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The Cash Nexus

by Carl E. Schneider

If you attempt to shave too closely in money matters—grabbing when a patient . . . [is] so low that it is no longer decent to take fees; or hungrily holding watches, jewelry, or other articles as security for payment of your fees; or compelling their wounded or half-dead owners to pawn or sell them for your benefit; or [being] . . . too vigorous in your efforts to collect fees from persons in narrow circumstances—[this] would not only be brutal barbarity, but would be very apt to . . . create a widespread community feeling of hostility against you. . . . It is almost better to be defrauded than to collect your fees by such method . . .

—Daniel Webster Cathell
The Physician Himself

Courts and legislatures have labored for decades to protect patients' choice of medical treatments, even though patients seize that gift less eagerly than lawmakers expect. Yet while courts have rushed to build the whited sepulchre of informed consent, they have fled from a related problem that patients actually yearn to solve and that actually can be ameliorated—the plight of patients who perforce agree to a treatment before they know its costs and who receive a bill both unrelated to the treatment's value and several times what an insured patient would pay.

Increasingly, patients must be consumers in the medical marketplace. This frightens patients, and should. Medical bills can be as alarming and baffling as medical ailments. The costs of illness—particularly medical bills—contribute to

more than half the personal bankruptcies in the United States. Even insured patients may find themselves paying for uncovered services that can be both numerous and dear. Furthermore, managed care's effort to subdue health costs by inducing doctors to save money has been badly battered, and the new cry is to give patients such inducements instead. "Consumer-directed health care" makes patients consumers by asking them to purchase insurance programs shrewdly and by using high deductibles (one to five thousand dollars) and health savings accounts to make them purchase specific treatments. In short, individually we must increasingly worry about buying care wisely, and nationally we must worry about our latest adventure in financing health care.

So why should courts protect patients as consumers? You, dear consumer, should protect yourself (caveat emptor) by evaluating what you buy, and the market should protect you by disciplining vendors who compete for your business. Evangelists of consumer-directed health care fondly imagine just such a market.

Really? You arrive at the doctor's office or the hospital and are told to sign a contract. Like this:

In consideration of hospital services rendered to the patient, I jointly or severally, do hereby agree to pay Athens Regional Medical Center any and every account presented to me, or us jointly or severally, for said service or services in accor-

dance with the rates and terms of the hospital.¹

In other words, "Do you want help? Sign a blank check. We'll fill it in later. As we wish." You do want help, so you sign. (And even if you don't, accepting services binds you to pay for them.)

Consumer! You must shop for capable care at palatable prices. True, doctors don't advertise prices. So you telephone: "I'm a good consumer trying to direct my health care. How expensive is Dr. Jones?" Even if a human being answers, even if the human being thinks this question tolerable, what answer can you fairly expect? Do you know how long your visit will be? What services you will need? Which of the myriad insurance policies you have? If you don't know—and who does?—what doctor's staff can predict the charges? (And finding out fees is a dream compared to ascertaining the quality of the doctor's work.)

Or you ask the clerk about the hospital's prices. The clerk has no idea and resents your impudence. You press up the ladder. Still no idea, still more resentment. After you are discharged, you receive an ingeniously indecipherable bill that no one will explain. Eventually, you discover that bills are

determined according to the hospital's "Charge Master," a confidential list of charges made by the hospital for all its goods and services, which is used to compute charges for all private commercial patients who are treated on a fee-for-service basis. The Charge Master is compiled and maintained by the hospital's chief financial officer on the hospital's computer system. In 1991, the Charge Master contained approximately 295 pages and listed prices for approximately 7,650 items [and today it would usually be several times that number]. The Charge Master is considered confidential proprietary information and is not shown to anyone other than the officers and employees of the hospital and authorized consultants. The Charge Master is adjusted on a weekly basis to reflect current cost

data; the hospital's costs are marked up by a mathematical formula designed to produce a targeted amount of profit for the hospital.²

Now another *diablerie*. Because your insurance doesn't cover your treatment, the hospital is charging two to four times what it would pay an insurer for what you received. The *Wall Street Journal* described a patient treated two days for a suspected heart attack, for whom the "bill for the hospital stay totaled \$29,500. That bill did not include an additional \$6,800 from the cardiologist, \$1,000 for the ambulance ride, and \$7,500" for a stent. Had the patient "been poor enough to qualify for state-sponsored healthcare through Medicaid, the hospital would have accepted a payment of only \$6,000 for the twenty-one hour hospital stay, \$1,000 for the cardiologist, and \$165 for the ambulance ride."

