independent contractors

110. *See infra* notes 115–116 and accompanying text.
111. *Id.* at 856.
112. *Id.*
113. *Id.*
114. *Id.* at 855.
115. *See Franklin*, 297 Cal. Rptr. 3d at 860.
116. *Id.*

shows how futile the admitting nurse's statement was, as well as the language contained in the HAC signed by Franklin, in ensuring that he was giving knowing and free assent to releasing the hospital from any liability for the medical negligence of the doctors treating him.[117]

The practical effect of the independent contractor language contained in HACs is to give hospitals a quick out via summary judgment whenever they are named as a defendant in any legal action in which a patient is seeking recovery for medical malpractice.[118] As a result, hospitals have no incentive to become involved in any settlement talks related to the patient's injuries. The net effect is to reduce the patient's likelihood of recovering for their injuries.[119]

Does the patient's signature on an HAC that contains an independent contractor clause really indicate that the patient knowingly and freely agrees to discharge the hospital from any potential liability it may have as the employer of the doctors that work at the hospital for any injury the patient may suffer due to physician negligence? This Article argues that the answer is clearly, no![120] Patients sign the HAC not because they agree to anything, but because they have to in order to receive medical treatment.[121] Provisions such as this are unfair and should not be enforced.

D. Assignment of Non-Health Insurance Benefits

There is nothing unfair or wrong with a hospital collecting the fair and reasonable value of their healthcare services.[122] Nothing in this Article suggests otherwise. However, it is wrong for hospitals to price gouge patients,[123] unnecessarily inflate the cost of healthcare by

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117. Expecting the average patient to comprehend the legal implication of this and the other provisions of the HAC, especially given the context in which they are signed, is ridiculous.

118. Hospitals may argue that there is no harm in a patient acknowledging what is simply a fact: the doctor is an independent contractor. However, as discussed above, it is not that simple. First, the issue of independent contractor/employee is not conclusively established by the agreement between the doctor and the hospital, regardless of what they label their relationship. It depends on control and that is always a fact-based question. Second, even if the court concludes that legally the doctor is an independent contractor, the hospital may still be liable if the hospital's acts have led the patient to reasonably believe that the doctor is an employee. Thus, the hospital always has potential liability for the negligence of any doctor working at the hospital, unless the patient has agreed that the doctor is an independent contractor.

119. *See*, *e.g.*, discussion of the *Franklin* case *supra* text accompanying notes 100–118.

120. *See infra* Section III.A.

121. *See infra* Section III.A.

122. *See generally* Nation, *Contracting for Healthcare*, *supra* note 10 (arguing for the payment of fair and reasonable prices for healthcare).

123. *See generally* Nation, *Chargemaster*, *supra* note 27.

gaming the commercial health insurance system, and take advantage of patients' misfortune in order to recover a financial windfall at the expense of their patients.[124]

The broad assignment of benefits provision is concerned to some extent with all of these reprehensible practices, but it is particularly focused on the last one.[125] That is, hospitals use the assignment

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124. *See* George A. Nation III, *The Valuation of Medical Expense Damages in Tort: Debunking the Myth that Chargemaster-Based "Billed Charges" Are Relevant to Determining the Reasonable Value of Medical Care*, 95 TUL. L. REV. 937, 938–41 (2021) (providing a fictional narrative based on the facts of Whitley v. Baptist Health. No. 4:16-cv-624-DPM, 2019 WL 4411962 (E.D. Ark. Sept. 13, 2019)).

> One night while driving home, John was hit head on by a drunk driver who was on the wrong side of the highway. The drunk driver was killed instantly in the crash, and John was seriously injured. Both of John's legs were broken in the accident, and he received morphine on his way to the hospital. Thankfully, John was eventually able to recover, but he missed nine months of work. John was covered by medical insurance at the time of the accident and luckily, he thought, was taken to a hospital in his network. The driver who hit John was an alcoholic with no assets. John was relieved to find out that at least the driver had auto insurance from which John could recover, even though the policy limit was only $60,000.
>
> John checked with his health insurance company and was told that the amount the hospital had agreed to accept as full payment for the care John received was $9,000. This meant that there would be at least $51,000 available for John. However, John was shocked and angered when he found out that the hospital refused to file a claim with his health insurance company and instead planned to take the entire $60,000 as payment, [at CDM prices] for the medical services provided to him.
>
> . . . As a result of the hospital's action, John was left with nothing to help pay for all of the losses and other expenses that he suffered due to the crash. As noted, the other driver was an alcoholic and was drunk at the time of the accident. The hospital, however, when stealing John's meager recovery, was sober, and its actions were cold and calculated.
>
> . . . Since John's injuries were the result of a motor vehicle accident (MVA), his case was flagged as one where the medical bills should not be submitted to health insurance. John's case was typical in that the hospital claimed that it had the right to refuse to submit its bills to John's health insurer and instead to *see*k recovery from the liable third party based on an assignment provision in the admissions agreement that John signed in the emergency department when he was admitted to the hospital. Amazingly, the hospital claimed that the admissions agreement and the assignment provision were enforceable, notwithstanding the trauma John had suffered, the morphine John had received on the way to the hospital, the fact that the documents were signed in the emergency department, and the convoluted language and extreme unfairness of the provision regarding the assignment of insurance benefits.

125. *See*, *e.g.*, *Pre-Registration General Admission Information*, *supra* note 40. The form provides:

> Assignment of Benefits and Financial Responsibility
>
> As the individual who will be receiving services at [the "Hospital"], or the parent or guardian of the individual listed below as the patient, I agree to the following terms and conditions of this Assignment of Benefits and Financial Responsibility Agreement (the "Agreement"). As applicable,

of benefits provision as an excuse to charge their grossly excessive list price for care provided to patients who have had the misfortune of being injured in an accident.[126] Worse, the hospital does so without any regard for the financial harm that this does to their patient.[127]

I further agree that the terms and conditions of this Agreement apply to any newborn infant(s) I deliver while I am a patient in the Hospital.

Irrevocable Assignment of Benefits and Right of Action

For good and valuable consideration, I make the following irrevocable assignments to the "Hospital".

- Assignment of Health Insurance Benefits: I irrevocably assign to the "Hospital" all benefits for services rendered by the hospital, payable by a health insurance company, health plan, worker's compensation program, ERISA plan, or any other entity responsible for payment of the patient's total hospital bill. This assignment extends to the amount of the patient's total hospital bill(s), with interest as allowed by law. I authorize and expressly direct such entity to pay benefits directly to the "Hospital". I also authorize and instruct any such entity to assign and pay directly to physician groups providing hospital based services such as Pathology, Radiology, Anesthesiology, Cardiology and Emergency Physician Services, any insurance benefits due them.
- Assignment of Personal Injury Proceeds: I irrevocably assign and transfer to the "Hospital" all benefits for services rendered to the patient by the hospital payable under Personal Injury Protection, Medical Pay, Uninsured/Underinsured, and/or Liability provisions of any insurance policy under which patient is entitled to benefits as the result of an occurrence causing the patient's injuries and treatment. I agree this assignment extends to the amount of the patient's total hospital bill(s), with interest as allowed by law. I authorize and expressly direct the insurance company to pay benefits directly to the "Hospital". I also authorize and instruct any such entity to assign and pay directly to physician groups providing hospital-based services such as Pathology, Radiology, Anesthesiology, Cardiology and Emergency Physician Services, any insurance benefits due them.
- Assignment of Claims and Right of Action: I irrevocably assign and transfer to the "Hospital" all patient's rights, title and interest in any claim(s) patient may have against any third party responsible for causing patient's injuries, health insurance company, health plan, worker's compensation program, ERISA plan, or any other entity that is responsible for payment of the patient's hospital bill. I agree this assignment will allow the "Hospital" to pursue all legal and non-legal remedies against any such person and/or entity including the filing of a lawsuit as assignee of the patient. I agree that if it is necessary to retain legal counsel to enforce or utilize these assignment provisions, the "Hospital" is entitled to recover its attorney's fees and court cost as allowed by law. I understand that, subject to the terms of the applicable health plan(s), all persons signing this document may be financially responsible for charges not covered by this assignment of insurance benefits.

