UNCONSCIONABILITY AS A JUDICIAL MEANS FOR CURING THE HEALTHCARE CRISIS

JEFFREY T. HEWLETT†

I. INTRODUCTION

Rising healthcare costs continue to be a problem in the United States.[1] In just the past year alone, the U.S. spent $3.5 trillion on

† B.S., Biomolecular Science, 2016, University of Michigan; J.D., 2020, Wayne State University Law School. A special thank you to Professor Vincent Wellman for his guidance, support, and insight throughout this Note.

1. Yasmeen Abutaleb, *U.S. Healthcare Spending to Climb 5.3 Percent in 2018: Agency*, THOMSON REUTERS (Feb. 14, 2018, 4:07 PM), https://www.reuters.com/article/us-usa-healthcare-spending/us-healthcare-spending-to-climb-53-percent-in-2018-agency-idUSKCN1FY2ZD [http://web.archive.org/web/20200422141648/https://www.reuters.com/article/us-usa-

healthcare[2]—far and away the most in the developed world.[3] Even on a per capita basis, the U.S. spends twenty-five percent more than the next highest-spending country, Switzerland.[4] This is particularly problematic for uninsured patients, many of whom bear a disproportionate burden of these healthcare costs.[5]

The Affordable Care Act (ACA) attempted to remedy this discrepancy, but it has ultimately failed to do so.[6] The number of medically uninsured individuals continues to grow alongside rising healthcare costs.[7] Additionally, the advent of publicized hospital billing prices has failed to adequately inform healthcare consumers or contribute to lower healthcare prices.[8] Uninsured patients are thus frequently left without many options or recourse in the healthcare market.[9]

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healthcare-spending/us-healthcare-spending-to-climb-53-percent-in-2018-agency-idUSKCN1FY2ZD].

2. *Id.* Notably, this amounts to almost eighteen percent of the U.S.'s gross domestic product. *National Health Expenditure Data*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Dec. 17, 2019), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical [http://web.archive.org/web/20200422142049/https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical].

3. Gerard F. Anderson et al., *It's Still the Prices, Stupid: Why the US Spends So Much on Health Care, and a Tribute We Owe to Uwe Reinhardt*, 38 HEALTH AFF. 87, 88 (Jan. 2019).

4. *Id.*

5. INST. OF MED., HIDDEN COSTS, VALUES LOST: UNINSURANCE IN AMERICA 38 (Arthur L. Caplan et al. eds., 2003).

6. *See* George A. Nation III*, Determining the Fair and Reasonable Value of Medical Services: The Affordable Care Act, Government Insurers, Private Insurers and Uninsured Patients*, 65 BAYLOR L. REV. 425 (2013); *see also* Vann R. Newkirk II, *The American Health-Care System Increases Income Inequality*, ATLANTIC (Jan. 19, 2018) (citing Andrea S. Christopher et al., *The Effects of Household Medical Expenditures on Income Inequality in the United States*, 108 AM. J. OF PUB. HEALTH 351, 351–54 (Mar. 2018)), https://www.theatlantic.com/politics/archive/2018/01/health-care-income-inequality-premiums-deductibles-costs/550997/ [http://web.archive.org/web/20200422143031/https://www.theatlantic.com/politics/archive/2018/01/health-care-income-inequality-premiums-deductibles-costs/550997/].

7. *See* Abutaleb, *supra* note 1; *see also* Yasmeen Abutaleb, *U.S. Healthcare Uninsured Rises Most in Near Decade: Gallup*, THOMSON REUTERS (Jan. 16, 2018, 11:45 AM), https://www.reuters.com/article/us-usa-healthcare-uninsured/u-s-healthcare-uninsured-rises-most-in-near-decade-gallup-idUSKBN1F523O [http://web.archive.org/web/20200422143142/https://www.reuters.com/article/us-usa-healthcare-uninsured/u-s-healthcare-uninsured-rises-most-in-near-decade-gallup-idUSKBN1F523O] [hereinafter *U.S. Healthcare Uninsured Rises*].

8. *See infra* Parts II.C, III.A.

9. *See* INST. OF MED., *supra* note 5.

Courts have been equally as ineffective in helping uninsured patients recoup these costs.[10] In citing both common law contract principles and the sanctity of the medical healthcare market, courts have consistently disavowed claims against hospitals for the inequity of their pricing.[11] However, given the common law doctrine of unconscionability, courts could invalidate many of these inequitable hospital billing contracts.[12] Under the framework of *Williams v. Walker-Thomas Furniture*, unconscionability protects consumers from grossly inequitable contracts—particularly where there is disproportionate bargaining power or "an absence of meaningful [consumer] choice."[13] Quite frequently, medical billing contracts satisfy all the requisite conditions for unconscionability.[14]

This Note will explore courts' reluctance to utilize unconscionability in medical billing contexts, despite its otherwise seemingly natural fit.[15] It is this Note's primary contention that unconscionability should apply toward medical billing of uninsured patients.[16] Furthermore, it is this Note's contention that the "uniqueness of the healthcare market" has caused a rift between courts' application of common law unconscionability and medical billing unconscionability[17] and that this tension is not sufficient justification for refuting the doctrine.[18] Lastly, this Note argues that, because courts uniformly apply Uniform Commercial Code (U.C.C.) unconscionability and common law unconscionability across most every factual context,[19] and because there is no compelling justification to the contrary, unconscionability in medical billing contexts should apply just as frequently.[20]

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10. *See* George A. Nation III, *Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured*, 94 KY. L.J. 101 (2006) [hereinafter *Obscene Contracts*].

11. *See infra* Parts III.B.1–2.

12. *See infra* Part III.A.

13. Williams v. Walker-Thomas Furniture Co., 350 F.2d 445, 449 (D.C. Cir. 1965).

14. *Id.*

15. *See infra* Parts II, III.

16. *See infra* Part III.A.

17. *See infra* Part III.B.1.

18. *See infra* Part III.B.2.

19. *See infra* App. A; *see also* Larry A. DiMatteo & Bruce L. Rich, *A Consent Theory of Unconscionability: An Empirical Study of Law in Action*, 33 FLA. ST. U. L. REV. 1067 (2006).

20. *See infra* Part III.A.

II. BACKGROUND

A. A Brief History of Unconscionability

Unconscionability has its roots in antiquity, dating as far back as Roman law.[21] To uphold moral edicts requiring fair exchange in value, Roman courts would rescind inequitable contracts under *laesio enormis*.[22] However, *laesio enormis* applied only in narrow contexts for land contracts overvalued twofold[23] and, accordingly, did not give courts latitude to screen all contracts for fairness.[24]

Although Roman courts exercised an early precursor to unconscionability, courts of equity implemented a doctrine that more closely resembles contemporary unconscionability.[25] Common law rulings largely turned on a contract's fairness:[26] if an agreement was grossly unjust, or such that no reasonable man would enter into it, then courts only enforced the contract to its equitable extent.[27] Generally, courts of equity required more than mere hardship to invalidate a contract.[28] Rather, the contract needed to unduly leverage a party's necessity or weakness.[29] Few courts actually defined the term

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21. Harry G. Prince, *Unconscionability in California: A Need for Restraint and Consistency*, 46 HASTINGS L.J. 459, 467 (1995) (citing James Gordley, *Equality in Exchange*, 69 CAL. L. REV. 1587 (1981)).

