High-Deductible Health Plans: New Twists on Old Challenges from Tort and Contract

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1. The author acknowledges with gratitude the very helpful comments provided on earlier 
   versions of this paper by Marsha Cope Huie, J.D., Timothy Stoltzfus Jost, J.D., Nicholas P. 
   Terry, LL.M., Peter Jacobson, J.D., M.P.H., Lance Stell, Ph.D., and Howard Entman, M.D.

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I. INTRODUCTION

In just a few decades American health care financing has, in a sense, come full circle. After being largely patient-financed in the early twentieth century, generous insurance coverage in mid-century largely permitted providers to do as they wished and charge what they pleased—an Artesian Well of Money that left patients and physicians well-insulated from the costs of care. That system's inevitable explosion of costs spurred urgent efforts to contain health care expenditures, as payors sought to control or at least influence medical decisions. In many ways this "managed care" was clinically vexatious and economically disappointing. Its medically intrusive tactics have now largely though not entirely faded, and—back to the future—the current trend is to place economic responsibility back in patients' hands via "Consumer-Defined Health Plans" ("CDHPs") that couple catastrophic insurance coverage with large deductibles.

Across this trajectory of financial changes, the focus of health care litigation has evolved right alongside. When physicians largely controlled both care and costs, medical malpractice occupied center stage. Then, as managed care entities exerted greater financial and clinical control, they too became litigation targets, sometimes via direct corporate liability for their own financial and medical decisions, and sometimes under ostensible agency for alleged missteps of physicians with whom they associated. And now, as patients regain financial responsibility, the focus will shift yet again.

This Article explores that shift. After further surveying history and the current transition to CDHPs, I will examine three kinds of litigation that are especially likely to arise where patients pay for their own care. Torts questions will arise: when physicians do not disclose the projected costs of care, is this a breach of informed consent? Further issues may arise from the fact that, although physicians have a confidential relationship with patients, their financial interests can create significant conflicts of interest. Where physicians' medical recommendations are too cozy with their own financial interests, can this be a breach of fiduciary duty? Finally, contract questions will emerge around pricetags. Where prices are not agreed on in advance, they must generally be "reasonable." And yet price structures in health care are often too incomprehensible to discern what "reasonableness" might mean. When patients complain providers' charges are too high, jurors may be asked to address important questions of health care pricing.

Many of these potential litigation issues are not inherently novel. But they may arise with surprising force and frequency. When
large numbers of middle income people begin paying directly for substantial procedures out of pocket, they will likely begin scrutinizing more closely the economic as well as medical wisdom of their health care. This Article explores some of the directions that scrutiny may take.

A. History

American health care has undergone a remarkable, relentless series of economic changes. During the mid-twentieth century, as first-dollar insurance coverage became a standard workplace benefit, most citizens came to expect that health care should cost little or nothing from their own pockets. At the same time, health care costs began to soar.

Retrospective fee-for-service ("FFS") reimbursement paid for virtually any service because insurers were reluctant to challenge providers' judgments about appropriate care. In turn, the 1965 enactment of Medicare and Medicaid began to base payment for each service on what providers chose to charge, thereby sparking major price inflation as physicians' and hospitals' charges rose. When private insurers adopted similar reimbursement structures, health care was essentially financed by an "Artesian Well of Money" in which costs posed no obstacle.


3. See infra Part IV.C; see also B.B. Roe, Sounding Boards. The UCR Boondoggle: A Death Knell for Private Practice?, 305 NEW ENGL. J. MED. 41, 41–45 (1981). Private insurers followed the government's method for paying providers, via "CPR" (customary, prevailing, and reasonable) or "UCR" (usual, customary, and reasonable) fee schedules. As physicians learned how to manipulate these systems, they quickly discerned that health care could be very lucrative if they usually, customarily, and ever-so-reasonably charged very high fees. See also T.L. Delbanco et al., Paying the Physician's Fee: Blue Shield and the Reasonable Charge, 301 NEW ENGL. J. MED, 1314, 1314–20 (1979).

At the same time, insurers commonly deemed new drugs, devices, and procedures "medically necessary"—and thus a covered benefit—as soon as they received either government approval or physician acceptance. Manufacturers of drugs and devices, thus assured of sales and profits, added energetically to the armamentarium of costly medical interventions.5

The inflationary effects of such a system were inevitable and enormous.6 The 1970s and '80s witnessed myriad but largely unsuccessful cost containment efforts,7 as national health care expenditures continued to skyrocket.8 Meanwhile, the "Artesian" framework still instructed physicians that considering costs over patient welfare was unethical.9

By the late 1980s, employers facing international competition and a domestic recession determined that they no longer could absorb limitless increases in health care costs and gave health insurers an


6. John A. Siliciano, Wealth, Equity and the Unitary Medical Malpractice Standard, 77 VA. L. REV. 439, 441 (1991). Siliciano goes on to note: "The vast burgeoning of medical technology, the rapid inflation of medical costs, and the rise of defensive medicine during the last quarter century have greatly increased the costs of what is considered to be legally adequate care." Id. at 456.

7. In 1971 the Nixon administration applied a wage and price freeze that, even though generally lifted in 1973, was retained another year for health care and a few other industries. STARR, supra note 2, at 399. Thereafter came legislation attempting to restrain the proliferation and unnecessary duplication of costly technology, followed by the Carter administration's threat of mandatory price controls until hospitals agreed in 1979 to restrain their revenues voluntarily. In 1982 the federal government added DRGs—the diagnosis-related group payment system—in which hospitals are paid a flat sum for hospital care of a Medicare beneficiary, based on diagnosis and other factors such as gender, age, and commodities. Instead of being rewarded for doing more, hospitals would now do better by doing less. The system helped to restrain hospital spending but left overall Medicare costs largely intact as hospitals simply shifted numerous inpatient procedures to the outpatient setting where they would be paid for on the usual FFS basis. BALANCING ACT, supra note 2, at 14–15. Employers tried their own measures, such as increasing employees' copays, encouraging healthier lifestyles, and requiring second opinions for surgeries. BUTLER, supra note 2, at 27; Marc P. Freiman, Cost Sharing Lessons from the Private Sector, 3 HEALTH AFF. 85, 87–88 (1984); Robert E. Patricelli, Employers as Managers of Risk, Cost, and Quality, 6 HEALTH AFF. 75, 76–77 (1987).

8. STARR, supra note 2, at 414; BUTLER, supra note 2, at 17–25.

9. Morreim, supra note 4, at 81–82. As Havighurst observes:

Although the medical profession's advocacy of quality in medical care without regard to cost appeared to reflect a sincere concern for patient welfare, it also served providers' economic interests. Not only did the suppression of normal economizing impulses pave the way for expansive and demand-increasing definitions of the need for providers' own services, but it also allowed providers to set their fees and charges on a noncompetitive and therefore highly lucrative basis.

ultimatum: Limit premium prices or lose business. The Artesian era gave way to managed care.

Initial savings came easily enough, largely by trimming excessive hospitalization and specialist interventions. Easy cost cuts, once exhausted, gave way to gloves-off tactics such as utilization review, tight fee schedules or incentive systems for providers, and onerous gatekeeper requirements.

Horror stories proliferated in the press, and litigation spread throughout the courts. By the late 1990s, as a booming economy tightened the labor market, firms wanting to attract and retain good

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10. Lengthy inpatient stays had become common. Insurers had based coverage on the traditional catastrophic model of insurance, in which insurers cover only the high-dollar events—auto accidents and house fires—whose costs cannot be absorbed by the ordinary person's budget, while leaving routine matters such as oil changes and roof repairs in consumers' hands. Because health plans therefore typically paid only for the care of patients sick enough to be in the hospital, physicians often hospitalized patients to ensure the care would be covered. Against this background, once insurers realized how much hospitalization was not medically justified, reductions in hospital use generated substantial savings. Specialist services were also targeted because primary care physicians (PCPs) often charged considerably less and used fewer resources than specialists, even when caring for the same conditions. See David Azevedo, *New Strategies for Clamping Down on Referrals*, 72 MED. ECON. 58, 58–73 (1995); P.D. Gerber et al., *Generalist Physicians and the New Health Care System*, 97 AMER. J. MED. 554, 554–58 (1994); K. Grumbach & T. Bodenheimer, *The Organization of Health Care*, 273 J. AM. MED. ASSOC. 160, 160–67 (1995); J.P. Kassirer, *Access to Specialty Care*, 331 NEW ENGL. J. MED. 1151, 1151–53 (1994); J.C. Robinson & L.P. Casalino, *Vertical Integration and Organizational Networks in Health Care*, 15 HEALTH AFF. 7, 9 (Spring 1996); S. Shea et al., *Predisposing Factors for Severe, Uncontrolled Hypertension in an Inner-City Minority Population*, 327 NEW ENGL. J. MED. 776, 776–81 (1992).


labor needed to provide generous benefits. Managed care's gloves-off tactics eroded.

This relative indifference to health care costs was short-lived, however. As economic boom gave way to recession in 2001, corporations again needed to keep benefits expenses as low as possible, even while the cost of health care began to rise again. Firms were pressed between the unsavory options of cutting back on benefits, increasing employees' share of the cost, or even eliminating health benefits altogether. At the same time, managed care's cost containment "teeth" had already been largely lost during the boom-years.

B. Crossroads and Evolution

As the health care economy moved from the Artesian era to the Managed Care era, many commentators realized that the financial incentives guiding various participants were sometimes in sharp opposition. For instance, under DRGs Medicare typically paid hospitals a fixed amount no matter how long a given patient stayed or how many services he received, thus creating an incentive to discharge patients as efficiently as possible. Physicians, still paid fee-for-service, received another fee for every day and every service the patient consumed. Hence, hospitals' incentives directly conflicted with physicians'.

Such discrepancies precipitated efforts to "align" the interests of physicians, hospitals, clinics, insurers, health plans, administrators,

13. In essence, "[e]mployers seem to have lost their teeth entirely.... They are so constrained by tight labor markets they don't want to be aggressive with plans or employees." Ron Winslow et al., Back on the Front Burner, WALL ST. J., Feb. 21, 2001, at R3 (quoting Paul Ginsburg of the Center for Studying Health System Change); see also David Blumenthal, Controlling Health Care Expenditures, 344 NEW ENG. J. MED. 766 (2001).


employers, and governments via tools such as incentive systems and integrated networks.\textsuperscript{17}

All this aligning usually neglected one crucial party—patients\textsuperscript{18}—via two justifications. First, patients' top priority was presumably to get well. Ill people are often less capable of consumer deliberation and should not have to worry about costs, it was thought. Second, as an obverse corollary, patients who had little direct contact with the cost of their care were deemed ill-equipped to decide which care is worth buying, and could not be trusted to decide which care was cost-worthy.\textsuperscript{19} As patients were neither expected nor allowed to decide which care is worth buying, they were largely relegated to being passive recipients of others' decisions about what care they could receive from whom.

However, that exclusion is now changing dramatically. Many employers and payors have come to believe that if the patient has something financial at stake, he may be more interested in the economic as well as the medical value of his care. The Medicare Prescription Drug, Improvement, and Modernization Act ("MMA")\textsuperscript{20} of 2003 incorporated a provision permitting citizens to couple high-deductible catastrophic insurance policies with tax-free health savings accounts ("HSAs") from which users pay for medical expenses within the deductible, as well as health-related expenses not covered by insurance.\textsuperscript{21}

A qualifying catastrophic policy must have a deductible of at least $1,000 for an individual and $2,000 for a family.\textsuperscript{22} Employers or anyone else can contribute to a person's HSA, where the monies, including interest and earnings, remain tax-free so long as they are

\textsuperscript{17} E. Haavi Morreim, Diverse and Perverse Incentives of Managed Care: Bringing Patients into Alignment, 1 WID. L. SYMP. J. 89 (1996).

\textsuperscript{18} For more detailed discussion of these efforts to align incentives and the ways in which patients were excluded, see Morreim, supra note 17; see also Daniel P. Sulmasy, Managed Care and Managed Death, 155 ARCHIVE OF INTERNAL MED. 133 (1995); Mark C. Rogers et al., Cultural and Organizational Implications of Academic Managed-Care Networks, 331 NEW ENG. J. MED. 1374, 1376 (1994); L.I. Sederer, Managed Mental Health Care and Professional Compensation, 12 BEHAV. SCI. & LAW 367, 367-78 (1994); M.A. Hall, The Ethics of Health Care Rationing, 8 PUB. AFF. Q. 33, 34 (1994).


\textsuperscript{22} For further discussion, see Joseph P. Newhouse, Consumer- Directed Health Plans and the RAND Health Insurance Experiment, 23 HEALTH AFF. 107 (2004).
used for authorized health care expenses. Initially, up to $2,650 could be placed annually into an individual's HSA, and $5,250 into a family's—caps now raised to $2,700 and $5,450, respectively.23

These Consumer-Defined Health Plans ("CDHPs") are a rapidly growing segment of the health insurance industry. Most major insurers now offer such plans, and increasing numbers of employers are embracing them:24

[By mid-2004, some 50 insurers, including Aetna Inc., Cigna Corp. and Anthem Blue Cross & Blue Shield, a unit of Anthem Inc., have introduced the high-deductible health policies that people must have to open an HSA. Aetna says it has signed 25 large employers and 200 small companies to offer its HSA-qualified plan to employees, and it is rolling out one for individuals. . . . By next year, HSAs are expected to become a standard product of many health insurers and large financial-services firms. . . . In tandem, an increasing number of employers, from mom-and-pop operations to major corporations such as Pitney Bowes Inc., are offering HSAs to employees. A study by Mercer Human Resources in April found that 81 percent of all employers with 20,000 or more employees are "somewhat" or "very" likely to offer them by 2006.25

More than 3 million federal employees are also expected to have CDHPs with HSAs.26

C. Implications

The ramifications of bringing patients into the economics of their care will likely be substantial. Instead of demanding antibiotics for minor sore throats or begging their physicians to prescribe the latest high-cost drug advertised on television, patients are more likely to ask, "Do I really need that?" and "Can't I use generic?". A demand


for magnetic resonance imaging ("MRI") to diagnose lower back pain\(^{27}\) may instead be, "How much will that cost me, doctor?" Patients who never glanced at their insurer's "statement of benefits" may be more likely to scrutinize the bills when paying with their own money.\(^{28}\)

Instead of exploring all the economic implications and legal ramifications of CDHPs,\(^{29}\) this Article will explore a fairly circumscribed area, namely the care patients seek within their (now much larger) deductible—the care they buy directly out of their HSAs or their pockets. Although the great majority of health care dollars are spent on chronic diseases and on catastrophic illnesses and injuries, the great majority of people use relatively few resources in a given year. As noted by one observer, "85% of Americans spend less than $3000 a year on medical care, and 73% have less than $500 a year in claims."\(^{30}\) As of 1996, the top 10 percent of patients accounted for nearly 70 percent of total health expenditures, while the top 30 percent consumed 90 percent. This picture has not changed significantly over several decades.\(^{31}\) As a result, the great majority of

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\(^{28}\) It is important to note that CDHPs will present internal complexities. Insurers will not count each and every health-related expense toward the patient's deductible. If the patient's policy does not cover drugs, for instance, then his drug expenditures will not count toward his deductible. Sarah Rubenstein, *Watch Out For Some Pitfalls of Health Savings Accounts*, WALL ST. J., Dec. 17, 2004. Overall, many insurers offering CDHPs will use their

standard claims processing systems, including medical necessity review, to determine when the policy deductible (and, ultimately, the out-of-pocket maximum) has been met for any particular subscriber. In general, only insured expenses can be counted against a deductible. If a subscriber with a $3,000 deductible receives an outpatient surgery costing $2,500, insurers are unlikely to credit the cost of the surgery fully against the deductible without determining whether the surgery was a covered expense, whether $2,500 was a reasonable charge, and whether the subscriber received pre-approval for the surgery if required under the policy. In short, even while spending their own money from HSAs, subscribers will be subject to some managed care controls to the extent that they attempt to claim these expenses against their insurance deductibles.