Id.

126. *See* Nation, *Accident*, *supra* note 26, at 674; *see also* discussion of Whitley v. Baptist Health *supra* note 124.

127. *See* Nation, *Accident*, *supra* note 26, at 660–61.

Hospitals use the assignment of benefits provision to take advantage of what is referred to as third-party liability or "TPL" cases.[128] Third-party liability arises when the patient presents at the hospital with injuries resulting from an automobile accident or some other type of accident.[129]

If the accident was the fault of another person—the other driver, for example, in a motor vehicle accident—the at-fault party is liable to pay for all of the patient's damages caused by the accident.[130] These damages include lost wages, property damage, pain and suffering, and current and future medical expenses.[131] In addition, the other driver usually has liability insurance that would cover some or all of these damages.[132] Finally, no-fault insurance would cover the patient's medical and other expenses regardless of which driver was at fault.[133]

The purpose of the broad assignment provision is not to make sure the hospital recovers a fair price for the care provided but to allow the hospital to recover a financial windfall as a result of the patient's misfortune by charging its grossly excessive list price.[134]

The hospital's scheme depends on the disingenuous, deceitful, and opaque pricing, billing, and payment system that hospitals have devised.[135] Recall that the amount a hospital charges depends on the entity that is paying the bill on behalf of the patient.[136] If a TPL patient covered by in-network health insurance is treated by the hospital, the hospital is limited to charging the health insurer the amount agreed to in the applicable provider agreement.[137] Assume, for example, the insurer is Medicare, and the hospital has agreed to charge $10,000 for the care provided to the patient. If the same patient is covered by in-network commercial insurance, then the price the hospital can charge would be about $20,000.[138] But, if the hospital avoids charging the patient's medical insurance, then the hospital claims it is free to charge its list price, which would

128. *Id.* at 650.
129. *Id.*
130. *Id.*
131. *Id.*
132. *Id.*
133. *Id.*
134. *Id.* at 651.
135. *See generally* Nation, *Chargemaster*, *supra* note 27.
136. *See supra* Section I.A.
137. *See* Nation, *Accident*, *supra* note 26, at 649; *see also* discussion of Whitley v. Baptist Health *supra* note 124.
138. *See generally* Nation, *Accident*, *supra* note 26.

be $50,000 or $100,000.[139] This is because the provider agreement is between the hospital and the insurer and does not apply to the third-party liability insurer or to the individual who was at fault in causing the patient's injuries.[140]

The broad assignment of benefits provision allows the hospital to recover directly from third parties such as the patient's Medical Payments Coverage ("MedPay") insurer, Personal Injury Protection ("PIP") insurer, other applicable automobile insurers, any insurers that have provided any liability insurance to the person responsible for the accident, and the person responsible for the accident.[141]

The problems with this scheme are that it results in patients losing the benefit of their health insurance and losing their ability to recover for the other losses suffered as a result of the accident.[142] Liability insurance has a dollar limit which means that regardless of the total liability incurred, the insurance will pay out only up to the limit of the policy.[143] For example, a $25,000 or $50,000 cap is common for auto liability insurance.[144] The individual at-fault driver also has a limit to their financial resources.[145] As a result, there is only so much money available to pay to the victim of the automobile accident, regardless of the extent of the injuries/losses suffered.[146]

As noted, patients do not just incur medical expenses as a result of an automobile accident; they also suffer other losses such as lost wages, property damage, and pain and suffering.[147] If the hospital's scheme allows it to take an exorbitant fee, the remaining amount of the available insurance proceeds and/or financial resources of the other driver is reduced, leaving the patient little or nothing to cover other losses.[148] In other words, the hospital's greed is satisfied directly against the interests of the hospital's patients.[149]

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139. *Id.*
140. *Id.* at 651.
141. *Id.* at 657.
142. *Id.* at 651.
143. *See generally id.*
144. *See* Jason Metz & Amy Danise, *How Much Car Insurance Do I Need?*, FORBES ADVISOR (Apr. 26, 2023), https://tinyurl.com/mr25rsc9 [https://perma.cc/M5R2-AM32] ("The most common minimum limits for liability are $25,000 per person and $50,000 per accident for bodily injury and $25,000 for physical damage.").
145. *See generally* Nation, *Chargemaster*, *supra* note 27.
146. *Id.*
147. *See supra* notes 141–146 and accompanying text.
148. *See generally* Nation, *Accident*, *supra* note 26; *see also* discussion of Whitley v. Baptist Health *supra* note 124.
149. *See generally* Nation, *Accident*, *supra* note 26.

II. RELEVANT COMMON LAW OF CONTRACTS DOCTRINES

A. Mutual Assent

The law of contracts is the law of voluntary agreement.[150] The most fundamental requirement for the creation of a contract is mutual assent.[151] One cannot be forced into a contract; each party must freely choose to agree to the contract's terms.[152] Mutual assent means that the parties must knowingly and freely agree to be bound by the same terms.[153] It is that agreement, the knowing and freely given assent to common terms, that forms the basis for all of contract law.[154] The law of contracts—its rules and doctrines—must always reflect this fundamental requirement.[155]

The law of contracts is necessarily concerned with determining the intent of the parties.[156] In other words, to determine whether the parties have knowingly and freely entered into an agreement, a court must decide whether they intended to agree.[157] Historically, as the law of contracts became fundamental to the operation of a free-market economy, the need for certainty and predictability led courts to develop the doctrine of objective intent, which is used to determine intent for most contract-related purposes.[158]

Under the objective theory of contracts, the law is not concerned with a party's actual, subjective intent, rather the law determines intent objectively by focusing on a party's objective manifestations as interpreted by a reasonable person.[159] Objective manifestations are those things that a person does that others may perceive. Secretive or unexpressed thoughts, intentions, or desires are not relevant to determining objective intent.[160] As a result, in contract law, a person is deemed to have an intent that is consistent with the impression that he or she reasonably creates.[161] It is often stated that in contract

150. *See* JOHN D. CALAMARI & JOSEPH M. PERILLO, THE LAW OF CONTRACTS §§ 1-3 to 1-4 (2d ed. 1977) (discussing freedom of contract and the philosophical foundation of contract law, respectively).

151. *See* RESTATEMENT (SECOND) OF CONTRACTS, *supra* note 7, § 17 (stating that the formation of a contract requires bargaining in which there is a manifestation of mutual assent).

152. *Id.*

153. *See* Nation, *Contracting for Healthcare*, *supra* note 10, at 110 (discussing freedom of contract, mutual assent, objective intent and the duty to read and noting that each party must knowingly and freely choose to enter into the contract).

154. *Id.*

155. *Id.* at 111.

156. *Id.*

157. *Id.* at 112.