22. *Id.* (stating that *laesio enormis* roughly paralleled the modern-day unconscionability doctrine).

23. *Id.*

24. *Id.*

25. *See id.* (stating that "courts of equity would not enforce an unfair bargain if it would make the courts a tool in achieving an unjust or unfair result"); *see also* Amy J. Schmitz, *Embracing Unconscionability's Safety Net Function*, 58 ALA. L. REV. 73, 77 (2006) (citing James Gordley, *The Common Law in the Twentieth Century: Some Unfinished Business*, 88 CAL. L. REV. 1815, 1849–50 (2000)).

26. Robert A. Hillman, *Debunking Some Myths About Unconscionability: A New Framework for U.C.C. Section 2-302*, 67 CORNELL L. REV. 1, 26–27 (stating that courts of equity grew because English common law courts failed to employ fairness principles).

27. RESTATEMENT (SECOND) OF CONTRACTS § 208 (AM. LAW INST. 1981); *see also* Hume v. United States, 132 U.S. 406, 411 (1889) (quoting Earl of Chesterfield v. Janssen, 2 Ves. Sr. 125, 155, 28 Eng. Rep. 82, 100 (Ch. 1750) ("[S]uch as no man in his senses and not under delusion would make on the one hand, and as no honest and fair man would accept on the other.").

28. V. Woerner, Annotation, *"Unconscionability" as Ground for Refusing Enforcement of Contract for Sale of Goods or Agreement Collateral Thereto*, 18 A.L.R.3d 1305 (1968) (stating that unconscionability is inapplicable to mere hardship).

29. *Id.*

"unconscionability" in these decisions,[30] however, and instead relied upon purely equitable determinations.[31]

Modern courts have since merged the discrepancies between courts of law and equity;[32] consequently, unconscionability now applies more broadly, covering a variety of contract contexts.[33] Before the adoption of the U.C.C., courts policed inequitable contracts by adverse language construction, by bending the rules of offer and acceptance, or by constructions of public policy.[34] However, courts were often wary of rendering contracts "unconscionable,"[35] as the doctrine frequently clashed with common law notions of consideration[36]—in particular, unconscionability required courts to forego the common law practice of refusing to weigh the adequacy of consideration.[37]

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30. *See, e.g.*, Earl of Chesterfield v. Janssen, 2 Ves. Sr. 125, 155, 28 Eng. Rep. 82, 100 (Ch. 1750) ("[I]t may be apparent from the intrinsic nature and subject of the bargain itself; such as no man in his senses and not under delusion would make on the one hand, and as no honest and fair man would accept on the other; which are unequitable and *unconscientious* bargains." (emphasis added)).

31. RESTATEMENT (SECOND) OF CONTRACTS § 208 cmt. b (AM. LAW INST. 1981).

32. *Id.*

33. *See, e.g.*, Williams v. Walker-Thomas Furniture Co., 350 F.2d 445, 447–50 (D.C. Cir. 1965) (upholding unconscionability on a contract where the furniture company retained title to the product and could repossess the product for any defaulted payment); Vockner v. Erickson, 712 P.2d 379 (Alaska 1986) (upholding the trial court's determination of unconscionability in the sale of an apartment building to an experienced real estate purchaser when current payments were insufficient to cover accrued interest on the unpaid sale balance and an elderly grantor would have been 103 years old when the balloon payment became due); Bennett v. Bailey, 597 S.W.2d 532 (Tex. App. 1980) (upholding a jury determination of unconscionable conduct in pressuring an elderly widow to purchase expensive dance lessons).

34. U.C.C. § 2-302 cmt. 1 (AM. LAW INST. & UNIF. LAW COMM'N 1977).

35. Woerner, *supra* note 28 (stating that courts have seldomly defined the term unconscionability).

36. *See generally* Warren H. Hyman, *Adequacy of Consideration and the Unconscionable Contract*, 86 COM. L.J. 500 (1981) (stating that courts are generally against weighing consideration); *see also* RESTATEMENT (SECOND) OF CONTRACTS § 208 cmt. c (AM. LAW INST. 1981) (stating that inadequacy of consideration alone is not enough to invalidate a contract); MICH. L. REV. ASS'N, 67 MICH. L. REV. 1248, 1250 (1969); *see also* 17 C.J.S. *Contracts* §§ 175–78 (2020).

37. *See* Anne Fleming, *The Rise and Fall of Unconscionability as the "Law of the Poor"*, 102 GEO. L.J. 1383, 1402 (2014) (citing K. N. Llewellyn, Book Review, 52 HARV. L. REV. 700, 702–03 (1939)); MICH. L. REV. ASS'N, 67 MICH. L. REV. 1248, 1250 n.19 (1969) (citing 1 ARTHUR CORBIN, CORBIN ON CONTRACTS §§ 127, 128 (1963)) ("[C]ourts were initially unclear whether inadequate consideration alone constituted unconscionability.").

With the adoption of the U.C.C., the doctrine of unconscionability proliferated in modern courts.[38] Under U.C.C. § 2-302, courts could invalidate a sale-of-goods contract that contained unconscionable provisions.[39] But, with no statutory definition for "unconscionability," courts were left to define the doctrine themselves.[40] Regardless, the proliferation of common law unconscionability paralleled the growth of U.C.C. unconscionability,[41] largely because the Restatement of Contracts Second § 208 explicitly borrowed the same language from U.C.C. § 2-302.[42] Because U.C.C. § 2-302 was seen as forward-thinking in the realm of contract law, courts began using it by analogy in common law, even where the contract was not for a sale of goods.[43] Courts evaluating common law unconscionability would, and still do, use U.C.C. unconscionability rulings for guidance (and vice versa).[44] Unconscionability continued gaining popularity following the D.C. Circuit's 1965 decision in *Williams v. Walker-Thomas Furniture*, as many courts began invalidating contracts for unconscionable terms.[45] However, this growth was attenuated, as courts began limiting the

38. John A. Spanogle Jr., *Analyzing Unconscionability Problems*, 117 U. PA. L. REV. 931, 931 (1969).

39. U.C.C. § 2-302 (AM. LAW INST. & UNIF. LAW COMM'N 1977).

40. *See* Woerner, *supra* note 28 ("[I]t is to be noted that the term 'unconscionable' is not defined, nor are the factors or elements of 'unconscionability' [explicitly] enumerated.").

41. *See* U.C.C. § 2-302(1) (AM. LAW INST. & UNIF. LAW COMM'N 1977); DiMatteo, *supra* note 19, at 1115; *see also infra* App. A and Part III.B.1.