\(^{29}\) For some further discussion, see *Managed Care to Patient-Managed Care, supra* note 2; *Back to the Future, supra* note 2.


\(^{31}\) Marc L. Berk & Alan C. Monheit, *The Concentration of Health Care Expenditures, Revisited*, 20 *Health Aff.*, 9, 12 (2001). Similarly, Luft observed that one percent of the population consumes thirty percent of all medical care costs, while the bottom fifty percent
people in CDHPs will be completely responsible for their own health care costs. Although all will have financial help from the government via tax breaks, and most will have HSA subsidies from their employers, each medical expenditure will have a direct economic impact on the patient.

This Article discusses three kinds of legal issue that will likely arise when patients pay for their care. Part II explains that traditional informed consent conversations will increasingly incorporate an economic dimension as patients more often expect the physician to tell or at least help them find out what a proposed intervention will cost. Concomitantly, this financial interest will increase patients' need to know how important, medically, a proposed test or treatment is, and how well-grounded it is in medical research. Marginally useful interventions may be fine out of an insurer's pocket, but much less palatable out of one's own. Meanwhile, physicians can expect more patients to decline their recommendations due to cost concerns. Here, too, informed consent conversations will likely evolve as physicians need to explain more clearly the consequences of such refusals. When they do so carefully, doctrines like assumption of risk and contributory negligence/comparative fault can provide considerable insulation from tort claims when patients' refusals lead to bad outcomes.

Part III explains how physicians' financial stake in the care they recommend, and the conflicts of interest thereby spawned, could lead to claims for breach of fiduciary duty. In some cases, these conflicts might concern allegedly excessive services that boost physicians' income. Another potential conflict is "defensive medicine" practices in which the physician allegedly orders needless tests and treatments to protect herself from litigation; these, too, can increase the patient's bill but not his health. Although such issues have always posed the possibility of claims for breach of fiduciary duty, they have not triggered much interest heretofore, probably because such expenditures usually consume insurers' rather than patients' money. Where patients see their own pockets or HSAs drained to enhance what they believe to be the physician's rather than their own wellbeing, this sort of litigation would not be surprising.

Finally, fresh twists on contract law may emerge. As discussed in Part IV, patients may experience "sticker shock" on seeing their bill if costs were not discussed during treatment decisions. In a number of recent suits alleging that charges were excessive, courts have agreed accounts for only three percent of expenditures. Harold S. Luft, *Modifying Managed Competition to Address Cost and Quality*, 15 HEALTH AFF. 23, 26 (1995).
that fees for medical services must be "reasonable." Determining what constitutes "reasonableness," however, can be vexatious at best.

Overall, the goal of this Article is simply to anticipate the shifts in direction that litigation may take under CDHPs. Two caveats are in order. First, this Article focuses only on patients' own expenditures, i.e., those below the deductible threshold. Insurers providing catastrophic coverage will use their own approaches to constrain costs and, while interesting and important, these are quite different from the tensions that will arise within the physician-patient relationship when the patient's own money is at stake.

Second, these issues are neither new nor inherently novel. They can arise anywhere that people must pay for their own health care. All too many Americans lack health insurance entirely. What is distinctive is that, as CDHPs become widespread, those who personally pay substantial amounts will no longer be mainly the powerless and medically indigent. Rather, large numbers of middle-class people who are quite well insured via catastrophic coverage will nevertheless have a significant financial stake in their health care costs. Issues long lurking in the background can be expected to rise, with color and vehemence, to the foreground.

II. INFORMED CONSENT

In health care, breach of informed consent is ordinarily a negligence tort within the broader genre of medical malpractice. Classically, the physician provides some information but not enough for the patient to make a reasonably informed decision. Breach of informed consent is less severe than battery, which involves a complete lack of information or consent to the physician's contact.

Against this background, we can inquire what sort of tort case might be made for breach of informed consent if a physician fails to discuss costs with patients who personally pay for care. Our

32. As noted above, even these out-of-pocket or HSA expenses will commonly be subject to cost caps and/or utilization management. See Rubenstein, supra note 28.


34. The law of battery provides protection against unauthorized touching of the human body. While most cases in which this protection is invoked involve touchings that are harmful, this is not a requirement to establish battery. The law of battery also protects against touchings that are offensive, even if they do not inflict bodily harm. In so doing, battery protects "the purely dignitary interest in the body that it be free from offensive contact."

discussion will follow the classic elements of tort: duty and breach, injury, and causation, followed by an exploration of available defenses when a patient declines a recommendation because of cost and then suffers an adverse outcome.

A. Duty of Care

The standard of disclosure for informed consent is constructed in either of two ways. The older approach, consistent with traditional malpractice doctrines, looks to what the profession commonly discloses and requires the testimony of expert witnesses. In contrast, about half of states have adopted a newer standard that emerged through a trinity of cases in 1972. It asks what patients need to know to make an informed decision. Canterbury v. Spence defined this standard as whatever information would be “material” to the patient’s “right of self-decision.” At the same time, even states using this patient-based standard do not base a physician’s disclosure duty on the vagaries of what any specific patient would want to know. Rather, nearly all embrace an “objective” standard, namely, what the reasonable and prudent patient in similar circumstances would need to know.

35. Fuller v. Starnes, 597 S.W.2d 88, 90 (Ark. 1980) (stating that the “disclosure standard always requires expert medical testimony”).
37. Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972); Cobbs v. Grant, 502 P.2d 1 (Cal. 1972); Wilkinson v. Vesey, 295 A.2d 676 (R.I. 1972); see also Meisel, supra note 34, at 215. The Supreme Court of Connecticut voiced the transition well:

The incongruity of making the medical profession the sole arbiter of what information was necessary for an informed decision to be made by a patient concerning his own physical well-being has led to various judicial and legislative attempts within the last decade to define a standard tailored to the needs of the patient but not unreasonably burdensome upon the physician or wholly dispensing with the notion that ‘doctor knows best’ in some situations. While the essential ambivalence between the right of the patient to make a knowledgeable choice and the duty of the doctor to prescribe the treatment his professional judgment deems best for the patient has not been fully resolved, the outline has begun to emerge.

38. Canterbury, 464 F.2d at 786.
39. Id. Interestingly, although a number of states moved quickly to adopt the “patient-based” standard after 1972, several actually reversed course after physicians pressured state legislatures, including New York, Ohio, and Vermont. Logan, 465 A.2d at 300.
Via either standard, two kinds of information are likely to be of greatest interest: the anticipated costs of proposed interventions and their likely medical value.

1. Costs

When the patient pays directly for the proposed treatment or diagnostic test, cost will often be an important consideration. His headache may be well worth an $800 computed tomography ("CT") scan if insurance is paying, but shelling that sum out of his own HSA may suddenly prompt a keen interest in "watchful waiting" or other more conservative approaches.

One problem is that providers can not always produce, in advance, a layout of expected charges. For one thing, it may not be possible to predict all the services the patient will need, particularly if the problem is complex and unexpected findings could require quick changes of plans. Additionally, many providers do not have a set charge for each service. As discussed below, a provider's fee for a particular service can vary widely, depending on what fee schedules have been negotiated with a given payer.

Equally important, a physician often has no way to know other providers' charges for their goods and services. Pharmacy prices vary widely, and hospital services even more, as do charges for durable medical equipment, home nursing services—the whole panoply of health care. The problems are not entirely insuperable, however. A physician should ordinarily be able to tell a patient what he will charge for his own services. After all, for patients who are paying directly, the physician's billing office will usually expect payment at the conclusion of the visit. If the office can produce the charges just before the patient leaves, they should be able to find them a bit earlier, at the time of making decisions. Quite possibly the relevant fee schedules can be downloaded into hand-held Personal Digital Assistants ("PDAs") for easy access.

Similarly, a physician might be wise to have at least a general idea of the prevailing price-range for the most common interventions she might prescribe during an office encounter, such as ordinary medications. Although a physician should not be expected to know which pharmacies sell at what price, she should know the general


41. See infra Part IV.C (discussing the multiplicity of bases for computing charges).

42. See id. (discussing hospital pricing).
price range of the drugs she most commonly prescribes. Otherwise, the patient may not discover that he cannot afford the drug until he reaches the pharmacy. Thereafter, if he is too embarrassed to explain that he could not afford the prescription, future care may labor under the misimpression that the drug did not work, rather than the truth that it was never taken. Some familiarity with basic price ranges is thus part of good medical care, not just a potential element of informed consent.

Whether the failure to make such basic pricing available is a breach of informed consent, at least for the physician's own services, will likely depend on which standard is applied. Under a physician-based standard of disclosure, the question is whether physicians under the same or similar circumstances would provide fee information. This approach has the advantage of recognizing that it can be difficult to produce accurate figures and that only where prices are readily available might it be reasonable to hold a physician liable under breach of informed consent theory.

On the other hand, the physician-based standard might simply entrench undesirable habits if nondisclosure is the norm. As noted, a physician should at least disclose what he will charge for his own services—even if he is not obligated to know what portion of that fee a given insurer will count toward that patient's deductible. In contrast, the patient-based standard will ask whether price information is "material" to a decision about whether to purchase a recommended test or treatment. Many patients will think it is. Much of the routine care we seek is for symptomatic relief or for reassurance that the problem is benign. The patient may feel "$20 worth of miserable," but a bill for $200 could make him feel worse than the symptoms he wants to relieve.

Courts' views regarding materiality may be difficult to predict. On one hand, physicians can have some obligation to help patients with financial issues. In the case of Chew v. Meyer, Herbert Chew underwent surgery and asked his surgeon to document for his employer that Chew's absence from work was medically necessary. Dr. Meyer agreed to direct his secretary to complete the forms. However, despite multiple inquiries and proddings from Chew, Meyer did not send the forms until after Chew's employment was terminated for failure to furnish that documentation. The Maryland Court of Special Appeals held that the physician's promise constituted an undertaking that, although gratuitously made, carried a duty to

43. See Rubenstein, supra note 28.
discharge the promise in a proper and timely manner. The court also found another basis for liability:

[In earlier times, the plaintiff's claim] might well have been summarily rejected, on the basis that a physician's obligation ordinarily did not extend beyond his duty to use his best efforts to treat and cure. The traditional scope of the contractual relationship between doctor and patient, however, has expanded over the years as a result of the proliferation of health and disability insurance, sick pay and other employment benefits. Today, the patient commonly, and necessarily, enlists the aid of his or her physician in preparing claims forms for health and disability benefits. Such forms ordinarily require information possessed solely by the treating physician as well as the physician's signature attesting to the bona fides of that medical information.46

Therefore, the court concluded, the plaintiff had on these two grounds a "plausible cause of action for breach of contract."46

Although Chew does not directly support the idea that physicians should describe payment options to patients who balk at treatment by reason of cost, it does at least open the door to the possibility that a court could expect a physician to help patients answer financial questions directly related to treatment.47

On the other hand, in Arato v. Avedon,48 the California Supreme Court held, as a matter of law, that a physician did not breach informed consent when he failed to reveal prognosis information that would have enabled the patient to put his financial affairs in order before his death. Reluctant to unleash unlimited duties, the court stipulated that physicians are not required to disclose information relevant to patients' nonmedical interests. Rather, the duty focuses on the risks, benefits, and alternatives of a medical intervention.49

Arato does not necessarily preclude a duty to disclose the projected costs of care. After all, costs are a direct "side-effect" of treatment, potentially as important to many patients as the likelihood of physical risks. The case does, nevertheless, caution against assuming that courts will be unified regarding "materiality" in this challenging area.

Overall, the physician should at least be prepared to respond when a patient asks about prices and know that some interventions are costly enough to prompt patients to pause. If he does not have

45. Id. at 832.
46. Id.
47. In Wickline v. State of California, 192 Cal. App.3d 1630, 1644 (1987), a case in which a payor denied extension of hospitalization despite the physician's request, the California court of appeals said in dicta that "the physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care."
49. Id. at 607.
pricing information readily available, he may be able to help the patient investigate. Several online sources now make drug prices available,\(^{50}\) for instance, and if a computer or internet-linked PDA is available in the office, the relevant information might be found.\(^{51}\)

2. Medical Importance

Costs are not the sole element of choice. If patients are to decide intelligently whether a proposed intervention is worth its cost, they must know not just its price but also its medical merit. Hence, physicians must be prepared to explain the medical importance and reasonable alternatives to the care they propose. These are classic requisites of informed consent. In \textit{Truman v. Thomas},\(^{52}\) for instance, a woman declined a pap smear on grounds of cost.\(^{53}\) When she died from cervical cancer that might have been diagnosed in time for successful treatment if she'd had the test, the Supreme Court of California held that the physician's duty of informed consent required him to tell the patient the consequences of foregoing the proposed recommendation.\(^{54}\)

In \textit{Smith v. Reisig},\(^{55}\) a patient injured during a hysterectomy later learned that an alternative treatment might have permitted her to avoid the hysterectomy entirely. The Supreme Court of Oklahoma held that when the physician fails to disclose medially viable alternatives, the damages can include the cost of the treatment itself as well as any complications arising from that treatment.\(^{56}\)

Across the American health care system, it has been argued that much of our care is unnecessary.\(^{57}\) CT scans for minor head injuries

\(^{50}\) Robert Pear, \textit{Price Comparison for Drugs Is Put on Federal Web Site}, \textit{N.Y. Times}, Sept. 16, 2004. The Web site shows, for example, that Zocor, a top-selling Merck product used to treat high cholesterol, costs an average of $89.38 for a month's supply of 20 milligram tablets. The site displays several "lower-cost options," including Altace ($57.19), made by Andrx Pharmaceuticals; Lescol ($63.13), sold by Novartis; and Lipitor ($66.08), made by Pfizer. \textit{Id.}

\(^{51}\) \textit{See infra} Part V.