158. *Id.*

159. *Id.*

160. *Id.*

161. *Id.*

law, a person has the intent that a reasonable person in the other contracting party's position would think they have.[162]

Several doctrines have been developed relating to objective intent. For example, when a party's signature appears on a written agreement, the court takes this as objective evidence that the contract has been read and understood by the signer.[163] In addition, the doctrine of a duty to read reinforces this notion by providing that a party has a duty to read and understand or question a written agreement before they sign it.[164] Once their signature is on the agreement, courts will not allow the signing party to raise as a defense the fact that they did not read or did not understand what they signed.[165]

In general, in the case of negotiated contracts, the rules and doctrines associated with objective intent are fair, important, and necessary in order to allow contract law to fulfill its role of supporting a free market economic system.[166] However, as discussed below, in the case of non-negotiated contracts known as adhesive contracts, which are dictated by the stronger party to the weaker party under circumstances that preclude any meaningful negotiation, the unthinking and reflexive application of the rules and doctrines of objective intent is unfair and makes a mockery of contract law.[167] It is precisely this judicial fecklessness that allows the grossly unfair provisions of HACs to be enforced.[168]

However, not all courts suffer from this witlessness, and, for those willing to see the circumstances surrounding HACs clearly, the law as it stands supports an application of objective intent that would conclude that the patient and hospital have not, in fact, entered into an express contract memorialized by the HAC, notwithstanding the patient's signature on the document.[169]

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162. *See*, *e.g.*, CALAMARI & PERILLO, *supra* note 150, § 2-2 (discussing objective and subjective intention). A party's intention will be held to be what a reasonable man in the position of the other party would conclude his manifestations to mean. *Id.*

163. *See* Nation, *Contracting for Healthcare*, *supra* note 10, at 115 (discussing the duty to read and the presumptions flowing from a patient's signature on a contract).

164. *Id.*

165. *Id.*

166. *Id.* (noting that like the objective intent doctrine, the duty to read concept makes good sense in the context of negotiated contracts but may produce pernicious consequences in the context of adhesion contracts).

167. *See* discussion of the *Dennis* case *supra* note 3.

168. *Id.*

169. *See infra* Part III.

B. Capacity

The requirement of contractual capacity reflects that a person who is unable to understand a contract and its potential impact cannot give free and knowing assent and thus cannot enter into a contract.[170] Enforcing a contract against such an individual is inconsistent with the very idea of contract law as the law of voluntary agreement.[171]

Common categories of people courts recognize as lacking capacity include minors under the age of 18, those under the influence of alcohol or other drugs at the time of contracting, and those suffering from a mental defect that prevents free and knowing agreement.[172]

A less common category includes people who are deemed to lack capacity due to the extreme circumstances existing at the time their agreement was given.[173] For example, some courts have recognized that a reasonable person in a hospital emergency department may lack the capacity to contract due to the trauma and anxiety experienced by those confronted with a health emergency.[174] One court concluded that a hospital emergency room is certainly not a place where a reasonable person could be expected to exercise "calm and dispassionate judgment."[175] According to the court, a reasonable person would give a hospital admission contract at most "cursory attention."[176] The court concluded that a hospital "should not be permitted to enforce a contractual obligation entered into under such tension-laden circumstances."[177]

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170. *See*, *e.g.*, CALAMARI & PERILLO, *supra* note 150, § 8-10 (discussing contractual capacity).

171. *Id.*

172. *Id.*

173. *Id.* (noting other forms of mental infirmity resulting in a loss of capacity such as temporary delirium deriving from physical injuries sustained in accidents); Murray v. Ready, 292 P.2d 87, 88 (Colo. 1930) (noting that a person being in great pain and/or being under the influence of drugs can support the conclusion that the person is not competent to contract).

174. *See, e.g.*, St. John's Episcopal Hosp. v. McAdoo, 405 N.Y.S.2d 935, 936 (N.Y. Civ. Ct. 1978). The court recognized the trauma and anxiety experienced by those confronted with an emergency medical crisis and concluded that a hospital emergency room is certainly not a place where a reasonable person could be expected to exercise "calm and dispassionate judgment." *Id.* According to the court, a reasonable person would give a hospital admission contract "cursory attention" at most. *Id.* The court concluded that a hospital "should not be permitted to enforce a contractual obligation entered into under such tension-laden circumstances." *Id.*

175. *Id.*

176. *Id.*

177. *Id.*

C. Contracts of Adhesion

A contract of adhesion is one in which one party has superior bargaining power and is able to dictate the terms of the contract to the other party, and the other party has no ability to negotiate the terms.[178] A contract of adhesion is presented on a take it or leave it basis.[179] The weaker party's only choice is to agree to the exact terms demanded by the stronger party or walk away.[180]

Theoretically, it would be possible for the weaker party to seek out a seller who is willing to negotiate, but this is often not a practical option because the same considerations that gave rise to the contract of adhesion in the first instance usually result in all sellers of such goods or services presenting customers with very similar contracts of adhesion.[181] Thus, the real choice for the weaker party is to agree to the adhesive contract as written or do without the goods or services.[182] Obviously, in the case of medical care, doing without medical care is not an acceptable option.

Courts have recognized that the unique characteristics of adhesive contracts require a special analysis to ensure that the weaker party is not taken advantage of by the stronger party.[183] For example, if the contract as a whole or any provision of it does not fall within the reasonable expectations of the weaker or "adhering" party, then the contract or the offending provisions will not be enforced.[184] Also, any contract or provision that is, in the context of the contract, unduly

178. *See* Nation, *Contracting for Healthcare*, *supra* note 10, at 113 (noting that the hallmarks of a contract of adhesion are unequal bargaining power between the contracting parties, an imbalance of knowledge that favors the party who drafted the agreement or otherwise dictated the terms of the agreement, and an inability of the weaker a party to meaningfully negotiate the terms of the agreement).

179. *Id.*

180. *Id. See* Wheeler v. St. Joseph Hosp., 133 Cal. Rptr. 775, 783 (Cal. Ct. App. 1976). "The term 'adhesion contract' refers to standardized contract forms offered to consumers of goods and services on essentially a 'take it or leave it' basis without affording the consumer a realistic opportunity to bargain and under such conditions that the consumer cannot obtain the desired product or services except by acquiescing in the form contract." *Id.*

181. *See* Nation, *Contracting for Healthcare*, *supra* note 10, at 113.

182. *Id.*

183. *See* CALAMARI & PERILLO, *supra* note 150, § 9-44 ("There has been a tendency, particularly in recent years, to treat contracts of adhesion or standard form contracts differently from other contracts."); *see also* Banner Health v. Medical Sav. Ins. Co., 163 P.3d 1096, 1104 (Ariz. Ct. App. 2007) (Kessler, J., dissenting in part).

184. *See*, *e.g.*, Broemmer v. Abortion Servs., 840 P.2d 1013, 1016–17 (Ariz. 1992) (discussing an agreement to arbitrate included in the admissions documents provided to a patient at a clinic and concluding that "[c]ontracts of adhesion will not be enforced unless they are conscionable and within the reasonable expectations of the parties").

oppressive or unfair will not be enforced even if such provision is consistent with the reasonable expectations of the parties.[185]

The Restatement (Second) of Contracts provides that standardized agreements (adhesive contracts) are enforceable except where a "[stronger] party has reason to believe that the [weaker] party manifesting . . . assent would not do so if he knew that the writing contained a particular term."[186]

The Restatement's position is consistent with the proper application of the objective intent doctrine, which charges the "other party" with the knowledge of the actual other party (the hospital) in the transaction.[187] In other words, one must ask: What would a reasonable person in the hospital's position think the patient's intent was in signing the HAC, knowing what the hospital knows about the provisions contained in the HAC and the patient's condition and available options at the time of signing the HAC?[188]

Thus, under the common law, any unfair or unexpected provisions of an adhesion contract are unenforceable.[189] HACs are adhesive contracts because a patient in an emergency medical situation has no real alternative but to sign as directed by the hospital.[190] Even in the case of non-emergent but necessary medical services, patients often feel they have no choice but to go to the hospital to which their

185. *Id.*

186. RESTATEMENT (SECOND) OF CONTRACTS, *supra* note 7, § 211(3). The Restatement notes that standardized agreements are enforceable except where a "[better-positioned] party has reason to believe that the [weaker] party manifesting . . . assent would not do so if he knew that the writing contained a particular term." *Id.* The Comment goes on to state that "[s]uch a belief or assumption may be shown by prior negotiations or inferred from the circumstances. Reason to believe may be inferred from the fact that the term is bizarre or oppressive." *Id.* at cmt. F.