42. *See* RESTATEMENT (SECOND) OF CONTRACTS § 208 (AM. LAW INST. 1981). Comment a states:

> Uniform Commercial Code § 2-302 is literally inapplicable to contracts not involving the sale of goods, but it has proven very influential in non-sales cases. It has many times been used either by analogy or because it was felt to embody a generally accepted social attitude of fairness going beyond its statutory application to sales of goods.

Id. at cmt. a.

43. Charles Knapp, *Unconscionability in American Contract Law: A Twenty-First Century Survey*, UNIV. OF CAL. HASTINGS C. OF L., Legal Research Paper Series, Research Paper No. 71, 2 (2013), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2346498 [http://web.archive.org/web/20200422145722/https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2346498]. Importantly, the *Williams* opinion asserts that the principles behind unconscionability pre-dated U.C.C. § 2-302. Williams v. Walker-Thomas Furniture Co., 350 F.2d 445, 448–49 (D.C. Cir. 1965). The U.C.C. was not yet effective in the District of Columbia at the time the *Williams* contracts were executed. *See id.*

44. Knapp, *supra* note 43, at 1; *see also* DiMatteo, *supra* note 19, at 1115.

45. *See* Fleming, *supra* note 37, at 1387; *see also Williams*, 350 F.2d at 450 (holding that a consumer contract was unconscionable where the seller retained title to all items of a sale on credit, even though the consumer only defaulted on a single installment payment).

doctrine to only consumer contracts.[46] Presently, unconscionability almost exclusively applies to consumer contracts, regardless of whether they fall under the U.C.C. or under the common law.[47]

B. Modern Courts' Interpretation of Unconscionability

Unconscionability typically consists of a two-prong inquiry: procedural unconscionability and substantive unconscionability.[48] Both prongs must ordinarily be present to constitute unconscionability, although courts will occasionally hold that substantive unconscionability alone is sufficient.[49] In all practicality, however, substantive unconscionability rarely exists independent of procedural unconscionability.[50] Almost all cases of unconscionability will consist of both substantive and procedural elements.[51]

Procedural unconscionability turns on the bargaining power of the parties.[52] Accordingly, this inquiry looks at circumstances prior to contract formation.[53] The absence of meaningful choice, high pressure tactics, discrepancies in sophistication or wealth of the parties, whether terms were explained to the weaker party, and unfair surprise or lack of negotiation are all meaningful inquiries in determining procedural unconscionability.[54] Substantive unconscionability turns on the reasonability of contractually imposed duties or terms.[55] Contracts with an overall imbalance in the parties' rights or obligations, such as significant cost-price discrepancies, are frequently said to be substantively unconscionable.[56]

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46. *See* Jane P. Mallor, *Unconscionability in Contracts Between Merchants*, 40 SW. L.J. 1065, 1066 (1986); *see also* 17 C.J.S. *Contracts* § 3 (2018); Fleming, *supra* note 37, at 1387 (stating that the doctrine of unconscionability experienced a brief resurgence in the late 1960s following Williams v. Walker Thomas Furniture); Knapp, *supra* note 43, at 3–4.

47. *See generally* Mallor, *supra* note 46. *See also* 17 C.J.S. *Contracts* § 3 (2018). For a more detailed history of unconscionability, *see generally* Knapp, *supra* note 43.

48. 17A AM. JUR. 2D *Contracts* § 272 (2020).

49. *Id.*

50. Mallor, *supra* note 46, at 1073.

51. *Id.*

52. 17A AM. JUR. 2D *Contracts* § 272 (2020).

53. *Id.*

54. *Id.* (citing *In re* Colony Beach & Tennis Club Ass'n, 454 B.R. 209 (M.D. Fla. 2011); THI of New Mexico at Vida Encantada, LLC v. Lovato, 848 F. Supp. 2d 1309 (D.N.M. 2012); McGowan & Co., v. Bogan, 93 F. Supp. 3d 624 (S.D. Tex. 2015)).

55. *Id.*

56. *See, e.g.*, Hanover Ins. Co. v. Northern Bldg. Co., 751 F.3d 788 (7th Cir. 2014); Mohamed v. Uber Techs., Inc., 109 F. Supp. 3d 1185 (N.D. Cal. 2015); Coup v.

Although unconscionability typically applies only in consumer settings, this is not a preclusive factor.[57] The U.C.C. and Restatement of Contracts Second both fail to mention a consumer context limitation;[58] accordingly, unconscionability is technically applicable in commercial settings.[59] Nevertheless, courts almost universally require a consumer contract as a prerequisite for unconscionability.[60]

Modern courts enforce unconscionability sporadically, with only about thirty-eight percent of unconscionability claims succeeding on the merits.[61] Even where unconscionability elements are present, courts may choose to only invalidate the unconscionable provisions of the contract[62]—in other words, courts can, and will, bifurcate the unconscionable clause while enforcing the remainder of the contract.[63] Effectively, unconscionability may or may not be a material breach, although courts frequently treat it as immaterial.[64]

C. Problems in Medical Billing Practices

The increasing cost of healthcare and medical care is a continuing problem for uninsured patients.[65] A 2017 census report determined that around 28.5 million United States citizens are medically uninsured and

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Scottsdale Plaza Resort, LLC, 823 F. Supp. 2d 931 (D. Ariz. 2011); Zullo v. Superior Court, 127 Cal. Rptr. 3d 461 (Ct. App. 2011).

57. *See* Mallor, *supra* note 46 (citing Langemeier v. Nat'l Oats Co., 775 F.2d 975, 976–77 (8th Cir. 1985) (popcorn grower); Weaver v. Am. Oil Co., 276 N.E.2d 144, 148 (Ind. 1971) (service station operator); Pittsfield Weaving Co. v. Grove Textiles, Inc., 430 A.2d 638, 640 (N.H. 1981) (commercial weaving business)).

58. *Compare* U.C.C. § 2-302 (AM. LAW INST. & UNIF. LAW COMM'N 1977), *with* RESTATEMENT (SECOND) OF CONTRACTS § 208 (AM. LAW INST. 1981).

59. *See supra* note 57 and accompanying text.

60. *See* DiMatteo, *supra* note 19, at 1097 (stating that while common law unconscionability claims for consumers are successful 37.8% of the time, and while sale of goods unconscionability claims are successful 30% of the time, merchant claims are only successful 16% of the time.).

61. *See id.* at 1100.

62. *See* Restatement (SECOND) OF CONTRACTS § 208 (AM. LAW INST. 1981). U.C.C. Section 2-302, comment two states:

> [U]nder this section the court, in its discretion, may refuse to enforce the contract as a whole if it is permeated by the unconscionability, or it may strike any single clause or group of clauses which are so tainted or which are contrary to the essential purpose of the agreement, or it may simply limit unconscionable clauses so as to avoid unconscionable results.

U.C.C. § 2-302 cmt. 2 (AM. LAW INST. & UNIF. LAW COMM'N 1977).

63. RESTATEMENT (SECOND) OF CONTRACTS § 208 (AM. LAW INST. 1981); U.C.C. § 2-302 (AM. LAW INST. & UNIF. LAW COMM'N 1977).

64. *See supra* note 52 and accompanying text.