\(^{52}\) \textit{Truman v. Thomas}, 611 P.2d 902, 904 (Cal. 1980).

\(^{53}\) \textit{Id.}

\(^{54}\) The court stated patients must be informed "not only of the risks inherent in the procedure [prescribed, but also] the risks of a decision not to undergo the treatment, and the probability of a successful outcome of the treatment." \textit{Id.} at 906 (citing Cobbs v. Grant, 502 P.2d 1, 10 (Cal. 1972)).


\(^{56}\) \textit{Id.} at 288.

\(^{57}\) "Researchers at Dartmouth Medical School, who have been studying Medicare's performance for three decades, estimate that as much as $1 of every $3 is wasted on unnecessary or inappropriate care. Other analysts put the figure as high as 40 percent." Gilbert M. Gaul, \textit{Bad Practices Net Hospitals More Money}, \textit{Wash. Post}, July 24, 2005, at A01. Another commentator notes that "several studies estimate that only 15 to 20 percent of medical practices can be
provide a helpful example. Around one million people are evaluated for minor head trauma every year. Fewer than 10 percent of those who retain a normal level of consciousness have intracranial injuries, and less than 1 percent require neurosurgical intervention.\textsuperscript{58} Even so, physicians commonly order costly CT scans to rule out rarities. Two guidelines, the "New Orleans Criteria" and the "Canadian CT Head Rule", were shown several years ago to be effective in greatly reducing overuse of CT scans while capturing virtually all of the important population.\textsuperscript{59}

Nevertheless, even though just a 20 percent reduction in the use of CT scans for this purpose would save over $17 million annually and significantly reduce overcrowding in emergency rooms,\textsuperscript{60} these guidelines have been slow to take hold. Although somewhat speculative, it is reasonable to suppose that a number of low-risk patients—those who have only a bump on the head and no alteration of consciousness—would not spend hundreds of their dollars on a CT scan if they were told it has virtually no chance of identifying a real problem.


\textsuperscript{59} The NOC “would have reduced CT use by an estimated 23% and would have identified 100% of patients with intracranial injury,” while the CCHR would have reduced CT use by an estimated 68% and would have identified 100% of patients who required neurosurgical intervention,” although the CCHR would not have detected every instance of patients with less severe intracranial injury. Id. at 1552.

\textsuperscript{60} Id. at 1553.
B. Injury

Like any tort, breach of informed consent requires an injury. In *Truman*, the patient died from cervical cancer diagnosed too late.\(^{61}\) In *Smith* the patient experienced an inadvertent puncture of her bladder.\(^{62}\) Failure to identify medical alternatives or to explain the importance of the proposed intervention can be a tort when it leads to medical injuries like these. More interesting is the question of how a failure to disclose costs can figure as a potential basis for liability. Two scenarios arise.

In the first, there is no medical injury, just an expense the patient would not have agreed to incur, had he known how costly the test or treatment was. He pays for the CT scan that shows, predictably, his little head bump is just that. If the problem extends no further, the patient may have an item for small claims court\(^ {63}\) or perhaps a complaint under contract, as discussed in Part IV.\(^ {64}\) In a variation on this scenario, if the patient can show that this costly test or treatment was a needless intervention that the physician recommended just to boost her financial interests, the problem might be breach of fiduciary duty, addressed in Part III.\(^ {65}\) In still another variation, if the patient truly needed the intervention and no cheaper alternative was reasonable, he almost certainly will not have a tort cause of action. In sum, absent any medical injury, courts are unlikely to find tortious wrong simply because care is costly or even excessive.

In the second scenario, the patient does suffer a medical injury. Importantly, that injury need not be caused by medical negligence to give rise to an informed consent tort. It could simply be a recognized, non-negligent medical complication. The only requisite is that, had the patient (or more precisely, a reasonable person in the patient’s situation) known the undisclosed information, he would not have agreed to the procedure at all, and hence would have avoided the injury. In this scenario the key question will focus on causality, discussed just below.

Overall, because breach of informed consent is a negligence tort requiring an injury, courts are unlikely to recognize failure to disclose cost information as a stand-alone malpractice tort under breach of informed consent, where the omission leads to no cognizable non-
C. Causality

In breach of informed consent litigation, causality is ordinarily evaluated via an objective standard, requiring the jury to find that a reasonable person in the patient’s situation would have refused this intervention had the physician provided the required information. Where that information concerns costs, the question is whether a reasonable person in the patient’s situation would have refused the intervention because of its great cost or, more precisely, its anticipated medical value compared to its high cost. While detailed discussion of this scenario is beyond the scope of this Article, suffice it to say that jurors in such a scenario would be treading rather new ground, and actual verdicts would likely depend on jurors’ beliefs about whether the health care system respects their own needs and financial means. Jurors might well find for the plaintiff if they believe, first, that the test or treatment that caused the injury wasn’t really necessary and second, that it was so expensive compared to its projected medical value that they—as "reasonable people"—would not have deemed it worth buying out of pocket.

D. Defenses

A very different situation will arise, not where the patient regrets agreeing to a costly intervention, but rather where she needed but refused care because of its cost. These cases arise, not from a failure to disclose costs, but rather from a price disclosure that prompts the patient to reject the proffered test or treatment. For many physicians, a nightmare scenario looms in which, despite his best efforts to educate the patient about the need for treatment, the risks of refusal, and the medically reasonable alternatives, the patient still refuses and then suffers harm.

66. For further discussion about the objective standard by which causality is determined in breach of informed consent cases, see E. Haavi Morreim, Medical Research Litigation and Malpractice Tort Doctrines: Courts on a Learning Curve, 4 HOUS. J. OF HEALTH L. AND POLY 1, 79–85 (2003).

67. Here, the physician’s obligation to present viable alternatives becomes especially pressing. If he has failed to present cheaper, medically acceptable options, then the physician may well be both factually and legally a cause—a material and substantial factor—of the patient’s decision to reject care and thereby of any injury arising from lack of intervention. If the patient believed the only option was the one the physician presented, declined it by reason of...
A strong body of case law appears to protect physicians from liability where patients freely make informed decisions to forego care because of cost. The primary doctrines are assumption of risk and contributory negligence/comparative fault. Although the two overlap to some extent, together they mark a clear statement that patients cannot shift onto physicians the responsibility for their own well-informed cost-benefit decisions.

1. Assumption of Risk

"Assumption of risk is the deliberate and voluntary choice to assume a known risk.... The doctrine ... embodies the principle that one should not be permitted knowingly and voluntarily to incur an obvious risk of harm and then hold another person responsible for his injury."69 "The doctrine of assumption of risk lies in the maxim volenti non fit injuria. Based as it is upon the plaintiff's assent to endure a situation created by the negligence of the defendant, it relieves the defendant from performing a duty which might otherwise be owed to the plaintiff."70

Assumption of risk comes in several varieties. At the outset, "express" must be distinguished from "implied." In express assumption of risk, the plaintiff and defendant have explicitly agreed, "in advance, that defendant owes no legal duty to plaintiff and therefore, that plaintiff cannot recover for injuries caused either by risks inherent in the situation or by dangers created by defendant's negligence."71 The plaintiff effectively contracts to "relieve the defendant of an obligation of conduct toward him, and to take his
chances of injury from a known risk arising from what the defendant is to do or leave undone.”

In health care, the best-known cases on assumption of risk feature unconventional treatments or clear refusals of conventional lifesaving treatments. Both Schneider v. Revici and Boyle v. Revici featured women with breast cancer who, rejecting conventional surgery and chemotherapy, sought out Dr. Revici’s alternative treatments. When his dietary regimens failed to arrest the disease and the patients continued to follow them despite Revici’s own urgings to seek conventional care, the court refused to hold the physician at fault. These patients’ express assumption of risk—which included explicit information that Revici’s remedies were experimental and not FDA-approved and, in Schneider’s case, a written statement that she understood these facts—was a bar to all recovery.

Similarly, a patient with heel spurs sought podiatric care, then agreed to surgery but failed to comply with post-surgical care such as wearing a corrective device. The South Carolina Supreme Court held: "When a patient seeks treatment by a particular type of practitioner, he may be held to have assumed the risk of the method of treatment of the particular school of thought chosen.”

A Jehovah’s Witness’s refusal of life-saving blood transfusions invokes the same principles and will ordinarily exempt the physician


In appropriate situations, the parties to a transaction should be able to agree which of them should bear the risk of injury, even when the injury is caused by a party’s legally culpable conduct. That policy is not altered or undermined by the adoption of comparative responsibility. Consequently, a valid contractual limitation on liability, within its terms, creates an absolute bar to a plaintiff’s recovery from the other party to the contract. A valid contractual limitation on liability does not provide an occasion for the factfinder to assign a percentage of responsibility to any other party or other person.

RESTATEMENT (THIRD) OF TORTS § 2, cmt. b (2000).

73. 817 F.2d 987 (2d Cir. 1987).
74. 961 F.2d 1060 (2d Cir. 1992).
75. Faile v Bycura, 346 S.E.2d 528, 529–30 (S.C. 1986).
from liability. In an important caveat, courts have also held that even though physicians may be exonerated from the direct consequences of failing to transfuse blood, they are not exempt from liability for other acts that may have been negligent. In *Corlett v. Caserta*, 76 for instance, a physician's continued use of aspirin in a patient who had developed gastrointestinal bleeding was the very thing that occasioned the need for blood in the first place. The physician was liable for this error. Similarly, in *Shorter v. Drury*, 77 the gynecologist whose dilation and curettage procedure caused a severe perforation in the uterus could be responsible for any negligence in performing the procedure, even if the patient bore responsibility for her refusal of life-saving blood.

Express assumption of risk is generally based on contract law, not tort. 78 It is an open agreement that, even though the defendant might owe the plaintiff certain duties, these are waived so that the patient can pursue other goals of his choosing. 79

"Implied" assumption of risk differs markedly from "express." Here, the "plaintiff's willingness to assume a known risk is determined from the conduct of the parties rather than from an explicit agreement." 80 Primary assumption of risk applies where the plaintiff has assumed the risks inherent in a particular activity, not created by defendant's negligence. 81 Examples include high-risk sports such as skydiving or horseback riding. 82 In secondary implied

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77. 695 P.2d 116 (Wash. 1985).
78. *Schneider*, 817 F.2d at 994 ("While assumption of risk, like contributory negligence, barred recovery, it was predicated on a theory of contract rather than on a theory of culpable conduct: the plaintiff's agreement, either express or implied, to absolve the defendant from responsibility."); *Shorter*, 695 P.2d at 119-20; *Colton v. N.Y. Hosp.*, 414 N.Y.S.2d 866, 876 (N.Y. 1979).
79. As noted by the Second Circuit in *Schneider*:
[W]e see no reason why a patient should not be allowed to make an informed decision to go outside currently approved medical methods in search of an unconventional treatment. While a patient should be encouraged to exercise care for his own safety, we believe that an informed decision to avoid surgery and conventional chemotherapy is within the patient's right to determine what shall be done with his own body.
81. *Id.* at 1038.
The primary label has been applied to situations where a plaintiff has assumed known risks inherent in a particular activity or situation. The assumed risks there are not those created by defendant's negligence but rather by the nature of the activity itself. Thus, primary implied assumption of risk is, arguably, not a true negligence defense since no cause of action for negligence is ever alleged.
assumption of risk, the plaintiff implicitly assumes the risks of the defendant’s negligence. It is functionally similar to, and has now been essentially collapsed into, contributory negligence or comparative fault.\footnote{Duffy, 481 N.E.2d at 1038, 1041.}

2. Contributory Negligence and Comparative Fault

Whereas express assumption of risk is founded on contract, contributory negligence operates in tort.\footnote{The doctrine of contributory negligence embodies the principle that an injured person should not be permitted to ask from others greater care than he himself exercises for his own welfare. If in the exercise of ordinary care, the plaintiff might have avoided the consequences of defendant’s negligence, he is author of his own injury in the eyes of the law. Hawkins v. Pathology Assocs. of Greenville., 498 S.E.2d 395, 402 (S.C. App. 1998) (quoting Wallace v. Owens-Illinois, Inc., 389 S.E.2d 155, 157 (S.C. App. 1989)). Otherwise stated, contributory negligence is a lack of ordinary care on the part of a person injured by the negligence of another which combines and contributes to the injury as a proximate cause without which the injury would not have occurred. . . . A plaintiff who fails to exercise ordinary care for his own welfare is the author of his own injury in the eyes of the law. Baxley v. Rosenblum, 400 S.E.2d 502, 506 (S.C. App. 1991). Technically, “contributory negligence” often refers to the doctrine that states that if the plaintiff bears any responsibility whatever for his adverse outcome, his negligence poses a complete bar to recovery against the defendant. In all but a few states, this stringent limitation has been replaced by the doctrine of “comparative fault,” which states that each party is to be responsible according to its own degree of fault. E.g., DAN B. DOBBS & PAUL T. HAYDEN, TORTS AND COMPENSATION: PERSONAL ACCOUNTABILITY AND SOCIAL RESPONSIBILITY FOR INJURY 272–77 (5th ed. 2005). Nevertheless, “contributory negligence” is often used in a more generic sense to refer simply to the plaintiff’s negligence in contributing to his own injury, whether the consequence is to bar or merely to diminish his recovery. DAN B. DOBBS ET AL., PROSSER AND KEETON ON TORTS 451 (5th ed. 2005).}

Courts have been entirely willing to apply the doctrine. In \textit{Baxley v. Rosenblum}\footnote{See, e.g., Schneider v. Revici, 817 F.2d 987, 994 (2d Cir. 1987); Eaton v McLain, 891 S.W.2d 587, 592 (Tenn. 1994); McIntyre v. Balentine, 833 S.W.2d 52 (Tenn. 1992); Shorter, 695 P.2d at 119; Hawkins, 498 S.E.2d at 396; Corlett v. Caserta, 562 N.E.2d 257, 261 (Ill. App. 1 Dist. 1990); Duffy, 481 N.E.2d at 1041; Murphy, supra note 72, at 160.}

the patient, himself a physician, initially saw a urologist for painful, bloody urination. Baxley declined to follow the urologist’s advice. When his symptoms worsened under self-treatment, Baxley saw a non-urologist physician and then declined to follow the latter’s recommendations. The South Carolina appellate court held that “one should not be permitted knowingly and
voluntarily to incur an obvious risk of harm and then hold another person responsible for his injury."^{87}

The failure to make recommended follow-up visits also figured in Forman v. Pillsbury.^{88} According to the District of Columbia court, a mother who failed to bring her child in for scheduled blood monitoring could not blame the physician for her own failure to adhere to medical recommendations.