187. *See* CALAMARI & PERILLO, *supra* note 150, § 2-2 ("By testing the meaning to be given to a party's words from the point of view of the reasonable man in the second party's position, the subjective element of this party's particular knowledge is incorporated into the objective test. In other words, the test considers what the second party knows or should know about the intention of the first party.").

188. *Id.*

189. *See* Graham v. Scissor-Tail, Inc., 623 P.2d 165, 172 (1981).

> Generally speaking, there are two judicially imposed limitations on the enforcement of adhesion contracts or provisions thereof. The first is that such a contract or provision which does not fall within the reasonable expectations of the weaker or "adhering" party will not be enforced against him. The second—a principle of equity applicable to all contracts generally—is that a contract or provision, even if consistent with the reasonable expectations of the parties, will be denied enforcement if, considered in its context, it is unduly oppressive or "unconscionable."

Id. at 172–73 (citations omitted).

190. St. John's Episcopal Hosp. v. McAdoo, 405 N.Y.S.2d 935, 936 (N.Y. Civ. Ct. 1978) ("There are circumstances under which a reasonable person might sign [an admission agreement under emergency conditions], without reading it or understanding it, so that requiring adherence to its terms would be grossly unfair.").

doctor directed them.[191] Moreover, even if the patient went to a different hospital, the HAC presented there would likely be the same as any other in all material respects.[192]

D. Unconscionability

Unconscionability concerns fairness.[193] The doctrine of unconscionability can be applied to make an entire agreement or only certain specific provisions of the agreement unenforceable.[194] Unconscionability has long been part of English and U.S. law, but an exact definition of unconscionability remains elusive. The Supreme Court has stated, quoting an early English case, that a bargain is unconscionable if it is "such as no man in his senses and not under delusion

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191. *See*, *e.g.*, Wheeler v. St. Joseph Hosp., 63 Cal. App. 3d 345, 366 (Cal. Ct. App. 1976) ("A patient like Mr. Wheeler realistically has no choice but to seek admission to the hospital to which he has been directed by his physician and to sign the printed forms necessary to gain admission.").

192. *See* Friedrich Kessler, *Contracts of Adhesion—Some Thoughts About Freedom of Contract*, 43 COLUM. L. REV. 629, 632 (1943). When referring to the traditional application of freedom of contract doctrine to contracts that are not negotiated contracts—e.g., contracts of adhesion—Kessler stated:

> Freedom of contract enables enterprisers to legislate by contract and, what is even more important, to legislate in a substantially authoritarian manner without using the appearance of authoritarian forms. Standard contracts in particular could thus become effective instruments in the hands of powerful industrial and commercial overlords enabling them to impose a new feudal order of their own making up on a vast host of vassals.

Id. at 640.

193. *See* FRIEDRICH KESSLER ET AL., CONTRACTS: CASES & MATERIALS 560 (3d ed. 1986) (noting that courts of equity developed the doctrine of unconscionability to protect victims of sharp dealing).

194. *See*, *e.g.*, Ellsworth Dobbs, Inc. v. Johnson, 236 A.2d 843, 856 (N.J. 1967) (holding that a clause of a real estate listing contract is unconscionable and thus unenforceable). The court stated:

> Courts and legislatures have grown increasingly sensitive to imposition, conscious or otherwise, on members of the public by persons with whom they deal, who through experience, specialization, licensure, economic strength or position, or membership in associations created for their mutual benefit and education, have acquired such expertise or monopolistic or practical control in the business transaction involved as to give them an undue advantage. Grossly unfair contractual obligations resulting from the use of such expertise or control by the one possessing it, which result in assumption by the other contracting party of a burden which is at odds with the common understanding of the ordinary and untrained member of the public, are considered unconscionable and therefore unenforceable. . . . The perimeter of public policy is an ever increasing one. Although courts continue to recognize that persons should not be unnecessarily restricted in their freedom to contract, there is an increasing willingness to invalidate unconscionable contractual provisions which clearly tend to injure the public in some way.

Id. at 856–57.

would make on the one hand, and as no honest and fair man would accept on the other."[195]

The Uniform Commercial Code recognizes unconscionability but also fails to provide a definition, although the Official Comments to Section 2-302 read, "the basic test is whether, in the light of the general commercial background and the commercial needs of the particular trade or case, the clauses involved are so one-sided as to be unconscionable under the circumstances existing at the time of the making of the contract."[196] The Restatement (Second) of Contracts, which applies to contracts generally, also recognizes the doctrine of unconscionability but includes no definition.[197]

In applying the doctrine of unconscionability, most courts have used an analytical framework that focuses on both the process of contracting and the resulting contract.[198] Specifically, this framework requires a finding of a defect in the contracting process such that the party alleging unconscionability has given less than knowing and free assent to the terms of the contract.[199] This requirement is known as procedural unconscionability.[200] For example, contracts of adhesion, very small print, or confusing language have all been used to satisfy the procedural unconscionability requirement.[201]

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195. Hume v. United States, 132 U.S. 406, 415 (1889); *see also* Eyre v. Potter, 56 U.S. 42, 60 (1953) (describing behavior sufficiently outrageous to shock the conscience of the court).

196. *See* U.C.C. § 2-302 cmt. 1 (UNIF. L. COMM'N 1990). If the court as a matter of law finds the contract or any clause of the contract to have been unconscionable at the time it was made, the court may refuse to enforce the contract, enforce the remainder of the contract without the unconscionable clause, or limit the application of any unconscionable clause as to avoid any unconscionable result. *Id.* Article 2 applies only to the sale of goods. *See id.*

197. *See* RESTATEMENT (SECOND) OF CONTRACTS, *supra* note 7, § 208.

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

Id.

198. *See generally* Arthur Allen Leff, *Unconscionability and the Code—The Emperor's New Clause*, 115 U. PA. L. REV. 485 (1967) (critiquing U.C.C. § 2-302 and offering the now famous two-prong analysis).

199. *See id.* at 486–87.

200. *See id.* at 487.

201. *See*, *e.g.*, Williams v. Walker-Thomas Furniture Co., 350 F.2d 445, 449 (D.C. Cir. 1965) ("Unconscionability has generally been recognized to include an absence of meaningful choice on the part of one of the parties together with contract terms which are unreasonably favorable to the other party."). The court noted that "[i]nquiry into the relative bargaining power of the two parties is not an inquiry wholly divorced from the general question of unconscionability, since a one-sided bargain is itself evidence of the inequality of the bargaining parties." *Id.* at 449 n.7; Tunkl v. Regents of Univ. of Cal., 383 P.2d 441, 447 (Cal. 1963) (concerning an

In addition, the contract or clause in question must be grossly unfair in its application or contain terms that are so one-sided or unfair as to shock the conscience of the court.[202] This requirement is known as substantive unconscionability.[203] Substantive unconscionability is concerned with the terms of the agreement between the parties and not with the process from which they resulted.[204]

In one case, for example, a financing agreement that was confusingly written to keep a balance owing on every past item purchased until all items were paid in full was deemed substantively unconscionable,[205] as was a financing agreement in another case that provided financing charges that greatly exceeded the price of the item financed.[206] Context, including specific characteristics of the weaker party to the contract, becomes very important in these cases.[207]

Substantive unconscionability may be found if the contract or clause creates an unreasonable or unexpected allocation of risks between the parties, provides for the unexpected assumption of a burden by the weaker party, or is contrary to common fairness.[208] For example, a provision in an HAC signed by a non-patient imposing personal liability on the signer for medical care provided to the patient was deemed beyond the reasonable expectations of the party signing the agreement.[209] Some courts will make a finding of unconscionability based on substantive unconscionability alone, and even courts that require both procedural and substantive

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exculpatory clause in a hospital admission contract). The court noted that "the hospital certainly exercises a decisive advantage in bargaining. The would-be patient is in no position to reject the proffered agreement, to bargain with the hospital, or in lieu of agreement to find another hospital." *Id. See also infra* note 218 and accompanying text.