65. Nation*, supra* note 6, at 426.

that as many as ten to sixteen percent of minority populations are uninsured.[66] Between 2016 and 2017, the number of uninsured citizens rose by 3.2 million people.[67] To complicate matters, the rising number of medically uninsured coincides with large increases in the cost of medical care.[68] As of 2016, the United States had the highest healthcare spending of any developed country in the world at $9,892 per capita.[69] This amounted to more than double the median amount and is twenty-five percent higher than the second-highest spending country, Switzerland.[70] In some parts of the United States, healthcare costs have been so high that patients (including, notably, some of whom are insured in the United States) are crossing into Mexico or Canada for cheaper medical treatment.[71] Along the Texas border, in particular, approximately thirty-seven percent of adults surveyed reported visiting Mexico for healthcare.[72] Merely by crossing the border, many American citizens

66. Edward R. Berchick et al., *Health Insurance Coverage in the United States: 2017*, U.S. CENSUS BUREAU (Sept. 12, 2018), https://www.census.gov/library/publications/2018/demo/p60-264.html [http://web.archive.org/web/20200422151015/https://www.census.gov/library/publications/2018/demo/p60-264.html].

67. *See U.S. Healthcare Uninsured Rises*, *supra* note 7.

68. Ellie Kincaid, *What's Driving Healthcare Costs up in the U.S.*, FORBES (Nov. 17, 2017, 11:20 AM), https://www.forbes.com/sites/elliekincaid/2017/11/07/whats-driving-health-care-costs-up-in-the-u-s/#5bad25b176b6 [http://web.archive.org/web/20200422151133/https://www.forbes.com/sites/elliekincaid/2017/11/07/whats-driving-health-care-costs-up-in-the-u-s/].

69. Johns Hopkins Bloomberg Sch. of Pub. Health, *U.S. Health Care Spending Highest Among Developed Countries*, JOHNS HOPKINS UNIV. (Jan. 7, 2019), https://www.jhsph.edu/news/news-releases/2019/us-health-care-spending-highest-among-developed-countries.html [http://web.archive.org/web/20200422151319/https://www.jhsph.edu/news/news-releases/2019/us-health-care-spending-highest-among-developed-countries.html].

70. *Id.*

71. Emma Davie, *Quiet Resurgence: Americans Coming North to Fill Prescriptions on the Rise Again*, CANADIAN BROADCASTING CORP. (May 20, 2019, 7:00 AM), https://www.cbc.ca/news/canada/nova-scotia/u-s-canada-prescriptions-border-1.5137350 [https://web.archive.org/web/20200623043320/https://www.cbc.ca/news/canada/nova-scotia/u-s-canada-prescriptions-border-1.5137350]; Anna Gorman, *Health Care, and Patients, Go South—to Mexico*, U.S.A. TODAY (May 7, 2014, 10:43 AM), https://www.usatoday.com/story/news/nation/2014/05/07/healthcare-mexico-obamacare/8517917/ [http://web.archive.org/web/20200422151539/https://www.usatoday.com/story/news/nation/2014/05/07/healthcare-mexico-obamacare/8517917/].

72. Dajun Su et al., *Cross-Border Utilization of Health Care: Evidence from a Population-Based Study in South Texas*, 46 HEALTH SERVS. RES. J. 859, 859–61 (June 2011), https://onlinelibrary.wiley.com/doi/full/10.1111/j.1475-6773.2010.01220.x [http://web.archive.org/web/20200422151746/https://onlinelibrary.wiley.com/doi/full/10.1111/j.1475-6773.2010.01220.x].

save upwards of fifty percent on medication[73] and pay as little as fifteen dollars for a standard check-up.[74] Individuals going to Canada experience similar savings, often buying healthcare supplies such as insulin at a tenth of the price in the United States.[75]

One of the major contributing factors to high healthcare costs in the United States concerns its medical billing practices.[76] This Note will examine these billing practices in the context of hospitals.[77]

When hospitals issue medical bills, they typically negotiate and contract with insurers for the price of services rendered.[78] Hospital billing is a complicated process, beginning with what is known as a "chargemaster."[79]A chargemaster is a list containing all the goods and services a hospital provides, along with their list price.[80] Ultimately, the hospital will use its chargemaster to inventory costs and to negotiate with insurers for the cost of medical services.[81] Chargemaster prices, however, are arbitrarily determined[82] and tend to be incredibly overpriced.[83] It is

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73. *See id.*

74. Gorman, *supra* note 71.

75. Davie, *supra* note 71.

76. *See* George A. Nation III, *Hospital Chargemaster Insanity: Healing the Healers*, 43 PEPP. L. REV. 745, 746 (2016) [hereinafter *Hospital Chargemaster Insanity*].

77. *See infra* Parts II.D, III.

78. *Hospital Chargemaster Insanity*, *supra* note 76, at 758.

79. *See generally id.*

80. *Id.* at 746.

81. *Id.*

82. *Id.* at 747 (citing Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alts. Inc., 832 A.2d 501, 510 (Pa. Super. Ct. 2003) and noting that chargemaster prices "bear no relationship to the amount typically paid for those services"). In a New York Times article, Rosenthal reported:

> [H]ow do hospitals set prices? They set prices to maximize revenue, and they raise prices as much as they can—all the research supports that . . . [c]hargemaster prices are basically arbitrary, not connected to underlying costs or market prices . . . . Hospitals 'can set them at any level they want' . . . . [T]here are no market constraints.

Elisabeth Rosenthal, *As Hospital Prices Soar, A Stitch Tops $500*, N.Y. TIMES (Dec. 2, 2013), https://www.nytimes.com/2013/12/03/health/as-hospital-costs-soar-single-stitch-tops-500.html [http://web.archive.org/web/20200422152616/https://www.nytimes.com/2013/12/03/health/as-hospital-costs-soar-single-stitch-tops-500.html]; *see also* Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy*, 25 HEALTH AFF. 57, 59 (2006) (noting that chargemaster rates "do not bear any systematic relationship to the amounts third-party payers actually pay them for the listed services"); Christopher P. Tompkins et al., *The Precarious Pricing System for Hospital Services*, 25 HEALTH AFF. 45, 50–52 (2006) (explaining that individual items in the chargemaster are subject to smaller or larger than average increases based on the advice of an "arsenal of consultants and computer software . . . used to determine optimal increases in charges for various services. Optimality implies a higher payoff for a given rate of increase . . . . [O]ver time,

not uncommon for neighboring hospitals to have vastly different chargemaster prices for similar procedures.[84] Additionally, chargemaster prices typically bear no relationship to the quality or the cost of services rendered.[85] Essentially, the purpose of the chargemaster price list is to provide a starting point for negotiations with insurers.[86] Insurers typically mitigate these high prices in their negotiations with hospitals,[87] as an insurer will rarely contract for the full chargemaster list price.[88] Consequently, there is only a tenuous positive correlation between increases in chargemaster list prices and hospital revenue.[89]