Of course, consumer, you should have shopped better and taken your business elsewhere. But how? First, your hospital is typical; its infuriating practices are partly responses to incentives in the health care system. Second, what other suitable hospitals were available? Third, you "chose" this hospital because your doctor sent you there, and you don't want to leave your doctor, since you know and trust your doctor and your doctor knows you. (In other words, you've just discovered that medical institutions can have something like monopoly power, even though they may not be literal monopolies.)

The hospital is now your creditor. The law (as it must) offers creditors multiple ways to wrest money from debtors, and hospitals have wielded these tools impressively. So, the hospital sues you to enforce its contract.

Can't you defend yourself by saying that the hospital's charges are unfair? This is where courts are so complaisant. True, they won't enforce "unconscionable" contracts. True, courts have other doctrines for moderating harsh contracts. But courts dislike amending contracts. First, contract law assumes people can bargain for themselves and know better than courts what they need.

Second, courts typically doubt their competence to evaluate the fairness of contractual exchanges. Third, if courts often altered contracts, contracts would lose much of their predictability and hence much of their value.

So the court says that your contract "unambiguously creates an obligation for appellants to pay ARMC for hospital services 'in accordance with the rates and terms of the hospital.'" The "plain language of the contract leaves the discretion to set the rates solely with" the hospital. The hospital exercised its discretion. Tough. What's more, your state requires hospitals to summarize a few of their charges on request. "Therefore," the state's policy "is that purchasers of hospital services use this pricing information to compare hospital charges and make cost effective decisions. This represents the . . . [legislature's] decision to let market forces control health care costs . . ."³

But isn't this a "contract of adhesion," a contract "which, imposed and drafted by the party of superior bargaining strength, relegates to the subscribing party only the opportunity to adhere to the contract or reject it"? Alas, another uphill battle. One mother signed a contract where the hospital "told me to sign, so they would give [my son] medical treatment because he needed it because he was bleeding out of his ears, out of his mouth, the bone out of his elbow was sticking out through the skin." The court managed to restrain its sympathy:

One can gather she was hurried and under stress. She did not take the time to read the contract. That was no fault of the hospital. There was no duress; there was no fraud practiced upon Mrs. Chamberlin. The hospital . . . could withhold its services unless and until Mrs. Chamberlin signed the agreement. It is useless to speculate whether it would have done so, just as it is useless to speculate whether Mrs. Chamberlin would have signed the agreement, knowing she was obligating herself to pay the hospital bill, if the hospital had withheld its ser-

vices to her son until she had so done.⁴

But come closer, Starbuck; thou requirest a little lower layer. No doubt your hospital treats patients the way an airline treats passengers, but like the airline it isn't making monopoly profits; it's squeezed by rising costs, thrifty governments, and hard-bargaining insurers. To compensate for the good rates insurers win for their patients, uninsured patients are charged (but don't necessarily pay) dreadful rates. Courts may achieve Dickensian levels of heartlessness ("And the Union workhouses?" demanded Scrooge. "Are they still in operation?"), but judicially regulating the health care market intelligently and effectively will require subduing a Nemean lion.

Nevertheless, it should (in the standard judicial phrase) shock the conscience of the court when a hospital tells the sick and dying, if you want our help (and good luck finding anybody else's), hand us your wallet, and you'll get back what we choose to give; then submits inexplicable and unexplained bills unrelated to any objective value of its services; and finally hustles the debtor off to bankruptcy. Courts have doctrines they can develop to curb egregious abuses of the law of contract, and they should use them. But meanwhile, pay up. And look forward to consumer-directed health care.

Acknowledgments

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1. *Cox v. Athens Regional Medical Center*, 631 SE2d 792, 795 (GaCtApp 2006).
2. *Doe v. HCA Health Services*, 46 SW3d 191, 194 (Tenn 2001).
3. *Cox* at 796-97.
4. *Hearland Health Services v. Chamberlin*, 871 SW3d 8, 11 (MoCtApp 1993).