202. *See* Leff, *supra* note 198, at 509.

203. *See id.* at 487.

204. *See id.* at 509.

205. *See Williams*, 350 F.2d at 448 (finding a financing agreement unconscionable).

206. *See*, *e.g.*, Jones v. Star Credit Corp., 298 N.Y.S.2d 264, 264 (N.Y. Sup. Ct. 1969) (noting that a freezer with a retail value of $300 sold for $1,234); Toker v. Westerman, 274 A.2d 78, 78 (D.N.J. 1970) (noting that a freezer with a retail value of $400 sold for $1,230).

207. *See Williams*, 350 F.2d at 449 (noting the average educational level of the store's customers).

208. *See, e.g.*, St. John's Episcopal Hosp. v. McAdoo, 405 N.Y.S.2d 935, 936–37 (N.Y. Civ. Ct. 1978) (finding a husband who signed a hospital admissions form for his estranged wife was not obligated to pay for medical care provided to his wife given the high stress at the time of signing); Phoenix Baptist Hosp. & Med. Ctr., Inc. v. Aiken, 877 P.2d 1345, 1350 (Ariz. Ct. App. 1994) (finding a husband's property could not be taken to satisfy payment for medical debt given the stressful circumstances the agreement to pay was made under).

209. *See generally* Leff, *supra* note 198.

unconscionability will often allow extremes in either one to compensate for a much lesser presence of the other.[210]

III. ANALYSIS

A. Mutual Assent Is Lacking

The patient's signature on the HAC does not establish the patient's knowing and free agreement under the objective theory of contracts, and therefore mutual assent is lacking, and no contract exists based on the HAC.[211] This is because a reasonable person in the hospital's position at the time the patient signs the HAC—knowing what the hospital knows about the patient's likely state of mind given the patient's medical condition, with which the hospital is intimately familiar, and the patient's presence in the hospital for imminent medical care—would realize that the only reasonable intent to be derived from the patient's signature on the HAC is that the patient signed the HAC because the patient needed medical care and believed a signature on the HAC was needed to obtain such care.[212] A reasonable person in the hospital's position and knowing what the hospital knows would not think the patient was knowingly and freely agreeing to the many complicated and harsh terms contained in the HAC.[213] The patient's objective intent is to receive medical care, and a reasonable person in the hospital's position would not think the patient knowingly and freely agreed to anything else.[214]

The proper application of the doctrine of objective intent and its corollaries requires recognition of the fact that HACs are signed under circumstances that give the patient no choice but to sign

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210. Tacoma Boatbuilding Inc. v. Delta Fishing Co., No. 165-72C3, 1980 U.S. Dist. LEXIS 17830, at *20 n.20 (W.D. Wash. Jan. 4, 1980) ("[T]he substantive/procedural analysis is more of a sliding scale than a true dichotomy."); JAMES J. WHITE & ROBERT S. SUMMERS, UNIFORM COMMERCIAL CODE 134, 206, 231 (4th ed. 1995) ("[A] contract that is ninety-eight parts substantively unconscionable may require only two parts of procedural unconscionability to render it unenforceable and vice versa.").

211. *See, e.g.*, *McAdoo*, 405 N.Y.S.2d at 936–37 (recognizing that the trauma and anxiety of a hospital emergency room is not an environment where a reasonable person could be expected to exercise "calm and dispassionate judgment"). *See also* discussion *supra* note 178.

212. *See* Nation, *Contracting for Healthcare*, *supra* note 10, at 116–17 (discussing the correct application of objective intent).

213. *See* CALAMARI & PERILLO, *supra* note 150, at § 2-2 ("By testing the meaning to be given to a party's words from the point of view of the reasonable man in the second party's position, the subjective element of this party's particular knowledge is incorporated into the objective test. In other words, the test considers what the second party knows or should know about the intention of the first party.").

214. *See id*.

whatever agreement is presented by the hospital.[215] Moreover, these agreements are entered into in circumstances where the patient has little opportunity to understand the terms offered and no choice but to agree to whatever terms the hospital dictates.[216] The lack of a commercial setting, a bargaining table, or time to read and negotiate all contribute substantially to the unenforceability of hospital admission contracts.[217] But, while all of these things contribute to the conclusion that there is no mutual assent when a patient signs an HAC, the overriding factor that refutes the existence of mutual assent is that urgent medical services are necessities, and time is virtually always important.[218] Thus, even if a patient were to somehow understand the terms in the hospital admission contract and decided he or she did not want to agree to them, the patient is in no position to shop for an alternative supplier of urgently needed medical services.[219] The patient must agree to the terms the hospital offers because the patient needs medical care.[220]

It is not the fault of the hospital that circumstances force patients to agree to whatever terms the hospital offers, but this does make express hospital admission contracts unenforceable due to a lack of mutual assent.[221] However, a determination that no enforceable express contract was entered based on the HAC does not mean that

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215. *See McAdoo*, 405 N.Y.S.2d at 936 (finding that a husband who signed a hospital admission form for his estranged wife was not obligated to pay for medical care given the high stress at the time of signing). The court stated:

> It is reasonable in this situation for defendant to have seen himself as powerless to do anything other than sign the form. A hospital emergency room is certainly not a place in which any but the strongest can be expected to exercise calm and dispassionate judgment. . . . Plaintiff hospital is surely no stranger to the trauma and anxiety experienced by those confronted with emergency medical crises. Armed with this knowledge it should have prepared the form it uses to impose liability so that the person being asked to sign it can readily grasp its meaning, even through a quick reading. Moreover, plaintiff should not be permitted to enforce a contractual obligation entered into under such tension-laden circumstances, as those defendants described.

Id. at 937.

216. *See id.* at 936–37.

217. *See* Tunkl v. Regents of Univ. of Cal., 383 P.2d 441, 447 (Cal. 1963).

218. George A. Nation III, *Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured*, 94 KY. L.J. 101, 112 n.73 (2005) [hereinafter Nation, *Obscene Contracts*] ("[A] valid distinction may be drawn between necessary medical services, whether rendered on an emergency basis or on a planned basis, and elective medical services such as elective cosmetic surgery.").

219. *Id.* at 112.

220. *Id.* at 112–113.

221. *See supra* notes 210–219 and accompanying text.

there is no contract between the hospital and the patient.[222] On the contrary, there will be either an implied-in-fact or an implied-in-law (quasi-contract) contract, as appropriate, between the hospital and the patient.[223] In either case, the terms of the contract would be provided by the court based on what is fair and reasonable.[224] For example, a fair and reasonable HAC would require the patient to pay no more than the fair and reasonable value of the healthcare received. It would not contain an independent contractor acknowledgment, a pre-dispute binding arbitration clause, nor an assignment clause that could be used by the hospital to extract a financial windfall at the patient's expense.[225]

Attacking HACs via a lack of mutual assent is the approach most consistent with the theoretical foundations of contract law.[226] But, unfortunately, as discussed above, common judicial misapplication of the doctrine of objective intent and its corollaries in the case of adhesive contracts presents significant practical problems to using mutual assent to prevent the enforcement of HACs.[227] Thus, as discussed below, patients should always argue alternatively that the patient lacked capacity at the time the HAC was signed or alternatively that the harsh provisions contained therein are not enforceable under either a contract of adhesion analysis or as unconscionable provisions.[228]

B. No Capacity to Contract

Courts assume individuals are competent to enter contractual relationships, and as a result, challenging a contract based on a lack of capacity is treated as an affirmative defense.[229] This means that the party claiming to lack capacity has the burden of producing sufficient evidence to convince the court that the capacity to contract is lacking.[230]

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222. *See* Nation, *Contracting for Healthcare*, *supra* note 10, at 133–36 (discussing the creation of implied-in-law and implied-in-fact contracts in the medical context).