Because insurers rarely pay the full chargemaster price, hospitals frequently argue that high chargemaster prices are inconsequential.[90] However, this is mistaken, particularly when it comes to medical billing for uninsured patients.[91] High chargemaster prices have contributed to the United States having higher medical costs in the United States than in any other developed country.[92] Additionally, the lack of transparency in chargemaster pricing has made it difficult for patients to compare prices across hospitals, resulting in hindered competition and price discrimination for uninsured patients.[93] Unfortunately, there is little to disincentivize hospitals from increasing their chargemaster list prices[94]—indeed, from 1984 to 2004 "chargemaster prices increased 10.7% per year."[95]

While chargemasters apply equally to both insured and uninsured patients, the negotiation process that takes place with medical insurers over chargemaster prices ultimately does not apply to billing uninsured

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a hospital's chargemaster is bent, stretched, and distorted by numerous pressures and responses."); Lucette Lagnado, *California Hospitals Open Books, Showing Huge Price Differences*, WALL ST. J. (Dec. 27, 2004), https://www.wsj.com/articles/SB110410465492809649 [http://web.archive.org/web/20200422153129/https://www.wsj.com/articles/SB110410465492809649] ("There is no method to the madness[;] . . . [a]s we went through the years, we had these cockamamie formulas . . . . We multiplied our costs to set our charges.").

83. *See Hospital Chargemaster Insanity*, *supra* note 76, at 747.
84. *Id.* at 746–47.
85. *Id.* at 748.
86. *Id.*
87. *Id.* at 747.
88. *Id.* at 747–48.
89. *Id.*
90. *Id.* at 748.
91. *Id.* at 748–49.
92. *Id.* at 749.
93. *Id.* at 749–50.
94. *See* Nation, *supra* note 6, at 428.
95. *Id.*

patients.[96] Medical prices on chargemasters often run ten times higher than prices a hospital will routinely accept from an insurer.[97] Patients paying out-of-pocket are often expected to pay the full chargemaster amount, as hospitals frequently refuse to reduce their pricing for such patients.[98] Hospitals will often issue these bills without the uninsured patient's negotiation, without explanation or justification for the pricing, and without giving the patient any meaningful choice in the matter.[99] Consequently, uninsured patients frequently receive contractually-binding medical bills that are unreasonably high and far exceed those of insured patients.[100]

Scholars have posited that treating patients as consumers in an open healthcare market would help ameliorate some of the problems confronting uninsured patients.[101] However, there are multiple dilemmas to this approach.[102] Even when patients know the chargemaster pricing, they are not necessarily aware of what they are purchasing.[103] A patient may know that he needs a hernia repair, but a layperson may not know what the procedure requires—the number of sutures, gloves, man-hours, medical instruments, or medicine that such a procedure requires, for example.[104] The situation is further complicated when patients do not even know what treatment they require, something that frequently occurs in emergency scenarios.[105] Facial exposure to a chargemaster provides little predictive value to your average patient, unless they themselves happen to be a medical expert.[106] Accordingly, where patient-consumers encounter a chargemaster system, it is exceedingly difficult for such individuals to negotiate price.[107]

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96. *See generally Obscene Contracts*, *supra* note 10.

97. *Hospital Chargemaster Insanity*, *supra* note 76, at 748.

98. *Id.* at 748–49; *see also* Steven Brill, *Bitter Pill: Why Medical Bills Are Killing Us*, TIME (Apr. 4, 2013), https://time.com/198/bitter-pill-why-medical-bills-are-killing-us/ [http://web.archive.org/web/20200422153901/https://time.com/198/bitter-pill-why-medical-bills-are-killing-us/] (recounting various examples of self-pay patients being billed full charges by hospitals); *Obscene Contracts*, *supra* note 10, at 101–05.

99. *See generally Hospital Chargemaster Insanity*, *supra* note 76, at 748–49.

100. *Id.*

101. *See* Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643 (2008).

102. *See* Nation, *supra* note 6, at 428.

103. *See id.*

104. *See id.*

105. *See id.* at 428–29.

106. *See id.* at 429.

107. *See id.* at 436 (noting that uninsured patients are often unaware of the chargemaster system or its intricacies).

The ACA has also failed to effectively remedy this situation.[108] In order for a hospital to remain tax-exempt as a non-profit, the ACA provides that hospitals cannot charge particular uninsured patients more than the "amounts generally billed to individuals who have insurance covering such care."[109] However, the ACA does not provide any particular criteria by which these hospitals must abide;[110] consequently, hospitals are free to set their own criteria concerning who qualifies as "uninsured."[111] Perhaps most unfortunately, the provision incentivizes higher chargemaster prices, as hospitals must bill certain uninsured patients at equal or lesser rates than insured patients.[112] Even with the advent of the ACA, the number of uninsured citizens continues to rise along with the cost of medical care.[113]

As of January 1, 2019, the ACA also mandates that hospitals across the United States publish their chargemasters online.[114] Ostensibly, the new requirement aims to provide the public with more transparent pricing in the healthcare market.[115] However, experts are doubtful that this new mandate will lower healthcare costs.[116] For both insured and uninsured patients, the prices listed on public chargemasters are infrequently the actual cost that a patient pays out-of-pocket.[117] Even if public chargemasters were actual sticker-prices, prices for the same procedure vary wildly in price.[118] Within small geographic areas such as southeast Michigan, a hip replacement surgery lists $70,621 at Detroit's Henry Ford Hospital, $79,178 at the University of Michigan Health System, and $90,556 at Detroit Medical Center's Harper Hospital in 2019.[119]

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108. *See infra* text accompanying notes 108–25 and accompanying text.

109. *See* Nation, *supra* note 6, at 467 (citing I.R.C. § 501(r)(5)(A) (2011)).

110. *See id.* at 468.

111. *See id.*

112. *See id.* at 468–69.

113. Abutaleb, s*upra* notes 1; *see also U.S. Healthcare Uninsured Rises, supra* note 7.

114. JC Reindl, *Hospitals Now Required to List Prices Online for Every Medical Procedure, Service*, DET. FREE PRESS (Jan. 3, 2019, 12:27 PM), https://www.freep.com/story/money/business/2019/01/03/michigan-hospitals-post-prices-online/2462886002/ [https://web.archive.org/web/20200623052727/https://www.freep.com/story/money/business/2019/01/03/michigan-hospitals-post-prices-online/2462886002/].

115. *Id.*

116. *Id.* ("[Electronically available chargemasters] are not [] particularly useful datapoint[s] . . . I don't expect it to have a significant impact, and I don't expect it to be a driver of lower health care costs." (citing Marianne Udow-Phillips, executive director of the Center for Health and Research Transformation in Ann Arbor, Michigan)).