Refusing diagnostic work-up of breast lumps has likewise been deemed contributory negligence,^{89} as has failure to appear for follow-up care after elective abortion.^{90} Other cases follow the same pattern.^{91} In some instances, the patient appeared directly to cause his problem, while in others the patient failed to take reasonable actions to mitigate an injury caused by the physician.^{92} Notably, juries can find contributory negligence even if the defendant does not offer that as a defense.^{93}

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87. Baxley, 400 S.E.2d at 507. The court went on: "In this case, the evidence permitted a reasonable inference that Baxley voluntarily chose to incur known medical risks." Id.


91. See, e.g., Wisker v. Hart, 766 P.2d 168 (Kan. 1988) (injured man returned to strenuous work early, in contravention of medical instructions, causing his wounds to reopen); Ostrowski v. Azzara, 545 A.2d 148 (N.J. 1988) (patient failed to mitigate the damages of podiatrist's poor choice of treatment, as her continued smoking and poor glucose control made healing more difficult); Reikes v. Martin, 471 So. 2d 385 (Miss. 1985) (patient who developed decubitus ulcers (bedsores) failed to tell her doctor about this worsening problem); Meacham v. McLeay, 227 N.W.2d 829 (Neb. 1975) (patient's early departure from hospital and failure to appear for follow-up care delayed her diagnosis and exacerbated her condition); Musachia v. Rosman, 190 So. 2d 47 (Fla. Ct. App. 1966) (patient's failure to follow recommendations for rest and proper diet after injury meant patient could be contributorily negligent); Graze v. Lawless, 389 N.E.2d 957 (Ill. App. 3 Dist. 1979) (patient with chest pains insisted, contrary to his doctor's urging for immediate hospitalization, that he could drive himself to the hospital after taking care of some personal business); Seymour v. Victory Mem. Hosp., 376 N.E.2d 754 (Ill App. 2 Dist. 1978) (patient smoked in bed against explicit rule to the contrary, setting it afire); Shinholster v. Annapolis Hosp., 685 N.W.2d 275 (Mich. 2004) (patient's failure to take prescribed blood pressure medication for at least a year prior to her visits to the emergency room was admissible evidence of patient's comparative negligence in her eventual death from "mini-strokes").

92. "[A] plaintiff has a duty to mitigate the damages resulting from a defendant's negligence." Corlett v. Caserta, 562 N.E.2d 257, 261 (Ill. App. 1 Dist. 1990). At the same time, there are limits to patients' obligations to mitigate damages. Major surgery, for instance, appears to be clearly over the line. See Montgomery v. Terminal R.R. Ass'n, 392 N.E.2d 77, 81 (Ill. App. Ct. 1979) (quoting Rosenstein v. Chi. Transit Auth., 299 N.E.2d 396 (Ill. App. 1973) ("It is clear that an injured person has no duty to undergo surgery to mitigate his damages.").

93. Reikes, 471 So. 2d at 386.
3. Recommendations

Courts do not generally allow patients to foist onto physicians the consequences of their own decisions. As pointed out by the Nebraska Supreme Court, to hold a physician liable for his patient's decisions, "we would be required to say that [the physician] had a duty, in some indefinable method by coercion, threats, or pressure to prevail upon the plaintiff to report back to him and the hospital for the further necessary tests to complete the diagnosis." The court further noted, "[a] doctor cannot compel a patient to come to the office for treatment, nor can a doctor force a patient to follow his recommendations outside the office. In fact, few patients would appreciate the type of paternalistic intrusiveness plaintiff's proposed rule requires."

Nevertheless, certain responsibilities appear incumbent upon physicians. Assumption of risk and contributory negligence both presuppose a well-informed patient: "without clear proof of totally informed consent, the defense of assumption of risk is not successful." Accordingly, a physician who hopes to use these as defenses when patients refuse interventions because of cost, must provide ample information to patients—the importance of the intervention, the hazards of refusal, the alternatives, and perhaps

94. Meacham, 227 N.W.2d at 832.
95. Forman, 753 F. Supp. at 19. As further noted by the Second Circuit in Schneider:

[We see no reason why a patient should not be allowed to make an informed decision to go outside currently approved medical methods in search of an unconventional treatment. While a patient should be encouraged to exercise care for his own safety, we believe that an informed decision to avoid surgery and conventional chemotherapy is within the patient's right to determine what shall be done with his own body.

Schneider v. Revici, 817 F.2d 987, 995 (2d Cir. 1987) (internal quotation marks omitted).
96. Murphy, supra note 72, at 162. Murphy goes on to observe:

The health care crisis of recent years resulted in increased consumer activism and awareness of health care issues. Courts appear to be cognizant of this increasing consumer awareness and as a result are willing to hold a patient to a higher degree of responsibility for his own HC decisions. Thus, a patient's refusal to exercise due care to protect his own health needs is more likely to be found the proximate cause of a resultant harm. Accordingly, an injured patient can no longer rely on the requirement that his own negligence occurred concurrently with the physician's negligence. It appears that as health care consumers become more aware and involved in health care issues, there will be a corresponding increase in the degree of responsibility a patient will be required to assume in his own health care decisions. Because the disparity between the patient's and the physician's knowledge is diminishing, absolute trust in the physician's judgment is no longer justified in all cases. In a society concerned with health care issues, courts may increasingly demand individual responsibility for health care decisions. As noted by the Maryland Court of Appeals, "[t]o adopt the view that it is not negligent for [patients to ignore symptoms] that are obvious to them would def[y medical reality and thus be absurd."

also, when feasible, the available financing options. Equally important, the physician should document such discussions carefully. Indeed, in at least some instances where a patient refuses care by reason of cost, it may be appropriate to invite him to sign a form akin to the "A.M.A." ("against medical advice") form that patients who want to leave a hospital prematurely are asked to sign.

III. BREACH OF FIDUCIARY DUTY

A. Defining Fiduciaries

The foregoing discussion suggested that physicians may have a duty to disclose the costs of their own professional services and to know, within at least a rough range, the anticipated costs for the most common services or products they might prescribe.\(^\text{97}\) Nevertheless, finding a legally cognizable injury, for purposes of tort, is difficult when there is no physical injury but only unwanted economic cost. The absence of physical injury raises two scenarios for discussion.\(^\text{98}\) First, if an allegedly needless test or treatment is part of a broader pattern of prescribing needless interventions to enhance the physician’s financial or other interests, the issue may be breach of fiduciary duty. Second, even if the patient needed the intervention, excessive pricing may sound in contract. The former issue will be addressed in this Part, and the latter in Part IV.

We need not discuss in depth the nature of a fiduciary relationship and its bearing on the physician-patient relationship, for that is accomplished elsewhere in this issue by Professor Mehlman.\(^\text{99}\) A brief summary will suffice.

As Professor DeMott has noted, “Fiduciary obligation is one of the most elusive concepts in Anglo-American law.”\(^\text{100}\) It arose initially in the law of trust, in which a trustee holds property for the benefit of another party. Over time it expanded to include agency, in which one person represents another, again for promoting the latter’s interests.

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97. See supra Part II.A.1 (discussion of costs).
98. See supra Part II.B (discussion of injury).
Its subsequent development encompassed other relationships, such as partners, directors and officers, executors, attorneys, and priests.101

Shepherd identifies three traditional classifications.102 From the law of trusts comes the property-holder who holds, manages, or controls property to benefit the beneficiary. Next is the representative, a concept from the law of agency in which the agent stands as the representative or surrogate of the principal, acting on his behalf for the sake of the latter's betterment. Finally, based on the law of undue influence, is the adviser. An adviser can become a fiduciary by providing advice and expertise on which the advisee needs to rely. Yet the bare fact that one person decides to trust another's judgment does not, of itself, create a fiduciary bond. Certain other conditions must also be met. Although it is debatable whether physicians are fiduciaries in the strictest sense,103 many courts have found it to be such,104 and is best understood within the "adviser" category.105


105. SHEPHERD, supra note 102, at 29.
Across all three classifications, virtually all fiduciaries share a fairly distinctive set of features. Fiduciaries invariably have discretion and power. In order to manage property, to represent someone, or to advise, the fiduciary must have sufficient leeway to make the kinds of judgments that can, in fact, promote the best interests of the beneficiary.106

Because the fiduciary has this power and because it is usually difficult, if not impossible, for the beneficiary to monitor the fiduciary’s performance,107 the fiduciary has a significant opportunity to exploit the latter’s vulnerability for her own gain. That is, the same power and discretion that enable her to do her job also enable her to exploit the very one whose benefit she should promote. For this reason, the law imposes the strongest duty of loyalty. “A trustee is held to something stricter than the morals of the market place. Not honesty alone, but the punctilio of an honor the most sensitive, is then the standard of behavior.”108

By implication, the physician must not exploit the patient to promote his own gain. He must not enter into avoidable conflicts of interest that would pit his own welfare against the patient’s or, when unavoidable, he must disclose such conflicts of interest and permit the

106. “If the relationship, as the parties structure it, does not confer discretion on the ‘fiduciary,’ then his actions are not subject to the fiduciary constraint. Even a designated ‘trustee’ may not be a fiduciary if he entirely lacks authority and thus has no discretionary power.” DeMott, supra note 100, at 901. In sum, “[t]he United States Supreme Court has noted that the central purpose of fiduciary law is to govern the exercise of discretion in making decisions that are not, and cannot be, controlled in advance by legal means.” Peter J. Jacobson & Michael T. Cahill, Applying Fiduciary Responsibilities in the Managed Care Context, 26 AM. J.L. & MED. 155, 160 (2000). As noted by Rodwin, fiduciaries usually “have specialized knowledge or expertise. Their work requires judgment and discretion.” Rodwin, supra note 103, at 244; see also Cooter & Freedman, supra note 101, at 1048–49 (explaining that the beneficiary/fiduciary relationship is not governed by “specific rules that dictate how the fiduciary should manage the asset,” but rather “the fiduciary’s responsibilities are open-ended’); Frankel, supra note 101, at 810 (explaining that “[t]he delegated power that enables the fiduciary to benefit the entrustor also enables him to injure the entrustor”).

107. “Often the party that the fiduciary serves cannot effectively monitor the fiduciary’s performance. The fiduciary relationship is based on dependence, reliance, and trust.” Rodwin, supra note 103, at 244.


The Restatement (Second) of Agency defines agency as a “fiduciary relationship” in which the agent [has] ... a duty “to act solely for the benefit of the principal in all matters connected with his agency.” Similarly, the Restatement (Second) of Trusts defines a trust as a “fiduciary relationship with respect to property,” with the trustee being under a duty “to administer the trust solely in the interest of the beneficiary.”

Id. at 25. As similarly noted by Shepherd, “[a] fiduciary relationship exists whenever any person acquires a power of any type on condition that he also receive with it a duty to utilize that power in the best interests of another.” SHEPHERD, supra note 102, at 35, 93.
patient to decide whether he may continue as physician-fiduciary. Across fiduciary relationships this obligation is so strong that, if the beneficiary can prove that his fiduciary is in a conflict of interest, the law will presume that the fiduciary abused his power or exploited the beneficiary, and thereby will place on the fiduciary the burden of proving he did not. As Professor Mehlman notes, penalties for breach of fiduciary duty can go beyond restitution to include punitive damages.

B. Opportunities for Breach of Fiduciary Duty

Practicing physicians cannot entirely escape conflicts of interest. Every form of compensation creates the potential to serve oneself rather than the patient. Fee-for-service can encourage too many services and excessive fees; capitation\(^{112}\) can reward withholding services; and salary can encourage the physician to see as few patients as possible, promptly closing the doors at 5:00 p.m.

Hence, it has always been possible for patients to raise questions about physician loyalty. Many concerns were raised, for instance, about the conflicts embedded in managed care arrangements such as capitation. Fee-for-service conflicts are more long-standing.

109. "Fiduciary law creates a cluster of presumptive rules of conduct compendiously described as the duty of loyalty. The obligations comprising this duty restrict the permissible scope of a fiduciary's behavior whenever possible conflicts of interest arise between the principal and the fiduciary." Cooter & Freedman, supra note 101, at 1053–54. “Other rules of fiduciary conduct include, for example, the rule against conflicts of duty, the rule against self-interested transactions, the rule against bribes and secret commissions, the rule against purchasing trust property, and the rule regarding fiduciary opportunities.” Id. at 1053 n.19; see also Frankel, supra note 101, at 824; Rodwin, supra note 103, at 244; SHEPHERD, supra note 102, at 41.

110. Cooter & Freedman, supra note 101, at 1048; DeMott, supra note 100, at 900; Angela R. Holder, Do Researchers and Subjects Have a Fiduciary Relationship?, 4 IRB 6 (Jan. 1982); AUSTIN WAKEMAN SCOTT, THE LAW OF TRUSTS 40 (Little, Brown & Co. 3rd ed. 1967).


112. Payment by capitation typically involves paying the physician a flat amount, per patient per month, to provide any services needed within a designated range. For instance, the physician might be obligated to provide all professional, laboratory, and x-ray services up to $5,000, after which the health plan assumes responsibility.

and, if more obvious, have been less worrisome to patients so long as an insurer paid for any potentially excessive services or fees. That may change, however. When patients pay far more of their own bills under CDHPs, they may pay far more attention to such issues.