223. *See id.*

224. *See id.*

225. *See supra* Part I.

226. *See supra* Section III.A.

227. *See, e.g.*, Rory v. Cont'l Ins. Co., 703 N.W.2d 23, 35 (Mich. 2005) ("An 'adhesion contract' is simply that: a contract. It must be enforced according to its plain terms unless one of the traditional contract defenses applies.").

228. *See infra* Section III.D.

229. E. ALLAN FARNSWORTH, FARNSWORTH ON CONTRACTS § 4.2 (3d ed. 2004) (stating that only under extreme circumstances will the law find a person's power to contract impaired because of a lack of mental capacity).

230. Autumn Smith, *You Can't Judge Me: Mental Capacity Challenges to Arbitration Provisions*, 56 BAYLOR L. REV. 1051, 1055–56 (2004) (discussing the level of proof required to prove mental incapacity in different courts).

Even in the healthcare context, where patients sign contracts under extreme physical and/or mental distress—which naturally calls capacity to contract into question—the burden of overcoming the presumption of capacity is a heavy one.[231] The two following cases illustrate the potential and the difficulty of using a capacity defense for an HAC.

In *Kindred Hospitals Limited Partnership v. White*,[232] the Kentucky Court of Appeals reversed the circuit court's finding that an arbitration clause included in the admissions paperwork signed by a patient was void due to lack of capacity.[233] The lower court based its finding of a lack of capacity on the following facts: The patient was brought to the hospital late at night via ambulance, and during the ride to the hospital her prescription eyeglasses were misplaced; the patient was alone and had no family members to assist her during admission; the patient was administered pain medications including oxycodone prior to signing the HAC; and the patient had been diagnosed with Stage III lung cancer and had recently undergone a procedure in which she was subjected to the insertion of a metal tracheostomy tube which made her unable to speak.[234]

In its reversal, the Court of Appeals started by noting that there is a presumption of contractual capacity, and it is the patient's obligation to refute it.[235] Next, the Court went through each of the reasons for the lower court's conclusion and found that none of them sufficiently refuted the presumption of capacity.[236]

For example, the court did not think that the evidence established that the patient needed her prescription eyeglasses to read the admissions paperwork.[237] The court also found that having a family member present is not necessary for a finding of capacity to contract.[238] With regard to the medications given to the patient, the court said that the record was not clear as to when the patient had received her last dose of oxycodone before signing the admissions

231. *See infra* Section III.B.

232. Kindred Hosps. Ltd. P'ship v. White, No. 2016-CA-001048-MR, 2017 WL 4464339 (Ky. Ct. App. Oct. 6, 2017).

233. *See id*. at *7.

234. *See id.* at *3.

235. *See id.*

236. *See id.* at *3–5.

237. *See id.* at *3 (noting that nothing in the record demonstrates that the patient was incapable of reading the ADR agreement without the use of her prescription glasses). More importantly, nothing in the record supports that the patient's eyeglasses were ever misplaced, or that the patient did not have them with her when she executed the ADR agreement. *See id.*

238. *Id*. at *4 (noting that the record does not clearly show that the patient had no family members to assist her during the admissions process and does not disclose precisely when the patient executed the ADR agreement).

paperwork.[239] Finally, with respect to being unable to speak, the Court stated that the ability to speak is not necessary for the capacity to contract.[240]

Interestingly, the Court of Appeals cited the following medical record as evidence of the patient's ability to communicate:

> According to GL McFall RN's notes from 03/02/14, [Patient] "ask[ed] appropriate questions" and "verbalize[d]/state[d] full understanding" of a discussion they had regarding "medications, nutrition, oral health, equipment, rehab techniques, pain management, tests/procedures, disease process, safety, discharge planning, [and] infection control precautions."[241]

In fact, it is much more likely that many of the "notes" in medical records are self-serving boilerplate that hospital personnel use as a matter of routine rather than an accurate reflection of the patient's status.[242] This particular record seems to be such an example due to its broad, general, and conclusory statements, and this record is made even more suspect by another record cited by the court which states: "Another nurse . . . noted [patient] was capable of mouthing words with enough proficiency to communicate that 'her husband . . . would be able to give needed information and that he was due to visit her in approximately 1 hour.'"[243] Given the limited number of patients to which such an observation could apply, this record seems much more likely to reflect an actual observation. Moreover, as noted, this record places further doubt on the veracity of the first record as it seems very unlikely that the patient went from being able to ask appropriate questions and verbalize/state full understanding to having to mouth words to communicate to her nurse and the apparent necessity of awaiting the husband's arrival to obtain complete information regarding the patient.[244]

White illustrates the practical difficulty associated with carrying the burden of proof with respect to affirmative defenses.[245] Adding insult to injury, the Court of Appeals in *White* noted that a finding of

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239. *Id.*

240. *Id.* at *5 (noting that the patient's medical records and legible signature on the ADR agreement demonstrate that her inability to speak did not render her unable to otherwise communicate).

241. *Id.* at *5 n.6.

242. *See* Saul J. Weiner et al., *How Accurate is the Medical Record? A Comparison of the Physician's Note with a Concealed Audio Recording in Unannounced Standardized Patient Encounters*, 27 J. AM MED. INFO. ASS'N 770, 770 (finding 90 percent of notes contained at least 1 error).

243. *White,* 2017 WL 4464339, at *5 n.6.

244. *See id*. at *5.

245. *See id.* at *3–5.

lack of capacity *could* be sustained *if* substantial evidence supports a lack of capacity.[246] However, according to the court, the evidence in *White* was not sufficient.[247] The court's statement begs the question as to whether it would find any evidence sufficient. The court concluded that the patient was very ill, but that alone does not equate to a lack of capacity to enter a contract.[248]

Ironically, three years prior to the *White* decision, the same court in *Pikeville Medical Center v. Bevins*[249] found that a patient lacked the capacity to enter into a complex arbitration agreement that was included in the hospital's admissions paperwork.[250] *Bevins* illustrates the potential for a patient to successfully assert a capacity defense. The *Bevins* court reached its conclusion despite medical records evidence that indicated that the patient was awake and alert when he executed the agreement.[251] The court noted that this alone does not necessarily support a finding that the patient had capacity.[252]

In *Bevins,* an Admission History Report completed by the admitting physician contained this report: "Physical examination: General: Caucasian male patient. He is alert, awake, oriented. He is not in acute distress; actually pleasant and cooperative with examination."[253]

The hospital argued that this report directly contradicted the lower court's finding on the record that Bevins was "in very poor health," "in end stage renal failure, frail, and weak," and was "being admitted for placement of a dialysis catheter."[254] The Court of Appeals disagreed, noting that while the doctor may have found that Mr. Bevins was alert, awake, oriented, and cooperative at the time of examination, "what constitutes being alert, oriented, and communicative for medical purposes is not necessarily coextensive with what constitutes being alert, oriented, and communicative for matters of legal concern."[255] The court went on as follows:

> It is elementary law that capacity, both legal and mental, is a necessary and constituent element of a simple contract. . . .
>
> While Bevins may have been focused enough to respond to the doctor's questions and participate as necessary in the course of his medical treatment, the records clearly indicate that he was

246. *See id.* at *2 n.3.
247. *See id.* at *3.
248. *See id.*
249. Pikeville Med. Ctr., Inc. v. Bevins, No. 2013-Ca-000917-MR, 2014 WL 5420002 (Ky. Ct. App. Oct. 24, 2014).
250. *See id.* at *4.
251. *Id.* at *1.
252. *Id.* at *12.
253. *Id.* at *10.
254. *Id.* at *10–11.
255. *Id.* at *11.