117. *Id.*

118. *Id.*

119. *Id.*

However, even if a patient *knew* they needed a hip replacement surgery, the chargemasters are largely indecipherable to a lay-person.[120] For example, the University of Michigan's Health System chargemaster lists a "revision of hip or knee replacement w mcc" at $154,806, a "revision of hip or knee replacement w cc" at $88,441, and a "revision of hip or knee replacement w/o cc/mcc" at $70,601, while a "major hip and knee joint replacement or reattachment of lower extremity w/mcc" costs $83,610, and a "major hip and knee joint replacement or reattachment of lower extremity w/o mcc" costs $45,459.[121] Notably, all prices listed are the median and "DO NOT REPRESENT [THE PATIENT'S] ESTIMATED OUT OF POCKET COST."[122] Furthermore, there is no calculation concerning how the hospital system arrives at these seemingly arbitrary numbers.[123]

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120. *See infra* App. A and Part III.B.1; *see also Michigan Medicine Standard Charges*, UNIV. OF MICH. MED. (Nov. 1, 2018), https://www.uofmhealth.org/michigan-medicine-standard-charges [http://web.archive.org/web/20200422154542/https://www.uofmhealth.org/michigan-medicine-standard-charges] (referring to external link of "Michigan Medicine Diagnosis-Related Groups (DRG) Charges" under subsection "Standard Charges by Diagnosis-Related Groups (DRG)"). The author of this Note certainly considers himself a layperson and has no idea what "mcc," "cc," or "without mcc/cc" means. The chargemaster itself provided no definition for these designations and also provided no guidance for how the hospital applies these designations. *See id.* A cursory Google search seems to indicate that "mcc" stands for "major complications or comorbidities," while "cc" stands for "code correction." What may constitute a major complication, comorbidity, or code correction is similarly unclear. *See, e.g.*, CTRS. FOR MED. & MEDICAID SERVS., MAJOR JOINT REPLACEMENT (HIP OR KNEE) (May 2017), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/jointreplacement-ICN909065Printfriendly.pdf [http://web.archive.org/web/20200422154843/https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/jointreplacement-ICN909065Printfriendly.pdf]. Neither a comorbidity nor complication is well-defined in medical literature, but broadly speaking, both are co-occurring health conditions that complicate another health condition or procedure (for example, arthritis may be considered a comorbidity for a hip replacement). Jose M. Valderas et al., *Defining Comorbidity: Implications for Understanding Health and Health Services*, 7 ANNALS OF FAM. MED. 357, 357–363 (Jul. 2009) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2713155/ [http://web.archive.org/web/20200422155011/https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2713155/]. Furthermore, the chargemaster is unclear what distinguishes a "major" comorbidity from just a "normal" comorbidity. *See Michigan Medicine Standard Charges*, *supra* note 120. As for what a "code correction" means, however, this author was unable to find any materials or definitions for the term. Presumably, it is an administrative classification that allows a hospital's billing department to adjust a price up or down depending on what chargemaster category fits best, but that is simply a guess.

121. *Michigan Medicine Standard Charges*, *supra* note 120.

122. *Id.*

123. *Id.*

Both the free market and legislation have largely failed to remedy the situation, as described above.[124] However, as discussed below, the judicial system has been equally as ineffective in its policing of uninsured medical billing.[125]

D. A Context-Specific Look at Unconscionability: How Courts Have Applied Unconscionability in Medical Billing Contracts for Uninsured Patients

Although courts have applied unconscionability in a variety of contexts, very few have invalidated uninsured billing contracts under unconscionability.[126] As a baseline measure, courts invalidate U.C.C. contracts under unconscionability around thirty-seven percent of the time.[127] Further, courts invalidate (common law) consumer unconscionability contracts around thirty to forty percent of the time.[128] Uninsured patients filing unconscionability claims for exorbitant medical bills should fall under this common law subset of thirty to forty percent—however, out of twenty-three cases surveyed for the purposes of this Note, only one court (five percent) has invalidated an uninsured patient's medical billing contract under unconscionability.[129]

This seemingly low percentage is perhaps explained by the many cases that would be suitable for unconscionability but nevertheless fail to address the doctrine.[130] For instance, in Michigan, three recent courts have looked at ambiguity,[131] unjust enrichment,[132] and consumer protection acts[133] concerning chargemaster billing of uninsured patients—yet none of the three cases considered unconscionability, and

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124. *See supra* Part II.C. Notably, medical bills are now among the leading causes of bankruptcy. *Obscene Contracts*, *supra* note 10, at 104 (citing Lucette Lagnado, *Taming Hospital Billing*, WALL ST. J., June 10, 2003, at B1).

125. *See infra* Part II.D.

126. *See* cases cited *infra* Part II.D.

127. *See* DiMatteo, *supra* note 19, at 1097; *see also infra* App. A and Part III.B.1.

128. *See* DiMatteo, *supra* note 19, at 1097.

129. *See* Moran v. Prime Healthcare Mgmt., Inc., 208 Cal. Rptr. 3d 303 (Ct. App. 2016).

130. *See, e.g.*, Grant v. Trinity Health-Mich., 390 F. Supp. 2d 643 (E.D. Mich. 2005).

131. *See* Holland v. Trinity Health Care Corp., 791 N.W.2d 724 (Mich. Ct. App. 2011).

132. *See Grant*, 390 F. Supp. 2d at 643.

133. *See, e.g.*, Geico Indem. Ins. Co. v. Kannaday, No. 6:06-CV-01067, 2007 WL 2990552 (D. Kan. Oct. 11, 2007); Burton v. William Beaumont Hosp., 347 F. Supp. 2d 486 (E.D. Mich. 2005); Kizzire v. Baptist Health Sys., 343 F. Supp. 2d 1074 (N.D. Ala. 2004).

all three cases upheld the contract.[134] Similarly, the Third Circuit has looked at duty of good faith and fair dealing, fiduciary duty, and statutory protections for uninsured patients charged higher rates than insured ones.[135] Yet again, unconscionability was never considered as a possible defense, and the court upheld the validity of the contract.[136]

The limited application of unconscionability to uninsured medical billing contracts is somewhat puzzling, given adamant scholarly advocacy to the contrary.[137] Uninsured patients receiving more expensive bills than their insured counterparts is not a new phenomenon.[138] Presumably, most of the chargemaster prices given to uninsured patients are not priced according to the market.[139] Yet, few courts have used this scholarly work to affirmatively apply unconscionability,[140] and some have even used it to support denying damages.[141]

Perhaps unsurprisingly, for the courts that do consider unconscionability in these medical contexts, the doctrine is often readily dismissed.[142] For example, the Supreme Court of Indiana refused to impute a reasonable price term into uninsured medical billing contracts, thereby overturning the court of appeals' affirmation of

134. *See generally Kannaday*, 2007 WL 2990552; *Burton*, 347 F. Supp. 2d; *Kizzire*, 343 F. Supp. 2d.

135. Dicarlo v. Saint Mary Hosp., 530 F. 3d 255 (3d Cir. 2008).

136. *Id.* at 260.

137. *See generally Obscene Contracts*, *supra* note 10; Hall & Schneider, *supra* note 101.

138. *Obscene Contracts*, *supra* note 10, at 101–04.

139. *See Hospital Chargemaster Insanity*, *supra* note 76, at 748–50.