A California court of appeals captured the issue well in discussing patient's vulnerability when his physician owns the pharmacy from which he buys his medications:

The doctor dictates what brand the patient is to buy . . . orders the amount of drugs and prescribes the quantity to be consumed. In other words, the patient is a captive consumer. There is no other profession or business where a member thereof can dictate to a consumer what brand he must buy, what amount he must buy, and how fast he must consume it and how much he must pay with the further condition to the consumer that any failure to fully comply must be at the risk of his own health. If the doctor interferes with the patient's free choice as to where he purchases his prescribed medicine, the patient then becomes a totally captive consumer and the doctor has a complete monopoly.114

In Strauss v. Biggs,115 for instance, a patient claimed not only that the podiatrist failed to do the procedure he promised and caused her harm by botching the services he did perform, but that out of greed he was running a "podiatric mill" and sending bogus bills to insurers such as hers.116 The Delaware Supreme Court held that punitive damages were warranted.117 Although breach of fiduciary duty was not listed as a cause of action in this case, it has potential where the patient, rather than the insurer, pays the bills.

In other cases, a physician might attempt dubious tactics to recoup revenues lost to managed care constraints. In one arrangement recently disclosed, some physicians developed "revenue sharing" relationships with clinical laboratories, in which the physician reaps substantial profits from each specimen he sends. The lab might charge the doctor $30 to analyze a skin biopsy, for instance,
while the physician then receives $109. Markups can reach 700 percent. The potential for exploitation is obvious, whether via needless biopsies or other lab analyses, or via sending specimens to the profitable lab regardless of whether its quality is acceptable.

Similarly, some physicians have brought sophisticated imaging equipment into their offices. According to one report, medical imaging services have risen at a rate three times faster than overall physician services, and costs have risen commensurately. "National Imaging Associates estimates from its own experience that about one-third of advanced imaging tests are either inappropriate for the medical problem at hand, or don’t contribute to a doctor’s diagnoses or a patient’s outcome,” and that many of the imaging facilities based in physicians’ offices may not measure up to quality standards either for equipment or for the qualifications of those reading the scans.

Evidence from the 1990s indicated that when physicians have an ownership interest in imaging facilities or other ancillary services to which they refer their own patients, overutilization, overpricing, poorer quality of care, and reduced overall access to these services can result. A 1989 report by the Department of Health and Human

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119. Armstrong describes an instance in which a physician sent a skin sample to a laboratory across the country, whose owner had once been director of a lab the state called a threat to public health. Id.

120. As noted by Ginsburg and Grossman, “more-sophisticated services such as magnetic resonance imaging (MRI) and other high-end imaging... have been brought into physician practices to an increasing degree.” Paul B. Ginsburg & Joy M. Grossman, When the Price Isn’t Right: How Inadvertent Payment Incentives Drive Medical Care, HEALTH AFF., Aug. 9 2005, available at http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.376v1.

121. V. Fuhrmans, Overuse of Medical Scans is Under Fire, WALL ST. J., Jan. 12, 2005, D1.

122. Id.

123. “Service use also is likely to increase because more care is being provided in settings where physician self-referral incentives come into play. Research shows that physician referrals are much higher when physicians have an ownership interest in the facility.” Ginsburg & Grossman, supra note 120. The Florida Cost Containment study alleged widespread problems of overutilization, overpricing, reduced access, and poorer quality of care, particularly in the areas of clinical laboratories, diagnostic imaging, physical therapy, and rehabilitation centers. STATE OF FLORIDA HEALTH CARE COST CONTAINMENT BOARD, JOINT VENTURES AMONG HEALTH CARE PROVIDERS IN FLORIDA (Aug. 1991); Jean M. Mitchell & Elton Scott, Physician Ownership of Physical Therapy Services: Effects on Charges, Utilization, Profits and Service Characteristics, 268 J. AM. MED. ASSN 2055 (1992) (concluding that “utilization, charges per patient, and profits are higher when physical therapy and rehabilitation facilities are owned by referring physicians”). Admittedly, such studies do not purport to define the comprehensive national picture, and they have been subject to substantial methodological criticism. Otis White, Where Business Has Turned Against Doctors, MED. ECON., Oct. 5, 1992, at 52 (criticizing Florida’s ban on self-referral). Still, they have fueled great concern about the hazards of physician investment and self-referral.
Services ("DHHS") Office of Inspector General ("OIG") found, in those days before the Stark anti-self-referral legislation,\(^{124}\) that Medicare patients referred to facilities in which their physicians had an interest received 45 percent more clinical laboratory services and 13 percent more physiologic testing than other Medicare patients.\(^{125}\) Importantly, although the Stark laws\(^{126}\) and regulations prohibit self-referral to free-standing facilities, they do not regulate physicians who bring those same technologies into their offices.

Perhaps the least recognized, yet most pervasive conflict of interest is defensive medicine, defined as "deviation from sound medical practice that is induced primarily by a threat of liability."\(^{127}\) Although some forms of defensive medicine do not directly generate extra costs—as, for instance, when a physician stops accepting high-risk patients or stops practicing in high-risk areas such as obstetrics—more common forms involve positive behaviors such as medically unnecessary tests, stronger treatments than needed, referrals to specialists, or invasive procedures that may actually be against professional judgment. By one recent estimate, some 92 percent of physicians engage in such "assurance behavior."\(^{128}\) The cost is said to range into billions of dollars.\(^{129}\)

125. U.S. DEPT. OF HEALTH & HUMAN SERVS., OFFICE OF THE INSPECTOR GENERAL, OAIG-12-12-88-01410, FINANCIAL ARRANGEMENTS BETWEEN PHYSICIANS AND HEALTH CARE BUSINESSES: REPORT TO CONGRESS iii (1989). Similarly, in a 1990 survey of in-office radiologic testing, Hillman and colleagues discovered that for several common procedures, physicians who had in-office equipment ordered four times as many studies, and ran costs up to seven times higher, than physicians who referred their patients to an independent radiologist. Bruce J. Hillman et al., Frequency and Costs of Diagnostic Imaging in Office Practice—A Comparison of Self-Referring and Radiologist-Referring Physicians, 323 NEW ENG. J. MED. 1604, 1604 (1990). In 1992, the same research group examined a broader range of clinical presentations with specific respect to a mostly elderly, chronically ill population. They concluded that in-office self-referral resulted in 1.7 to 7.7 times more frequent performance of radiologic imaging procedures and, for office-based (as distinct from hospital-based) imaging procedures, self-referring radiologists generally charged substantially more per episode of medical care than independent radiologists. Bruce J. Hillman et al., Physicians' Utilization and Charges for Outpatient Diagnostic Imaging in a Medicare Population, 268 J. AM. MED. ASS'N 2050, 2050 (1992); see also Jeffery H. Burkhardt & Jonathan H. Sunshine, Utilization of Radiologic Services in Different Payment Systems and Patient Populations, 200 RADIOLOGY 202 (1996).
128. Id. at 2612, 2616 (finding that fifty-nine percent of survey respondents "often ordered more diagnostic tests than were medically indicated," fifty-two percent "often referred patients to other specialists in unnecessary circumstances," and thirty-three percent "often prescribed more medications than were medically indicated" and "suggest[ed] invasive procedures which, in their professional judgment, were unwarranted").
129. One estimate pegged the cost of defensive medicine at $13.7 billion per year. Roger A. Reynolds et al., The Cost of Medical Professional Liability, 257 J. AM. MED. ASS'N 2776, 2778,
Here, too, the conflict of interest is obvious. To protect himself against some hypothetical legal threat his patient might pose, the physician undertakes interventions that, by definition, do not promote the patient's benefit. Under CDHPs with high deductibles, many more of these will be paid for by patients rather than insurers. If patients believe they have paid for essentially useless care—perhaps even exacerbating medical risks—some may cry foul. At this point, breach of fiduciary duty becomes a potential cause of action. The question then is whether courts will be receptive.

C. Judicial Responses to Breach of Fiduciary Duty

Many courts have agreed that the physician-patient relationship is fiduciary, or at least a relationship of trust and confidence. Most of these cases, however, focus on establishing physicians' duties toward patients, particularly in the area of informed consent. Far scantier is the case law addressing whether physicians can be liable for breach of fiduciary duty.

One prominent case in which a court was willing to hold a physician liable for breach of fiduciary duty is Moore v. Regents of the University of California. The physician who removed a patient's spleen for therapeutic purposes discerned that the patient's cells could be developed into a lucrative cell line. Thereafter, he told the patient...
to return repeatedly from his home in Seattle to the physician's office in Los Angeles—under the ruse that it was for his benefit—so that the physician could continue to gather various tissue samples for research and commercial purposes.\textsuperscript{133}

Finding that the patient had a cause of action both for breach of fiduciary duty and for breach of informed consent, the California Supreme Court held:

The law already recognizes that a reasonable patient would want to know whether a physician has an economic interest that might affect the physician's professional judgment. As the Court of Appeal has said, '[c]ertainly a sick patient deserves to be free of any reasonable suspicion that his doctor's judgment is influenced by a profit motive.' ... Accordingly, we hold that a physician who is seeking a patient's consent for a medical procedure must, in order to satisfy his fiduciary duty and to obtain the patient's informed consent, disclose personal interests unrelated to the patient's health, whether research or economic, that may affect his medical judgment.\textsuperscript{134}

As noted above in \textit{Strauss v. Biggs},\textsuperscript{135} courts have also been willing to impose punitive damages when they find a physician has exploited a patient with unnecessary procedures and bogus billing.\textsuperscript{136}

Courts, however, are far from unanimous. In \textit{D.A.B. v. Brown},\textsuperscript{137} physicians who prescribed synthetic growth hormone failed to reveal that they were receiving kickbacks from the drug's manufacturer. Once the physicians were convicted in federal court for violation of anti-kickback laws, the plaintiffs alleged, \textit{inter alia}, breach of fiduciary duty and conspiracy to commit breach of fiduciary duty. The Minnesota appellate court rejected this formulation of the issues, holding that the complaint sounded in malpractice, not breach of fiduciary duty, because the physicians' actions involved "medical diagnosis, treatment, and care of the patients."\textsuperscript{138} The court noted that this complaint did not allege that the patients' treatment was improper or resulted in any harm,\textsuperscript{139} and it explicitly declined to recognize breach of fiduciary duty as a new tort in the physician-patient relationship:

While we agree that a physician's advice about treatment options should be free from self-serving financial considerations, any cause of action based on that conduct

\textsuperscript{133} Although the California Supreme Court denied that the taking of these tissues constituted a claim for conversion of property, it did find that plaintiff stated a valid cause of action for a breach of fiduciary duty and of the duty to obtain informed consent. \textit{Id.} at 480.

\textsuperscript{134} \textit{Id.} at 483, 485.

\textsuperscript{135} 525 A.2d 992 (Del. 1987).

\textsuperscript{136} It can be noted, however, that the \textit{Strauss} complaint did not include breach of fiduciary duty. Nevertheless, the complaint has the essential elements of a fiduciary claim—vulnerability of the patient, exploitation by the party who has superior power, and the like.

\textsuperscript{137} 570 N.W.2d 168 (Minn. Ct. App. 1997).

\textsuperscript{138} \textit{Id.} at 171.

\textsuperscript{139} \textit{Id.}
necessarily flows from the therapeutic relationship. Any breach of fiduciary duty that may have occurred during the doctor's prescription of medication to his patients arose while the doctor was examining, diagnosing, treating, or caring for his patients.\footnote{Id. at 172.}

Because there was no allegation of injury relating to conduct and the complaint was filed after the two-year statute of limitations, the court dismissed plaintiffs' complaint for failure to state a claim.\footnote{Id.} The court also upheld dismissal of complaints that the defendants had violated the state's consumer fraud act, because plaintiffs had alleged no injury.\footnote{Id. at 172–73.}

In \textit{Neade v. Portes},\footnote{739 N.E.2d 496 (Ill. 2000).} an HMO physician who declined to authorize an angiogram for a patient with chest pain also failed to disclose the financial incentives encouraging him to limit treatment. The patient's estate sued for medical negligence and breach of fiduciary duty. Reversing the appellate court, the Illinois Supreme Court held that, although the state's courts recognize a fiduciary relationship between physician and patient,\footnote{Id. at 500.} the claim concerning fiduciary duty was duplicative of the medical malpractice claim.\footnote{Id. at 502. The court pointed out that:}

\begin{quote}
In order to sustain a breach of fiduciary duty claim against Dr. Portes, plaintiff would have to allege, \textit{inter alia}, that: (1) she had known of the Medical Incentive Fund she would have sought an opinion from another physician; (2) that the other physician would have ordered an angiogram for Mr. Neade; (3) that the angiogram would have detected Mr. Neade's heart condition; and (4) that treatment could have prevented his eventual myocardial infarction and subsequent death.
\end{quote}

\textit{Id.} at 503. These elements, the court concluded, were the very things the plaintiff would have to prove to establish malpractice—hence the two are duplicative. \textit{See also} \textit{Spoor v. Serota}, 852 P.2d 1292 (Colo. Ct. App. 1992) (dismissing breach of fiduciary duty as duplicative of negligence claim).\footnote{Neade, 739 N.E.2d at 502.} At most, the physician's incentives might be evidence to show bias if the physician were to testify at trial.\footnote{Id. at 506.} 

The \textit{Neade} court did not close the door on the possibility of a cause of action for breach of fiduciary duty in the physician-patient context, noting simply that the court had never addressed it and did
not need to do so here, since the claim was dismissed as duplicative.\textsuperscript{148} The court did observe, in dicta, that creating "a new cause of action for breach of fiduciary duty against a physician in these circumstances would be impractical,"\textsuperscript{149} since physicians often work for many HMOs with differing structures and incentive arrangements.

Neither of these decisions is fatal to the idea that patients who pay for their care out of their HSAs or pockets could have a legally cognizable claim for breach of fiduciary duty when they are exploited by physicians in undisclosed conflicts of interest. In both cases, the courts were troubled by the lack of any injury that was specifically and uniquely connected to the fiduciary duty, sufficient to permit a distinct claim to go forward. In \textit{D.A.B.}, there was no injury at all, while in \textit{Neade}, the injury was already covered by the malpractice claim. Yet both courts seemed to leave open the possibility that there could be such a claim under some circumstances.

In \textit{D.A.B.}, for example, the court explicitly noted that plaintiffs could not show any economic injury—no indication that their insurance premiums or co-payments had increased due to the physicians' actions, or that they paid a higher price than they would have from some other drug supplier.\textsuperscript{150} In so doing, the court seems to leave open the possibility that an economic injury could suffice. Although this court did not find an injury for plaintiffs whose expenses were already insured, presumably an injury might be found where patients must pay out of pocket—perhaps, for instance, for costly tests sent to a lab that gives the physician a large profit, or maybe for a medically needless, costly CT scan for a minor head bump, ordered simply to insulate the physician against potential malpractice litigation. The \textit{Neade} court might likewise accept such economic injuries, since they do not duplicate malpractice claims.