> admitted on transfer for treatment of late-stage kidney disease and that he was a very elderly, sick man at the time of admission. Accordingly, Bevins was not necessarily alert and oriented for purposes of reviewing and signing a complex contract of the kind presented to him in light of the various maladies from which he was suffering at the time.[256]

In *White*, the Court cited *Bevins* with approval, though it expressly noted that the decision is unpublished,[257] but found that in *White,* unlike *Bevins,* the patient did not carry her burden of proof with respect to proving lack of capacity. *White* is also an unpublished decision.[258] Whether differences in the facts or evidence presented in *White* and *Bevins* are really the cause of the differing results is hard to say.[259] The author is tempted to account for the different results by observing that a different panel of judges heard each case. If correct, this is a further indication of the difficulty of preventing the enforcement of HACs based on a lack of capacity. Not only is the defense very fact sensitive, but it may also be listener sensitive.

C. Adhesion Contract

In the alternative, if the court finds that an express contract was created based on the HAC, it is clearly a contract of adhesion, and therefore it can be argued that unexpected and/or unfair terms are not enforceable.[260] Recall that according to the Restatement, courts should closely examine contracts of adhesion and refuse to enforce any terms with respect to which the stronger party has reason to believe that the weaker party would not sign the contract if they knew that it contained a particular term.[261] Also, such a belief may be inferred from the circumstances.[262] In addition, the stronger party has reason to believe the weaker party would not agree to the contract if it contains terms that are either unexpected or oppressive.[263]

There is an important difference between negotiated contracts and adhesive contracts.[264] Courts that blindly enforce HACs typically

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256. *Id.* (citation omitted).

257. Kindred Hosps. Ltd. P'ship v. White, No. 2016-CA-001048-MR, 2017 WL 4464339, at *2 n.3 (Ky. Ct. App. Oct. 6, 2017).

258. *Id.* at *2.

259. In fact, the facts of *White see*m to provide stronger support for a finding the patient lacked capacity than those in *Bevins*. *See id.*

260. *See supra* Section II.C.

261. *See supra* notes 186–188 and accompanying text.

262. *See infra* notes 186–188 and accompanying text.

263. *See infra* notes 186–188 and accompanying text.

264. *See infra* notes 183–185 and accompanying text.

fail to appreciate this difference.[265] As a result, these courts, with their myopic view of contracts, struggle in vain to reach a just result because they are applying doctrines developed for negotiated contracts, without adjustment, to adhesive contracts.[266] With respect to negotiated contracts, the justness of, for example, the objective intent doctrine is virtually unassailable.[267] Contract law could not function effectively if, in the context of negotiated contracts, it was necessary to be concerned with the possible unexpressed or secret intentions of the parties.[268]

Likewise, contract law could not function effectively in the modern economy if the law only enforced negotiated contracts and rejected per se the enforceability of adhesive contracts.[269] Certainly, the majority of consumer contracts created today are adhesive contracts.[270] Adhesive contracts have important advantages that are

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265. *See, e.g.*, Friedrich Kessler, *Contracts of Adhesion—Some Thoughts About Freedom of Contract*, 43 COLUM. L. REV. 629, 632, 641–42 (1943).

> [T]he "law" will [not] protect the public against any abuse of freedom of contract . . . so long as we fail to realize that freedom of contract must mean different things for different types of contracts. Its meaning must change with the social importance of the type of contract and the degree of monopoly enjoyed by the author of the standardized contract.

Id.

266. *See, e.g.*, PHC-Martinsville, Inc. v. Dennis, No. 161019, 2017 WL 4053898, at *1 (Va. Sept. 14, 2017). The Supreme Court of Virginia engaged in a blind application of the doctrine to reverse the circuit court's holding that no mutual assent existed, stating that "contrary to the circuit court's ruling, the evidence established the Dennis assented to the terms of the contract. Whatever Dennis's unexpressed intentions may have been, his signature on the contract was clearly a manifestation of his intent to agree to its terms." *Id.* at *2.

267. *See* CALAMARI & PERILLO, *supra* note 150, §§ 1–3. A negotiated contract is the type that courts have traditionally had in mind when developing the rules of contract law. "[M]ost of contract law is premised upon the model consisting of two alert individuals, mindful of their self-interest, hammering out an agreement buy a process of hard bargaining." *Id.* These authors also note that there has been increasing recognition and legal literature that the bargaining process has become more limited in modern society. *Id.*

268. *See id.*, §§ 2-2, 9-46. The authors note that an objective test is believed to "protect the fundamental principle of the security of business transactions," but with respect to adhesive contracts, they state, "some of the more modern cases search not only for apparent objective assessment but also for a true assent. Under this view true assent does not exist unless there is a genuine opportunity to read the clause in question and its impact is explained by the dominant party and understood by the other party who has a reasonable choice under the circumstances, of accepting or rejecting the clause. . . ." *Id.* The Restatement (Second) goes one step further when it indicates that what is important, at least in contracts of adhesion, is whether a reasonable man would have expected to find such a clause in the contract. *See* RESTATEMENT (SECOND) OF CONTRACTS, *supra* note 7, § 211.

269. *See* Nation, *Contracting for Healthcare*, *supra* note 10, at 112–20 (discussing contracts of adhesion).

270. *Id.* at 118.

necessary for the efficient functioning of today's economy.[271] For example, adhesive contracts are inexpensive to create because the same one can be used for many transactions, and they are quick, cheap, and easy to enter into.[272]

However, the necessity and usefulness of adhesive contracts do not require or justify treating them as if they were the same as negotiated contracts.[273] They are not the same, and therefore courts must tailor their analysis to recognize the unique characteristics of adhesive contracts.[274] With respect to contracts of adhesion, the rote unthinking application of the objective intent doctrine and its supporting corollaries, such as the duty to read and presumptions based on the presence of a signature on a contract, becomes suspect and requires that care be taken in their application to avoid unfair, inequitable, and/or unjustifiable results.[275]

To be clear, the objective intent doctrine does apply to adhesive contracts, but the key to its proper application recognizes that the law's reasonable person—from whose perspective we must interpret the intent of the weaker party—is deemed to have the actual knowledge of the stronger party who drafted the adhesive contract.[276] As a result, for contracts of adhesion the relevant question under the objective intent doctrine is: What would a reasonable person—who knows that the contract signed by the weaker party is an adhesive contract and also knows the circumstances surrounding the contract's execution—think the weaker party's intent was in executing the adhesive contract?[277]

In the context of an HAC, hospitals argue that patients have assented to the terms of the HAC by signing the agreement.[278] However, the question for the court is what to make of the hospital's claim that the patient (the weaker party) has objectively agreed to the terms dictated by the hospital (the stronger party)?[279] This claimed

271. *Id.* at 111.
272. *Id.*
273. *See supra* Section II.C.
274. *Id.*
275. *See supra* Section III.A.
276. *Id.*
277. *Id.*
278. *Id.*
279. *Id. See*, *e.g.*, Broemmer v. Abortion Servs., 840 P.2d 1013, 1017 (Ariz. 1992) (discussing an agreement to arbitrate included in the admissions documents provided to a patient at a clinic). In Broemmer, the court cited with approval the Restatement (Second) of Contracts, Section 211 (Standardized Agreements): "Although customers typically adhere to standardized agreements and are bound by them without even appearing to know the standard terms in detail, they are not bound to unknown terms which are beyond the range of reasonable expectation." *Id.* (citing RESTATEMENT (SECOND) OF CONTRACTS, *supra* note 7, § 211). Further, the

objective agreement is not indicative of real assent by the patient under these circumstances.[280]