140. Upon performing a Westlaw references check, only seven cases cite George A. Nation's unconscionability article, mentioned *supra* in note 10. Only seventeen cite the Hall & Schneider article, mentioned *supra* in note 101.

141. *See, e.g.*, Nassau Anesthesia Assocs. P.C. v. Chin, 924 N.Y.S.2d 252, 255 (Nassau Dist. Ct. 2011).

142. *See, e.g.*, Geico Indem. Ins. Co. v. Kannaday, No. 6:06-CV-01067, 2007 WL 2990552 (D. Kan. Oct. 11, 2007); Colomar v. Mercy Hosp., Inc., No. 05-22409, 2007 WL 2083562 (S.D. Fla. July 20, 2007); Woodrum v. Integris Health, Inc., No. 05CV01224, 2007 WL 201045 (W.D. Okla. Jan. 24, 2007); Quinn v. BJC Health Sys., 364 F. Supp. 2d 1046, 1053 (E.D. Mo. 2005); Kizzire v. Baptist Health Sys., 343 F. Supp. 2d 1074 (N.D. Ala 2004); Banner Health v. Med. Sav. Ins. Co., 163 P.3d 1096, 1100 (Ariz. Ct. App. 2007); Morrell v. Wellstar Health Sys., Inc., 633 S.E.2d 68, 72 (Ga. Ct. App. 2006); Allen v. Clarian Health Partners, Inc., 980 N.E.2d 306 (Ind. 2012); Holland v. Trinity Health Care Corp., 791 N.W.2d 724, 728 (Mich. Ct. App. 2010); Shelton v. Duke Univ. Health Sys., Inc., 633 S.E.2d 113, 116 (N.C. Ct. App. 2006); Limberg v. Sanford Med. Ctr., 881 N.W.2d 658 (N.D. 2016); Firelands Reg'l Med. Ctr. v. Jeavons, No. E-07-068, 2008 WL 4408600, at *3 (Ohio Ct. App. 2008); Nygaard v. Sioux Valley Hosps. & Health Sys., 731 N.W.2d 184, 191–93 (S.D. 2007); Doe v. HCA Health Servs. of Tenn., Inc., 46 S.W.3d 191, 194 (Tenn. 2001); Woodruff v. Fort Sanders Sevier Med. Ctr., No. E2007-00727-COA-R3CV, 2008 WL 148951, at *3 (Tenn. Ct. App. Jan. 16, 2008).

unconscionability.[143] The Supreme Court of South Dakota has done likewise, affirming dismissal of an unconscionability claim.[144]

Justification for dismissal of unconscionability in medical contexts is fairly uniform across courts,[145] where the primary concern is the notion that the market for health care is unique.[146] Understandably, there is often concern for judicial determinations upending an intricate and delicately balanced market.[147] Additionally, determining precise prices prior to treatment is often impractical and cumbersome, meaning patients only have a nebulous idea of a procedure's cost going into (often medically necessary) treatment.[148] Notwithstanding the indefinite nature of chargemaster pricing, courts have typically permitted "low levels of specificity in medical contracts."[149] Uninsured patients also are known to bring unconscionability claims as plaintiffs, to which courts are typically unreceptive.[150]

Also of concern is the notion that unconscionability contradicts the "freedom to contract."[151] Courts have long been wary of imposing terms upon contracting parties, and unconscionability necessarily imposes "reasonable terms" upon the parties.[152] Nevertheless, unconscionability has been widely accepted by courts and legislatures,[153] arguably

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143. *See* cases cited *supra* note 142.

144. *See Nygaard*, 731 N.W.2d at 197.

145. *See id.*; Dicarlo v. Saint Mary Hosp., 530 F.3d 255, 255 (3d Cir. 2008); *Allen*, 980 N.E.2d at 306; *see also* cases cited *supra* note 142.

146. *Allen*, 980 N.E.2d at 311.

147. *Id.*

148. *Id.* at 310 ("[O]mitting a specific dollar amount is 'the only practical way in which the obligations of the patient to pay can be set forth, given the fact that nobody yet knows just what condition the patient has, and what treatments will be necessary to remedy what ails him or her.'"). Without knowledge of medical pricing prior to procedure, patients are unable to compare competitive prices across the marketplace. *See Obscene Contracts*, *supra* note 10, at 134.

149. *See* Hall & Schneider *supra* note 100, at 674.

150. *See* Nygaard v. Sioux Valley Hosps. & Health Sys., 731 N.W.2d 184, 195 (S.D. 2006) ("[T]he equitable theory of unconscionability has never been utilized to allow for the affirmative recovery of money damages." (quoting Cowin Equip. Co., Inc., v. Gen. Motors Corp., 734 F.2d 1581, 1582 (11th Cir. 1984))).

151. *Obscene Contracts*, *supra* note 10, at 108–09.

152. *See supra* Parts II.A, II.B.

153. *See Obscene Contracts*, *supra* note 10, at 108–09; *see also, e.g.*, Williams v. Walker-Thomas Furniture Co., 350 F.2d 445, 449 (D.C. Cir. 1965) ("[W]hether a meaningful choice is present in a particular case can only be determined by consideration of all the circumstances surrounding the transaction. In many cases the meaningfulness of the choice is negated by a gross inequality of bargaining power."). All fifty states have adopted at least part of the U.C.C., and only Louisiana has neglected to adopt article 2. *Commercial Law Research Guide*, GEO. L. LIBR. (Apr. 1, 2020, 2:41 PM), http://guides.ll.georgetown.edu/commerciallaw/ucc

promoting the "freedom to contract" in the process.[154] Unconscionability only works where courts acknowledge that "freedom to contract" is not absolute.[155] Accordingly, with the pervasive acceptance of unconscionability, arguments about unconscionability contradicting the "freedom to contract" necessarily fail.[156]

Very few courts have actually extended unconscionability to the medical billing context.[157] In *Moran v. Prime Healthcare Management*,[158] an uninsured patient challenged hospital services charged at grossly excessive rates.[159] But unlike the foregoing cases,[160] the court found both procedural and substantive unconscionability.[161] The fact that all patients had to agree to chargemaster pricing before treatment was sufficient for procedural unconscionability,[162] and the cost of care far exceeding market prices (by four to six times) was sufficient for substantive unconscionability.[163]

III. ANALYSIS

A. Unconscionability Unequivocally Applies to Many Medical Billing Contracts

Despite the courts' systematic denial of unconscionability, unconscionability should apply to *many* medical billing contracts, particularly those issued to uninsured patients.[164] In order for unconscionability to apply, a patient must demonstrate substantive and procedural unconscionability.[165] Additionally, there is the judicially-imposed requirement of the patient being a consumer.[166] With the

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[http://web.archive.org/web/20200422160949/http://guides.ll.georgetown.edu/commercialaw/ucc].