In sum, where a physician uses her superior power to promote her own interests over the patient's and in the process causes distinctly identifiable harms, courts may be willing to move beyond their current recognition that physicians' duties are founded in a fiduciary kind of relationship, to follow the \textit{Moore} court and find liability for breaches of fiduciary duty.\textsuperscript{151}

\begin{footnotes}
\item[148] Id. at 500.
\item[149] Id. at 504 (emphasis added).
\item[150] 570 N.W.2d 168, 173 (Minn. Ct. App. 1997).
\item[151] For arguments proposing that tort injuries might legitimately be expanded to encompass certain sorts of "dignitary torts," see Morreim, \textit{supra} note 66, at 78–85.
\end{footnotes}
IV. CONTRACT LAW

A curious combination of tort and contract—"contorts"—guides the physician-patient relationship. Although medical injuries are usually addressed in tort, the relationship is initiated and partly guided by principles of contract.

Periodically, contract figures directly in litigation that might otherwise focus on malpractice. In one case a Maryland appeals court held that a physician had a contract-based duty to help his patient file important health-related documents with the latter's employer. In another case the South Carolina Supreme Court held that a Jehovah's Witness patient had stated a claim for breach of contract, alongside claims for battery, when the surgeon reneged on his repeated promises not to transfuse blood.

Moreover, as patients pay more health care costs directly, we can expect an increased emphasis on contract alongside tort. People with high-deductible health plans can be responsible for as much as $5,000 per year as individuals or $10,000 per year as families. As observed by Professor Mariner, "[t]he more health care is perceived to be a consumer good, the more likely it is that contract principles will supersede tort principles in defining both access to care and rights and obligations in care."
A. Basic Contract Principles

A contract is a legally enforceable exchange of promises. Its major terms, such as quantity, price, and payment terms must be sufficiently definite to permit the parties (and the courts) to determine what was promised by each side, whether the contract was broken, and what would be an appropriate remedy for breach. Terms, except for quantity, can generally be left open. In some instances, rather than specifying an exact price for the goods or services to be exchanged, the contract will supply a reference to some independent, objective standard, such as a market index. Alternatively, a court might look to such evidence as the parties’ course of performance during a contract or their course of dealing under prior contracts. If one party sets the price, it must do so “in good faith.” Absent such helpful clues, the gap-filler for both the Uniform Commercial Code, governing the sale of goods, and the Restatement (Second) of Contracts, is reasonableness: If the price is not supplied by the parties, it must be a reasonable price.

In some instances the parties never form a contract, or what they form is unenforceable. In these cases, an important alternative can still be available. Under the theory of restitution, also known as unjust enrichment, quantum meruit, or quasi-contract, when one party has conferred a benefit upon another, neither gratuitously nor officiously, that party may be entitled to compensation as if there were

158. In some instances, a performance, rather than a promise, is sought from the promisor. See E. Allen Farnsworth, Contracts 151 (Foundation Press 6th ed. 2001).

159. Restatement (Second) of Contracts § 33 (1981) (requiring terms of contract to be "reasonably certain"); see also Farnsworth, supra note 158, at 251.

160. For goods, see U.C.C. § 2-305 (1977).


163. Id. § 2-305.

164. Restatement (Second) of Contracts, § 33 cmt. e (1981) states:

Indefinite price. Where the parties manifest an intention not to be bound unless the amount of money to be paid by one of them is fixed or agreed and it is not fixed or agreed there is no contract. Uniform Commercial Code § 2-305(4). Where they intend to conclude a contract for the sale of goods, however, and the price is not settled, the price is a reasonable price at the time of delivery if (a) nothing is said as to price, or (b) the price is left to be agreed by the parties and they fail to agree, or (c) the price is to be fixed in terms of some agreed market or other standard as set or recorded by a third person or agency and it is not so set or recorded. Uniform Commercial Code § 2-305(1). Or one party may be given power to fix the price within limits set by agreement or custom or good faith. Similar principles apply to contracts for the rendition of service. But substantial damages cannot be recovered unless they can be estimated with reasonable certainty (§ 352), and if the contract is entirely executory and specific performance is not an appropriate remedy, relief may be limited to the recovery of benefits conferred and specific expense incurred in reliance on the contract.
a contract.\textsuperscript{165} Here, too, the amount of compensation must be reasonable, reflecting the value of the benefit conferred.

\textbf{B. Case Law}

In the health care setting, prices are commonly discussed only after performance.\textsuperscript{166} Typically, the only antecedent inquiry is whether the patient is insured or otherwise able to pay.\textsuperscript{167} Not surprisingly, this has prompted a number of cases in which patients, in "sticker shock" over the amount they are asked to pay, either refuse to pay and are sued by providers, or pay and then sue to recover at least part of what they argue is an overcharge. Classic contract principles have governed these cases' resolutions.

Some cases have granted the hospital a clean victory. In \textit{Heartland Health Systems v. Chamberlin},\textsuperscript{168} the mother of an eighteen-year-old who had been in a motor vehicle accident claimed she did not realize what she was signing in the emergency room. Moreover, she argued, since this was a contract of adhesion the bills for her son's care should be limited by reasonable expectations. The court ruled that the hospital had not committed any fraud or duress. "[A] person is bound by the terms of a contract he signs,"\textsuperscript{169} and it was reasonable for the mother to expect that she would have to pay for her son's emergency care. Moreover, the uncontested testimony of the hospital's financial representative was that these charges were reasonable, customary, and consistent with those in the medical industry.\textsuperscript{170}

\textsuperscript{165} Farnsworth, supra note 158, at 103, 106–07; see also, \textsc{Restatement of Restitution} §§ 40, 53 (1936); \textit{Greenfield v. Manor Care, Inc.}, 705 So. 2d 926, 930–31 (Fla. Dist. App. Ct. 1997); Doe v. HCA Health Serv. of Tennessee, Inc. 46 S.W.3d 191, 198 (Tenn. 2001).

\textsuperscript{166} A prominent exception is cosmetic surgery. As a purely consumer product, these procedures are only provided to those who can pay, and prices are typically provided in advance. Interestingly, cosmetic surgery exhibits far more characteristics of a genuine market than the rest of health care. From 1992-2001, the rise in cost for medical services was 47% in comparison with the overall consumer price index, which rose 26%. In contrast, costs for cosmetic surgery rose only 16%. \textit{Kenneth T. Bowden, Determining a Reasonable Price for Health Care in the United States: Is This Possible?}, 34 SPG BRIEF 26 (Spring 2005).


\textsuperscript{168} \textit{Heartland Health Sys. v. Chamberlin}, 871 S.W.2d 8 (Mo. Ct. App. 1993).

\textsuperscript{169} Id. at 10.

\textsuperscript{170} Id. at 11–12. \textit{See DiCarlo v. St. Mary's Hosp.}, 2006 U.S. Dist. LEXIS 49000, *10 (D.N.J. 2006); \textit{Burton v. William Beaumont Hosp.}, 373 F. Supp. 2d 707, 718-19 (E.D. Mich. 2005); \textit{Morrell v. Wellstar Health System, Inc.}, 2006 Ga. App. LEXIS 736, *8-*9 (Ga. App. 2006). These cases are part of a multidistrict class action against not-for-profit hospitals in which plaintiffs allege, \textit{inter alia}, that defendant hospitals have not provided adequate charity care and charge indigent patients at excessively high rates. Because this body of litigation is quite recent and
Hall v. Humana Hospital Daytona Beach was a class action filed by a group of patients who wanted partial refunds on payments they argued were excessive and unreasonable. The sums they paid for pharmaceuticals, medical supplies, and lab services, the plaintiffs argued, were disproportionate to the market price of the same items in a non-market setting and therefore an "imposition." Examples included $11.50 for one tablet of Zantac, $52 for one of Tylenol with codeine, and $20.50 for one tablet of Cipro.

The Florida appellate court had no sympathy. Even if there may have been elements of compulsion when they or their loved ones were still hospitalized, the plaintiffs paid the bill when the need for care had ended and any duress no longer existed. "By voluntarily making payment of these alleged overcharges once the alleged coercion practiced by Humana had ceased, [plaintiffs] ratified or affirmed their prior agreement to pay these charges." Two years later, the same reasoning was applied by another Florida appellate court under analogous circumstances.

In contrast, a number of courts have held that the charges of institutional providers such as hospitals and nursing homes must be reasonable. In Mercy Hospital, Inc. v Carr, for instance, a Florida appeals court found that there was a valid contractual obligation owed by a patient whose wife had signed releases agreeing to pay "in accordance with existing standard and current rates as set forth in regular schedules which are available for inspection and review." However, noting that the patient's husband had "demanded without success to see the regular schedules containing the standard current rates referred to by plaintiff hospital," the court remanded the issue back to the trial court to resolve the amount of defendant's liability.

only limited numbers of decisions have emerged, these cases will not receive special attention in this Article.

173. Hall, 686 So. 2d at 657.
174. Greene v. Alachua Gen. Hosp., Inc., 705 So. 2d 953 (Fla. Dist. App. Ct. 1998) (affirming that voluntary payment on part of the debtor tends to show that an "imposition" did not exist). But see Burton, 373 F. Supp. 2d 719 (holding, unlike in Hall v Humana, that the fact that plaintiff had not paid the bill meant they were first to breach, hence could not "maintain an action against the other party for its subsequent breach or failure to perform").
176. Id. at 599.
177. Id.
The defendant was “entitled to question the reasonableness” of the hospital’s charges.\textsuperscript{178}

Similarly, in \textit{Victory Memorial Hospital v. Rice},\textsuperscript{179} an Illinois appellate court found that the defendant-patient did owe payment to the hospital. However, consistent with standard contract principles, the court held that:

\begin{quote}
where there is a contract, express or implied, under which one party supplies articles or services to another and there is no provision setting out the amount the supplier is to be compensated, the law implies that there is an agreement to pay a reasonable price for the goods and services.\textsuperscript{180}
\end{quote}

Although it would have been insufficient simply to show what the charges were,\textsuperscript{181} in this case the hospital had provided ample evidence about area hospitals’ charges and its own internal methods for setting prices. Hence, it had made a case for the reasonableness of its charges.

In \textit{Protestant Hospital Builders Club, Inc. v. Goedde},\textsuperscript{182} an Illinois appellate court likewise found that a valid contract existed, and that since there was no provision setting out the amount of compensation, the law implies that the price must be reasonable. Unlike \textit{Victory}, this hospital had failed to demonstrate the reasonableness of its charges. The court cited a paragraph in the hospital’s contract with the patient that,

\begin{quote}
in essence, vests in plaintiff unrestricted discretion in determining what price it will charge for its materials and services. It can hardly be said that this paragraph provides for a definite price where it offers no formula for computing prices other than the discretion of the supplier. Therefore, this paragraph does not rid plaintiff of its burden of establishing the reasonableness of its charges.\textsuperscript{183}
\end{quote}

Some hospitals have fared even less well. \textit{Payne v. Humana Hospital Orange Park}\textsuperscript{184} was a class action case in which plaintiff patients complained that “instead of fair or reasonable compensation, unreasonable, unconscionable, and excessive charges were exacted for pharmaceuticals, medical supplies, and laboratory services.”\textsuperscript{185} The court, making the familiar notation that “\textit{[w]hen a contract fails to fix

\textsuperscript{178} Id.
\textsuperscript{180} Id. at 119.
\textsuperscript{181} Id.
\textsuperscript{183} Id. at 1306. The court went on to note that simply showing the bills that were sent to the patient will not count as proof of reasonableness. Id.
\textsuperscript{185} Id. at 1239.
a price, a reasonable price is implied,"186 discussed the doctrine of "imposition." "Where a person taking advantage of his position, or the circumstances in which another is placed, extracts a greater price for services rendered than is fair and reasonable,..., the exaction of the unreasonable price for the service rendered may be said to be an imposition."187 Accordingly, the appellate court reversed the trial court's dismissal of the plaintiffs' claims against Humana.

In Greenfield v. Manor Care, Inc.,188 the plaintiff was the widow of a man who had been a patient in Manor Care nursing home. In addition to the home's daily rate, she had been charged for a number of additional services. Although she had signed agreements to pay such bills, she argued that the home's superior bargaining power permitted it to set charges solely at its own discretion, except for an obligation to disclose changes in the daily rate. Arguing that the ancillary charges were excessive, she claimed the home was unjustly enriched at her expense and demanded partial refund.

Citing Payne and other authorities, a Florida appellate court reversed summary judgment for the defendant, holding that

appellant in this case stated a cause of action for breach of the implied covenants of reasonableness, good faith, and fair dealing. Since the prices to be charged by the facility were not expressly stated within the four corners of the contract, a reasonable fee was implied, and appellant was not foreclosed from bringing an action based on Manor Care's breach of this implied covenant.189

Although voluntary payments cannot ordinarily be recovered, "when 'money is obtained through "imposition", express or implied, or extortion or oppression, or an undue advantage is taken of the plaintiff's situation,' the payment is not voluntary and does not bar an action for money had and received."190 The court agreed that plaintiff had stated a cause of action for unjust enrichment.191

Although the foregoing cases are predicated on a finding that a bona fide contract existed, and that the absent price term must be supplied by a reasonable price, some other courts have found that no

186. Id. at 1240.
187. Id. at 1241 (citing S. States Power Co. v. Ivey, 160 So. 46, 47 (Fla. 1935)) (emphasis added by Payne court). Another court has defined imposition as "something less than coercion...

189. Id. at 929.
190. Id. (citing Cullen v Seaboard Air Line R.R. Co., 58 So. 182, 184 (Fla. 1912)).
191. The court provided the three elements of unjust enrichment: (1) plaintiff conferred a benefit on defendant who is aware of the benefit; (2) defendant voluntarily accepted and retained the benefit; and (3) it would be inequitable for defendant to retain the benefit without paying for it. Id. at 930–31.
contract existed. In that situation, courts have been willing to grant providers reasonable compensation via quantum meruit.

In Galloway v. Methodist Hospitals, Inc., a woman presented to the emergency room in active labor. Her husband signed a form agreeing to receive treatment, but did not sign the form agreeing to pay. When the hospital sued for payment, an Indiana appellate court ruled that the hospital was entitled to receive compensation under a theory of unjust enrichment. Moreover, the testimony of the hospital's controller was found sufficient to establish the reasonableness of the charges—given that the defendants did not challenge the hospital's use of its controller to testify on that issue.