It is not reasonable to expect patients to read HACs, given the typical circumstances of hospital admission.[281] Moreover, reading the HAC is a fool's errand because nothing in it can be changed, and nothing will change the fact that the patient needs healthcare.[282] A patient's signature on hospital paperwork is not indicative of agreement, assent, or understanding; it merely shows the extreme power wielded by the hospital *vis-à-vis* the patient in these circumstances.[283]

In the HAC context, the hospital certainly has reason to know of the extreme, tension-filled, and anxiety provoking circumstances patients experience, and it also has reason to believe that no patient would knowingly and freely agree to pay many times more than the average patient (the payment provision), nor would he or she give

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court concluded that "[c]ontracts of adhesion will not be enforced unless they are conscionable and within the reasonable expectations of the parties." *Id.* at 1018. It stated: "This is a well-established principle of contract law; today we merely apply it to the undisputed facts of the case before us." *Id.* But *see* Rory v. Cont'l Ins. Co., 703 N.W.2d 23, 35 (Mich. 2005) ("An 'adhesion contract' is simply that: a contract. It must be enforced according to its plain terms unless one of the traditional contract defenses applies."). Rory was a 4-3 decision; Justice Kelly in dissent, joined by two other dissenting Justices, stated: "[T]he majority of the courts in this country has disavowed the strict construction policy in construing contracts of adhesion." *Id.* at 52 (Kelly, J., dissenting).

280. *See* CALAMARI & PERILLO, *supra* note 150, §§ 9-41 to 9-46. Many commentators have questioned the appropriateness of the duty to read doctrine in the context of contracts of adhesion. *See generally* Charles L. Knapp, *Is There a "Duty to Read?"*, 66 HASTINGS L. J. 1083 (2015); Ian Ayres & Alan Schwartz, *The No-Reading Problem in Consumer Contract Law*, 66 STAN. L. REV. 545 (2014); Randy E. Barnett, *Consenting to Form Contracts*, 71 FORDHAM L. REV. 627 (2002); John D. Calamari, *Duty to Read—A Changing Concept*, 43 FORDHAM L. REV. 341 (1974); Stewart Macaulay, *Private Legislation and the Duty to Read—Business Run by IBM Machine, the Law of Contracts and Credit Cards*, 19 VAND. L. REV. 1051 (1966); KARL N. LLEWELLYN, THE COMMON LAW TRADITION: DECIDING APPEALS 370 (1960).

281. *See supra* Section III.A.

282. *Id.* As one court noted, "failure to read an instrument is not negligence per se but must be considered in light of all surrounding facts and circumstances." Chandler v. Aero Mayflower Transit Co., 374 F.2d 129, 136 (4th Cir. 1967) (concerning a bill of lading).

283. *See supra* Section III.A; CALAMARI & PERILLO, *supra* note 150, § 9-46. Thus, some of the more modern cases search not only for apparent objective assessment but also for a true assent. Under this view, true assent does not exist unless there is a genuine opportunity to read the clause in question and its impact is explained by the dominant party and understood by the other party who has a reasonable choice under the circumstances, of accepting or rejecting the clause. The adhesive nature of the contract and the context in which it is signed are very important facts and circumstances indeed. *See*, *e.g.*, St. John's Episcopal Hosp. v. McAdoo, 405 N.Y.S.2d 935, 936 (N.Y. Civ. Ct. 1978) ("There are circumstances [such as an emergency hospital admission and a signature on an admission agreement] under which a reasonable person might sign a contract, without reading it or understanding it, so that requiring adherence to its terms would be grossly unfair.").

up their ability to sue the hospital and doctors in court for medical negligence (the independent contractor provision and the arbitration provision), nor give up their right to recover a fair settlement from a third party or entity responsible for injuring the patient (the assignment provision).[284] As a result, even if the HAC is considered a contract, the harsh provisions it contains are not enforceable.[285]

D. Unconscionable

In the alternative, the harsh terms included in the HAC are not enforceable because they are unconscionable.[286] A complete analysis of the unconscionability of hospitals charging self-pay patients CDM prices has been adequately addressed in other works.[287] It is sufficient here to note that unconscionability is likely to be a good defense to certain of the troublesome provisions contained in HACs but somewhat less well suited to others.[288]

As noted above, the second prong of unconscionability analysis requires that the provision in question be grossly or shockingly unfair.[289] As the author has explained in detail in other work, in the HAC context, this is clearly the case with respect to the price provision[290] and the assignment of non-health insurance provisions.[291] However, at least as a general proposition, arbitration provisions and independent contractor acknowledgments may not be grossly unfair if they are knowingly and freely entered into.[292] Of course, as discussed above, HACs are not knowingly and freely entered into.[293] But this only establishes procedural unconscionability and substantive unconscionability is also needed.[294]

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284. *See supra* Section III.A; CALAMARI & PERILLO, *supra* note 150, §2-2 (suggesting that the proper application of the objective intent standard incorporates the subjective knowledge of the actual party in whose position we place the hypothetical reasonable person).

285. *See supra* Section II.C; *see supra* Section III.A.

286. *See supra* Section II.D.

287. *See* Nation, *Obscene Contracts*, *supra* note 218 (arguing that an admission agreement between a hospital and a patient, in which the patient agrees to pay the hospital's "full charges" for necessary medical services, is unenforceable because it is unconscionable, and as a result the most that the patient is liable to pay the hospital is the reasonable value of the medical goods and services received).

288. *Id.* (price terms); *see generally* Nation, *Accident*, *supra* note 26 (assignment provision).

289. *See supra* Section II.D.

290. *See generally* Nation, *Obscene Contracts*, *supra* note 218 (price provisions).

291. *See generally* Nation, *Accident*, *supra* note 26 (assignment of non-health insurance provisions).

292. *See supra* Section I.B (noting both federal and State polices in favor of voluntary arbitration).

293. *See supra* Section III.A.

294. *See supra* Section II.D.

Some courts define substantive unconscionability as gross unfairness or as unfairness that shocks the conscience of the court.[295] It is possible that a court may find these provisions in an HAC unfair but not grossly or shockingly so.[296] In that case, using the adhesive contract theory and focusing on the fact that, in the specific case of HACs, hospitals have sufficient reason to believe that patients would not freely agree to these unexpected and/or oppressive terms may be more likely to find success.[297]

CONCLUSION

As discussed, the most promising defense to the enforcement of harsh terms in HACs is the doctrine of adhesion contracts because it recognizes the need to protect weaker parties from unfair surprises.[298] While a lack of mutual assent is the best reason for refusing to enforce HACs from a legal theory perspective, it has proven difficult in practice.[299] A lack of capacity will clearly apply in some cases,[300] but in general, it is very hard for patients to prove.[301] As noted, unconscionability is most likely to be effective regarding price terms tied to CDM prices and assignment provisions designed to produce a financial windfall for the hospital at patients' expense.[302]

Courts are not bound by the common law to enforce unfair and/or oppressive terms included in HACs even when a patient has signed the agreement.[303] The common law doctrines mentioned above have long been part of contract law and are available for courts to use in policing HACs to make sure patients are treated fairly.[304]

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295. *Id.*

296. The issue here is whether there is a relevant legal distinction between a provision that is unfair and one that is grossly unfair. The author has found no relevant case law directly addressing this issue but notes that some courts refer to unfair terms being substantively unconscionable, while others refer to substantively unconscionable terms as being grossly unfair.

297. *See supra* Section III.C.

298. *See supra* Section III.C.

299. *See supra* Section III.A.

300. For example, where the patient can clearly establish that they were under the influence of recently administered pain medication like morphine at the time of signing the HAC.

301. *See supra* Section III.B.

302. *See supra* Section III.D.

303. *See supra* Part III.

304. *See supra* Part II.