Perhaps the most interesting case in this area is Doe v. HCA Health Services of Tennessee. The plaintiff had received services from HCA's Donelson Hospital and, after insurance had paid its portion, owed $1,346. Although the Does had signed an agreement to be financially responsible, they claimed that the hospital's charges were unreasonable. The hospital replied that "charges" was not an indefinite term because it implicitly referred to the hospital's "charge master," a comprehensive list of all charges. The trial court found that there was a valid contract, and that although the price term was made definite by this reference to the charge master, nevertheless the hospital's charges must be reasonable.

The appellate court also required reasonableness, but via different reasoning. Although there was a valid contract, it did not incorporate the hospital's charge master by reference. Instead, price as a missing term must be supplied by "reasonableness."

193. Doe v. HCA Health Serv. of Tenn., Inc., 46 S.W.3d 191 (Tenn. 2001).
195. Id. at *2 ("It seems to us that the [trial] court applied a hospital exception to the general law of contracts. While finding that the contract incorporated a price term by reference (presumably the charge master), the court, nevertheless, held that the hospital's charges had to be reasonable."). Cf. DiCarlo v. St. Mary's Hosp., 2006 U.S. Dist. LEXIS 49000, *10 (D.N.J. 2006) (holding that, in contract signed by uninsured emergency room patient, contract unambiguously incorporated hospital's charge master as its price term); Burton v. William Beaumont Hosp., 373 F. Supp. 2d 707, 718-19 (E.D. Mich. 2005) (holding that contract signed by uninsured recipient of emergency room care, promising to pay all charges, was binding, and refusing to invoke the U.C.C.'s requirement for "reasonableness" where price term is open, because U.C.C. applies to goods, not service contracts such as those involved in this case); Morrell v. Wellstar Health System, Inc., 2006 Ga. App. LEXIS 736, *8-*9 (Ga. App. 2006) (holding that contract signed by uninsured recipient of emergency room care, promising to pay all charges, impliedly incorporated hospital's charge master list of prices, because Georgia statute requiring hospital to provide a written summary of prices upon request must be considered part of the contract).
The Tennessee Supreme Court also found that reasonable prices were required, but by yet a different line of reasoning. The court noted that the charge master was confidential—that is, it was proprietary information shown only to the hospital's officers, employees, and authorized consultants—and that it was adjusted weekly. There was no contract, the court concluded, because the agreement was indefinite.

Even absent a contract, however, under *quantum meruit* the hospital was still entitled to compensation for its services. The case was remanded for a finding of reasonable remuneration. Citing other case law, the court suggested that the trial court consider what is charged by other hospitals in the community, plus any factors relevant to that particular hospital.

Importantly, the requirement that fees be reasonable has been applied to physicians, just as to hospitals. In *Majid v. Stubblefield*, a patient who had undergone kidney stone removal made only partial payment for services, arguing that charges were excessive. The physician filed a small claims complaint to recover the rest. The court cited *Victory Memorial Hospital v. Rice*, which

held that when a hospital seeks to establish its charges are reasonable, the hospital must prove its charges are the usual and customary charges for that particular hospital and they are comparable to the charges of other area hospitals. While *Victory Memorial Hospital* dealt solely with hospital charges, we find that its holding also extends to doctors' fees.

The court went on to find one charge reasonable according to the evidence, and another not proven to be reasonable.

*Culverhouse v. Jackson* also featured a physician bringing suit to recover fees for professional services. The Georgia appellate court reversed a trial judgment for the physician and held that, absent

196. The court identified the elements of unjust enrichment as follows: (1) the lack of an enforceable contract; (2) the party seeking recovery provided goods or services; (3) the other party received them; and (4) the parties should have reasonably understood that the provider of goods or services expected to be compensated, and it would be unjust for recipient to retain the goods or services without paying for them. *Doe*, 46 S.W.3d at 198.

197. In dicta, the court suggested that the trial court "must include consideration and recognition of the particular hospital's costs, functions and services to make a valid determination of whether such charges were reasonable for that hospital alone or compared to the charges of other area hospitals." *Id.* at 199 (citing *Victory Mem'l Hosp. v. Rice*, 493 N.E.2d 117 (Ill. App. Ct. 1986)).


proof about the ordinary, reasonable value of the physician’s services, the evidence was not sufficient to authorize a judgment for the physician. \textsuperscript{203} “No proof was submitted as to the ordinary and reasonable value of the services. Thus the evidence was insufficient to authorize the judgment.” \textsuperscript{204}

C. “Reasonable Charge”: An Elusive Concept

By various means, then, a variety of courts have determined that providers, whether hospitals or individual physicians, can charge only reasonable fees for their services and goods. Unfortunately, “reasonable” remains murky and ill-defined. Some courts, probably focusing on the marketplace as a means for setting prices, suggest that a hospital “must prove its charges are the usual and customary charges for that particular hospital and they are comparable to the charges of other area hospitals.” \textsuperscript{205} In some instances such internal factors as the “particular hospital’s costs, functions and services” are permissible. \textsuperscript{206}

Unfortunately for hospitals and physicians, a strong case can be made that “prevailing” or “usual” or “customary” charges are not necessarily “reasonable,” particularly in the eyes of jurors who increasingly pay for health care out of their own HSAs or pockets. They, like the plaintiffs in \textit{Hall}, \textsuperscript{207} may not think it reasonable to charge $52 for a single tablet of Tylenol with codeine, no matter how customary that price might be. \textsuperscript{208}

Arguably the greatest factor prompting a disjunction between the supply-and-demand mechanism that usually sets market prices, versus the forces that set health care pricing, is third party payment for health care. \textsuperscript{209} As generous health insurance became standard during and after World War II, and expanded in 1965 to encompass

\textsuperscript{203} Id. at 586.
\textsuperscript{204} Id.; see also Poulson v. Foster, 293 N.W. 361, 362 (S.D. 1940) (holding in a case where a dentist sued his patient for failure to pay that it was insufficient for the dentist simply to state his charges; rather, he must show that they are reasonable).
\textsuperscript{206} Victory Mem’l Hosp., 493 N.E.2d at 120.
\textsuperscript{208} Id. at 655.
\textsuperscript{209} “In most of the economy, competitive markets are seen as the force that leads to a structure of prices that reflects the structure of costs. But since medical care is financed largely by third parties, this mechanism does not necessarily function.” Paul B. Ginsburg & Joy M. Grossman, \textit{When the Price Isn’t Right: How Inadvertent Payment Incentives Drive Medical Care}, HEALTH AFF., Aug. 9, 2005, available at http://content.healthaffairs.org.
the elderly and poor through Medicare and Medicaid, patients became increasingly insulated from the costs of their care. Physicians could order virtually any service or product, safe in the knowledge that it would be paid for, while patients had little concern about what costs their insurer would absorb. Even employers, who provided most of the coverage for working Americans, initially had little concern about the costs of health care because they enjoyed tax savings for providing this benefit.\textsuperscript{210}

Insurers' modes of reimbursement were probably even more important to the explosion of health care costs. As noted above,\textsuperscript{211} payment on a retrospective, fee-for-service basis encouraged hospitals and physicians to provide as many services as possible. The inflationary effects of FFS were compounded by fee structures that permitted providers to charge virtually whatever they wanted.\textsuperscript{212} From its inception, Medicare based providers' payment on its "customary, prevailing, and reasonable" ("CPR") system, while private insurers promptly installed their virtually identical "usual, customary, and reasonable" ("UCR") system.\textsuperscript{213}

In this UCR/CPR schema, the first component "is defined generally as the price that the individual physician most often charges for a given service."\textsuperscript{214} The second component "is based on aggregate charges in the community."\textsuperscript{215} Medicare "established the 75th percentile as the basis for its 'prevailing' allowance," while Blue Shield plans initially chose "the 90th percentile of charges in the community, i.e., the point at which only 10 percent of charges are higher."\textsuperscript{216} Finally, "reasonable" allowances under either system would permit a fee to go higher for an individual complex case.\textsuperscript{217}

The skyrocketing of providers' fees was predictable, as seen in two studies of physician fees following the enactment of Medicare/Medicaid. Benson Roe observed:

\begin{quote}
The explosion of fees started with a few audacious physicians who, recognizing the wide-open potential of the system, billed third-party insurers at very high levels—and got paid. They were generally young doctors just starting practice and lacking a previous
\end{quote}

\begin{footnotes}
\item[210] BALANCING ACT, supra note 2, at 8–17.
\item[211] See supra Part I.
\item[212] This arrangement was largely the product of lobbying by the then-powerful medical community. Roe, supra note 3, at 41-45. See generally Thomas L. Delbanco et al., Paying the Physician's Fee: Blue Shield and the Reasonable Charge, 301 NEW ENG. J. MED. 1314, 1314–20 (1979) (analyzing Medicare's impact on physician fees).
\item[213] Delbanco, supra note 212, at 1315–16.
\item[214] Id. at 1316.
\item[215] Id.
\item[216] Id.
\item[217] Id.
\end{footnotes}
record of charges, so that their 'usual' fee could be whatever they chose. . . . Later, when the carriers adopted some payment restrictions, these extraordinary charges were not initially reimbursed at the level submitted, but they contributed to raising the 'customary' average and established an individual profile of charges as the basis for future payments. . . . The older and more experienced practitioners tended to maintain their lower fees until they learned that young upstarts were being paid more than they were, so naturally their fees were raised to match—often to levels that most of them would not otherwise have considered. Thus the spiral began.218

Similarly, Dr. Thomas Delbanco et al. pointed out that

[al]though customary levels in the community are kept secret, it is easy for a physician to discover the maximum charge allowable for any given procedure or test. All the physician has to do is to charge a high fee and see what is paid. If the entire charge is accepted, he or she is at or below the customary level. Charges above this level help raise the customary allowance level at the next annual updating. Only charges more than twice the customary level are omitted from the pool of charges that determine changes in subsequent allowances.219

In the Washington, D.C., area, this generous fee structure meant, for instance, that fees for coronary artery bypass surgery surged 75 percent from 1975 to 1978.220

For hospitals, the same payment system produced the same results. Eventually, as noted above,221 financial structures began to change with the federal government's 1982 introduction of DRG payments for hospitalization of Medicare patients.222 Yet the effects were limited. Retrospective FFS payment remains in many health plans, and the historic power of UCR/CPR has helped to entrench a major disjunction between ordinary market pricing mechanisms and those within health care.

For hospitals, current pricing structures are mysterious at best. As noted in Doe, hospitals commonly use an internal document called a "charge master."223 It lists the hospital's official billing charges for thousands of goods and services. Charge masters are usually kept confidential, even from most of the hospital's employees, and typically are adjusted from week to week.224

218. Roe, supra note 3, at 41-42.
219. Delbanco, supra note 212, at 1317.
220. Id.
221. See supra Part I.
222. Under DRGs, instead of paying hospitals for each service they provided and for every day the patient stayed, the government radically altered the incentive structure. Hospitals would now be paid a set sum for that hospital episode, based on the patient's chief diagnosis and selected other factors such as sex, age, and comorbidities. Now the hospital would be rewarded by doing less, rather than by maximizing its services. BALANCING ACT, supra note 2, at 15; see also Ginsburg & Grossman, supra note 120.
223. Doe v. HCA Health Serv. of Tenn., Inc., 46 S.W.3d 191, 194 (Tenn. 2001).
224. Every hospital has a "Charge Master" . . . file of all costs and charges for every hospital service, drug, or procedure—which is used to generate both a hospital invoice
Furthermore, as explained in the appellant’s brief in *Doe*, \(^{225}\) prices in a charge master are not necessarily based on any analysis of the costs of providing various goods and services. In *Doe*, the hospital employee who set the charge master acknowledged in testimony that “he has never conducted studies to determine the actual costs of delivering goods and services in setting the Charge Master rates. Instead he just ‘estimates it’.” \(^{226}\)

In fairness to hospitals, basing charges on the actual costs of providing services can be very difficult. For instance, internal cost-shifting is widespread, in which prices for some common items are set high, to generate extra revenue to cover some of the costliest goods and services. \(^{227}\) For this and other reasons, determining the actual cost of providing a given service will ordinarily require considerable resources to track down its myriad sub-costs. There is little incentive to undertake such an effort, \(^{228}\) given that payors reimburse care according to actual or negotiated charges, not hospitals’ actual costs. The net result is little, if any, correlation between a charge master price and the price that the same service or product might have if purchased in a direct, supply-and-demand economy.

The wide discrepancies among various hospitals’ charge masters were recently revealed in California, where a new state law mandates their publication:

and the standard required federal UB-92 form that accounts for all inpatient or outpatient hospital procedures. The Centers for Medicare and Medicaid Services (CMS) compiles this information annually in its Medicare Cost Reports. The reports detail every hospital’s costs and charges by department and cost centers. Thus, Medicare knows each hospital’s average daily costs to provide care for a patient.

Randy Suttles & Merrill Matthews, *Investigative Report: Overcharging the Uninsured—Part 1*, HEALTH CARE NEWS, Sept. 1, 2003, available at http://www.heartland.org/Article.cfm?artId=12775. As noted in *Doe*, the charge master is “a confidential list of charges used to compute charges for all private commercial patients who are treated on a fee-for-service basis.” 46 S.W.3d at 194. In 1991, Donelson Hospital’s charge master had 7,650 items, running 295 pages. Id.


226. Id. at 18–19 (internal citations omitted).

227. Id. at 17. “Hospitals report that a strong motivation for expanding more profitable services is to cross-subsidize these less-well-paid services as well as to provide sufficient margins to fund uncompensated care.” Ginsburg & Grossman, *supra* note 120.

228. Assessing the unit costs of each of a large number of services requires major effort to gather information on direct inputs, such as labor, space, supplies, and equipment, and sophisticated formulas to allocate indirect costs, such as general management. Although estimating unit costs can be relatively easy for services in which a purchased input constitutes a large share of the cost, such as drugs or devices, estimating the costs of most services is far more difficult because the most important inputs produce numerous distinct services. Few hospitals use sophisticated cost accounting systems to set charges.

*Id.*
An examination of chargemasters at several hospitals shows that pricing strategies fluctuate wildly—on everything from brain scans to painkillers to leeches. Depending on a hospital’s pricing method, the charge for the same commodity or service, such as a blood test, can vary by as much as 17-fold from one institution to another.229

Examples were striking: a basic chest x-ray with two views ranged from $120 to $1,519; a comprehensive metabolic panel ranged from $97 to $1,733; CT scan of the head (without contrast) went from $882 to $4,038; a single tablet of Tylenol could be no charge or $7; leeches ranged from $19 to $81 each.230 The very idea of calling any of these “customary” or “usual” defies credibility. Clearly, what is customary is the variation, not the prices.

Further exacerbating this, most payors negotiate their own rates with providers, and any given payor will typically negotiate different payment arrangements with different providers.231 While some payors directly negotiate their own fees,232 others pay a specified percentage of the charge master.233

As a result, charge master listings are not the fees that most patients are asked to pay. Because of the deep discounts negotiated with most third-party payors, virtually the only ones who are actually expected to pay the charge master rates are those who lack insurance. Moreover, these charge masters are often highly inflated because the hospital needs to compensate for the deep discounts given to insurers.234 Data from one California hospital system showed that, although uninsured and walk-in patients accounted for less than 2


230. Id.

Some of the prices insurers pay for the latest technology are surprisingly high. Harvard Pilgrim pays $717 to $1,240 for a brain MRI, which is commonly used to look for tumors, and $2,141 to $3,180 for a knee arthroscopy, a minor surgical procedure to repair torn ligaments. Blue Cross, which lists the cost of 22 outpatient and overnight procedures, pays providers $2,000 to $3,500 for a cardiac catheterization to measure heart function, and $5,600 to $6,600 for a routine childbirth.

Liz Kowalczyk, Insurers Post Prices for Medical Care, BOSTON GLOBE, May 29, 2004; see also Vanessa Fuhrmans, Childbirth for Bargain-Hunters: Pregnant Women Take Lead In Negotiating Over Prices Amid Cutbacks in Coverage, WALL ST. J., April 5, 2005, at D1 (noting that the cost of childbirth can range from $7,000 to $12,000).

231. “Insurers post a price range for each procedure because they pay individual hospitals and doctors different fees based on the contracts they’ve negotiated.” Kowalczyk, supra note 230.

232. See, e.g., Brief of Appellee, Doe v. HCA Health Serv. of Tennessee, Inc., No. M1998-00267-SC-R11-CV, at 3 (Tenn. May 5, 2000) (noting that “Blue Cross/Blue Shield negotiates an item-by-item, lower-priced Charge Master and, then, pays only a percentage of the reduced charges.”); see also Suttles, supra note 224 (noting that “Medicare is required to ‘set rates that cover the costs efficient providers would incur in furnishing care to beneficiaries,’” and that Medicare and most HMOs have their own negotiated rates).

233. Id.

234. Bowden, supra note 166, at 2.
percent of the patient population, they accounted for as much as 35 percent of the chain's total profits.  

Costs for physician services are better organized. In 1991, the federal government introduced the Resource-Based Relative Value Scale (“RBRVS”), by which it pays for Medicare physician services.

Relative values for more than 4000 medical services, determined largely by Hsiao's research team and accounting for approximately 85 percent of Medicare's annual payments to physicians, were included in the HCFA's [Health Care Financing Administration's] proposed rule of June 5. Relative values for each service are calculated on the basis of the work provided by the physicians, physicians' office expenses (including the salaries of nonphysician personnel and the cost of office space, equipment, and supplies), and the malpractice insurance costs associated with every medical service. The estimates of work provided were calculated according to specialty.

"The reform was based on the assumption that fee-for-service medicine will remain the dominant mode of payment and that the government should reduce the disparity between payment for diagnostic and surgical procedures and payment for evaluation and management (cognitive services ...) and regulate fees more tightly."

Although this modicum of rationality has been introduced for Medicare's physician fees, the RBRVS system has likely become distorted over the years, because it is difficult to update. Further,

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235. Id. The burden on the uninsured is not quite as arbitrary as it may seem. Historically, under the UCR/CPR approach, providers were required to identify their "usual" fees. Typically, insurers paid a designated proportion, such as 80%, and the patient was expected to pay the remainder. However, if a provider routinely waived patients' copayments, it could constitute a form of insurance fraud because, in fact, the true "usual" fee would be the figure paid by insurance, not the larger amount billed. See Parrish v. Lamm, 758 P.2d 1356, 1362 (Colo. 1988) (noting that a regular practice of waiving certain fees could amount to health care abuse). Hence providers feared giving discounts to the uninsured—the only ones left to pay their usual fees—because of legal difficulties from federal antikickback statute and other laws. Bowden, supra note 166, at 2. The refusal to grant discounts to the uninsured is changing, however. "[O]n Feb 19, 2004, the Secretary of DHHS "informed the Amer Hospital Ass'n that discounts to the uninsured are permissible, and the OIG issued clarifying materials." Id. at 2. Thereafter, a number of major hospital corporations, including Tenet Healthcare, Centura Health, and HCA announced significant discounts for uninsured patients. Id. The importance of this change is that, if even the uninsured no longer must pay the charge master rates, then these price catalogues will be even more meaningless than in the past. Further, they will be even less of a basis for identifying a "reasonable" fee, in response to judicial mandates.


237. Iglehart, supra note 236, at 824.

238.
RBRVS does not dictate physicians' fees for non-Medicare patients. Like hospitals, physicians typically receive negotiated fees from various insurers, and these can vary substantially from one payor to the next. Although some health plans base their physician fees directly on RBRVS, others' fees are only loosely inspired by it.\textsuperscript{239} Moreover, independent factors can vary the fees further, such as the physician's prestige, the insurers' need to maintain an adequate provider network by matching competitors' fees,\textsuperscript{240} the number of physicians in the area, and whether the physician is in a large or small practice group.\textsuperscript{241}

Perhaps more important from patients' perspective, the amount a patient will owe a physician will depend on whether that physician is in her insurer's network. If not, the insurer will simply pay that physician whatever it deems "reasonable." If the physician nevertheless bills a higher amount, he may expect the patient to make up the difference.\textsuperscript{242} Additionally, some patients in CDHPs will not be in such networks in the first place. One of the proffered advantages of consumer-defined health care is that the patient is free to choose any providers she wants, at least for care within the deductible. She can negotiate with providers on her own, and seek out those willing to agree to acceptable fees. Many patients are doing just that.\textsuperscript{243}

\textit{D. Juries and the Quest for the Reasonable Fee}

From the foregoing, it is obvious that health care pricing differs significantly from ordinary markets. Third party payment and a host of other factors mean that pricing does not reflect supply and demand, but rather is more often a function of the incentives embedded in arcane, diverse, and constantly changing payment systems.

In contrast to hospital relative payments, those for physician services are based directly on estimates of relative costs. But even if the starting relative values were highly accurate, shortcomings related to updating the relative values have likely introduced important divergences from relative costs.\ldots. Recent research conducted for MedPAC suggests that factors other than costs play important roles in determining charges and that once charges are set for a new service, the vast majority are not revisited but are updated by uniform percentage increases.

Ginsburg & Grossman, \textit{supra} note 120.


\textsuperscript{240} Id. at 18.


\textsuperscript{243} Fuhrmans, \textit{supra} note 241.
Complicating all this is the usual difficulty for a patient to find out what a particular provider will charge for some service or product. "Insurers typically put confidentiality agreements into their contracts with medical providers, with the goal of keeping providers from getting information that could boost their bargaining power... Insurers also don't want rival insurers to know about the deals they strike with doctors, as the insurers compete with each other for business. Hospitals and doctors, who may accept less from one insurer than another, also have a stake in keeping the amounts they'll accept secret."  

Moreover, physicians who discuss fees with each other could engender antitrust scrutiny as possible price-fixing. And like health plans, physicians may not wish to forfeit the bargaining leverage that secrecy provides.  

Amidst this economic chaos, it is not at all clear how juries are to divine a "reasonable fee." Courts provide little guidance as they remand the issue to these triers of fact. Because fee structures are both diverse and secret, a provider's testimony that he considers his fees to be within community norms may not be based on any actual knowledge of those norms. Moreover, the only way jurors may be able to obtain information about what other providers charge is via detailed testimony from a variety of providers, and even this

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244. S. Rubenstein, Patients Paying for Medical Care Struggle to Divine the Costs New Tools Give Price of a Doctor Visit, WALL ST. J., Feb. 16, 2005. "The Charge Master is considered confidential proprietary information," shown only to the hospital's officers, selected employees, and authorized consultants. Doe v HCA Health Serv. of Tenn., Inc., 46 S.W.3d 191, 194 (Tenn. 2001).

Insured patients are supposed to be charged the same prices for their out-of-pocket costs that doctors or hospitals would charge the insurer. But insurers and many health-care providers generally consider those negotiated prices proprietary information that they don't want publicized. At most, health plans have made available just a range or estimated average of what a service costs in a specific region.

Fuhrmans, supra note 241.

245. Doctors also cite federal and state laws that say competing insurers and doctors can't band together with their rivals to set the same prices across the board. Though the Federal Trade Commission doesn't say a doctor can't tell an individual patient their negotiated rates, sharing those rates with other physicians can sometimes lead to government scrutiny, making doctors hesitant to talk about them with anybody, says William Jessee, a doctor and chief executive of the Medical Group Management Association, an organization of people who manage and lead group medical practices.

Rubenstein, supra note 244.

246. Bowden, supra note 166, at 1. See Doe, 46 S.W.3d at 198 (noting that no Tennessee appellate cases had considered how to determine whether hospital charges were reasonable); Mercy Hosp., Inc. v. Carr, 297 So. 2d 598, 598 (Fla. App. 1974) (remanding for determination of reasonableness); Victory Mem'l Hosp. v. Rice, 493 N.E.2d 117, 120 (Ill. App. Ct. 1986) (noting that a hospital's reasonable charges can include that particular hospital's, costs, facilities, functions, and services).
information provides no assurance that those charges are typical. Charge masters are likely to be viewed with increasing skepticism. The very idea of paying $52 for a single tablet of Tylenol with codeine, or $1,519 for a chest x-ray, or $4,038 for a CT of the head is unlikely to strike many jurors as "reasonable."

Indeed, the very concept of "usual" or "customary" charges will likely lose credibility, even though some courts have asked triers of fact to look to what other providers in the community charge. And in the unusual case where there is some consistency among providers' charges, the bare fact that "everyone else" also charges grossly inflated fees is unlikely to impress jurors who, as working men and women, are increasingly likely to be paying their own health care costs.

V. PROGNOSIS AND SOME HOPE

Health care pricing must become more rational, and it must become more visible. If CDHPs become as widespread as many observers predict, both these things are likely to happen, at least to some extent. Indeed, changes are already occurring.

One potential source of leverage for opening up pricing structures may be states' consumer protection laws. Although this important question is beyond the scope of this Article, it may be noted that some complaints about health care prices have included claims that these laws had been violated. Per one argument, consumer protection laws may, or at least should, mandate up-front price disclosures at the time treatment decisions are made.

Meanwhile, the marketplace is beginning to ameliorate the problem as patients themselves take the helm. With a direct interest

248. Lagnado, supra note 229.
251. See, e.g., Doe v HCA Health Serv. of Tenn., Inc., No. 01-A-01-9806-CV00306, 1999 WL 652003, at *1 (Tenn. Ct. App. July 6, 1999) (noting that the Consumer Protection Act claim was dismissed by the trial court judge).
in conserving their own resources, many are beginning to negotiate directly with their providers to secure affordable pricing. And physicians are often happy to cooperate.

Billions of dollars in medical bills go unpaid each year. Medical providers, therefore, are amenable to working with patients, even if it means accepting less than full price. . . . Medical providers often would rather have a reduced amount in hand than spend a bundle trying to track down bad debts.\textsuperscript{253}

In some cases, negotiating services have sprung up to work with physicians and hospitals on patients' behalf, for instance to arrange costs for childbirth.\textsuperscript{254}

Governments are beginning to release pricing information or to mandate that providers do so. Medicare, for instance, now places on its website price comparisons for brand name drugs used to treat such conditions as high blood pressure, arthritis, high cholesterol, and the like.\textsuperscript{255} As noted above, California now mandates that hospitals make public their charge masters.\textsuperscript{256} A new Illinois law requires hospitals and surgery centers to report costs of various outpatient procedures, as well as their success rates.\textsuperscript{257}

Insurers, too, are making finances more transparent. Several are now publishing on their websites what they pay to doctors and hospitals for various outpatient tests and procedures. These include Harvard Pilgrim and Tufts Health Plan.\textsuperscript{258} Others, such as Humana, Aetna, and Lumenos, provide tools to estimate the costs that patients will pay, based on their particular insurance package, for selected procedures at various local hospitals.\textsuperscript{259} Cigna is listing "specific price ranges for hospitals nationwide for 15 common admissions, such as childbirth, angioplasty, and coronary bypass surgery," in addition to the quality and efficiency rankings it already provides for these admissions.\textsuperscript{260} One hospital in Kansas now offers a "Price Line" service to help patients figure out what a hospitalization may cost.\textsuperscript{261}

\textsuperscript{254} Fuhrmans, supra note 241.  
\textsuperscript{256} Lagnado, supra note 248.  
\textsuperscript{257} Christi Parsons, \textit{State Will Post Surgery Prices: Outpatient Date to Go Online in January '07}, CHI. TRIB., June 15, 2005, at 1.  
\textsuperscript{258} Kowalczyk, supra note 230.  
\textsuperscript{259} Rubenstein, supra note 244.  
In perhaps the most striking departure from the confidentiality about fees, Aetna is now making available the exact prices it pays Cincinnati area physicians for a wide variety of tests and procedures. It plans to do the same elsewhere in the country, in the hope of fostering savvier consumers.\footnote{Fuhrmans, supra note 241.} In another instance, a private corporation plans to collect and make pricing information available in exchange for a modest fee.\footnote{Jon Sarche, Company Details True Cost of Health Care, MERCURY NEWS, Mar. 20, 2006, available at http://www.mercurynews.com/mld/mercurynews/living/health/14141815.htm.}

Perhaps with the sunshine of such exposure will come the pressure to force greater rationality on health care pricing. While the advantages and disadvantages of CDHPs and HSAs can be debated, the increasingly direct involvement of patients in the economics of their care is already triggering a move toward greater accountability and communication about this important aspect of care. If indeed that comes true, then perhaps at least some of the litigation discussed in this Article can be averted. It is to be sincerely hoped.

\footnote{Laura Landro, The Informed Patient: Hospitals Give Patients More Data, WALL ST. J., April 6, 2005, at D4.}