154. *See Obscene Contracts*, *supra* note 10, at 108 (citing *Williams*, 350 F.2d at 449).
155. *See id.* at 108–09, 123–24.
156. *See id.*
157. *See* Moran v. Prime Healthcare Mgmt., Inc., 208 Cal. Rptr. 3d 303, 303 (Ct. App. 2016).
158. *Compare id.*, *with* cases cited *supra* Part II.D.
159. *See Moran*, 208 Cal. Rptr. 3d at 303.
160. *Compare id.*, *with* cases cited *supra* Part II.D.
161. *Moran*, 208 Cal. Rptr. 3d at 316.
162. *Id.*
163. *Id.* at 315–16.
164. *See Obscene Contracts*, *supra* note 10.
165. *See supra* Part II.B (discussing modern requirements of unconscionability).
166. *See supra* Part II.B.

exception of a few outlying courts, this is all a patient must prove to succeed on a claim of unconscionability.[167]

First and foremost, there is a strong argument that patients are categorically consumers.[168] Just like a consumer shopping for a car, patients have the ability to select hospital systems, doctors, and the price of services they seek.[169] However, patients are typically more vulnerable than most consumers in other markets.[170] The healthcare market is notoriously precarious and difficult to traverse, particularly for uninsured patients.[171] Courts have typically used unconscionability for protecting vulnerable consumers;[172] accordingly, it would seem disingenuous to preclude a patient's unconscionability claim *solely* on the ground that they are not a consumer.[173]

Additionally, many medical billing contracts issued to uninsured patients satisfy the procedural requirement of unconscionability.[174] Procedural unconscionability turns on the overall bargaining power of the two contracting parties.[175] In the case of an uninsured patient seeking medical services, this element is frequently present.[176] Particularly where uninsured patients seek urgent or emergency medical services, procedural unconscionability is even more heightened.[177] Even in non-emergency scenarios—and even with the advent of public chargemasters—there is little predictive information available to prospective patients prior to their treatments.[178] In most cases, patients must receive their treatment *before* learning anything of its costs or their

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167. *See supra* Part II.B.

168. *See generally* Hall & Schneider, *supra* note 101; *see also* Nancy Tomes, *Patients or Health-Care Consumers? Why the History of Contested Terms Matters*, *in* HISTORY AND HEALTH POL'Y IN THE U.S. 83 (Rosemary A. Stevens et al. eds., Rutgers Univ. Press 2006).

169. *See generally* Hall & Schneider, *supra* note 101.

170. *Id.* at 646, 651.

171. *Id.* at 649–50.

172. *Id.* at 646.

173. *Id.* at 675–78.

174. *Obscene Contracts*, *supra* note 10, at 110–13.

175. *See supra* notes 52–54 and accompanying text.

176. *Obscene Contracts*, *supra* note 10, at 110–13.

177. George Nation states:

> The overriding factor . . . in finding hospital admission contracts procedurally unconscionable is that urgent medical services are necessities . . . . Thus, even if a patient understands the terms in the hospital admission contract and decides he does not want to agree to them, he is in no position to shop for an alternative . . . .

Obscene Contracts , *supra* note 10, at 112.

178. *See supra* Part II.C (discussing the inherent difficulty of interpreting chargemasters).

legal obligations.[179] Furthermore, most hospital admission contracts require patients to agree to the hospital's "full charges," which often amount to far more than charges issued to insured patients.[180] Where patients do not understand they are agreeing to pay the chargemaster's full price, have little opportunity to fully read the billing agreement, or have no choice but to accept the terms because of pressing medical needs, there is a strong case for procedural unconscionability.[181]

Similarly, many medical billing contracts satisfy the substantive requirement of unconscionability.[182] Substantive unconscionability turns on the reasonability of a contract's terms or duties.[183] In the context of medical billing for the uninsured, this typically comes in the form of unreasonably exorbitant cost.[184] Surely, not all chargemaster prices are so unreasonable as to warrant unconscionability.[185] However, it does not seem irrational to think that a $719,479 out-of-pocket charge for a "heart transplant or implant of heart assist system w mcc" might be unreasonable,[186] or that a $469,905 charge for a "lung transplant" might be unreasonable.[187] Seemingly, such prices would at least approach substantively unconscionable terms.[188]

Continuing along with these examples, both heart and lung transplants are relatively common[189] and frequently must occur within

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179. *Obscene Contracts*, *supra* note 10, at 112.

180. *Id.*

181. *Id.* at 110–13.

182. *Id.* at 113–15.

183. *See supra* notes 55–56 and accompanying text.

184. *Obscene Contracts*, *supra* note 10, at 114–15.

185. *See, e.g.*, *Common Lab Services*, UNIV. OF MICH. MED. (Apr. 2020), http://www.med.umich.edu/pdf/price-transparency/mm-lab-testing-uninsured.pdf [http://web.archive.org/web/20200422161622/http://www.med.umich.edu/pdf/price-transparency/mm-lab-testing-uninsured.pdf]. Surely, an uninsured patient would have a difficult time arguing that a discounted $66.80 renal function blood panel (or a $52.80 discounted lipid panel, for instance) is unreasonably priced. *Compare id.*, *with* Heather P. Whitley, et al., *Selecting an A1C Point of Care Instrument*, 28 DIABETES SPECTRUM 201, 201–08 (Aug. 2015) (examining various A1C home-testing devices, some priced as low as $40 and others upwards of $2,000 to $3,000 dollars).

186. *Michigan Medicine Standard Charges*, *supra* note 120.

187. *See id.*

188. *Compare* charges listed in *supra* note 185, *with* examples from *Obscene Contracts*, *supra* note 10, at 101–04.

189. Mayo Clinic Staff, *Heart Transplant*, MAYO CLINIC (Nov. 16, 2019), https://www.mayoclinic.org/tests-procedures/heart-transplant/about/pac-20384750 [http://web.archive.org/web/20200422162716/https://www.mayoclinic.org/tests-procedures/heart-transplant/about/pac-20384750] (stating that at any given time in the U.S., there are approximately 3,000 people awaiting heart transplants); *see also Organ Procurement and Transplantation Network*, U.S. DEPT. OF HEALTH & HUM. SERVS. (Jan. 30, 2019), https://optn.transplant.hrsa.gov/data/view-data-reports/national-data/#

time constraints.[190] It is also not unheard of to require both heart and lung transplants simultaneously.[191] When an *insured* patient receives such lifesaving procedures, cost typically is not a preclusive factor[192]—ultimately, their insurance company will negotiate with the hospital based on these chargemaster prices.[193] However, should an uninsured patient be admitted to the University of Michigan Hospital in need of one of these lifesaving procedures, *these are the starting prices the hospital will work with*: a $719,479 out-of-pocket charge for a heart transplant and a $469,905 charge for a lung transplant.[194] Is it reasonable to require an uninsured patient (who is already more likely to be of lower socioeconomic status than an insured counterpart[195]) to pay hundreds of thousands of dollars out-of-pocket where (1) they do not know what the exact, final price is until *after* the procedure; and (2) the procedure is, quite literally, necessary?[196]

All things considered, unconscionability should apply in many billing contracts issued to the uninsured.[197] The whole point of unconscionability is to protect vulnerable consumers from grossly inequitable contracts, particularly where they have little choice in the matter.[198] Regardless of the procedure, treatment, or health condition, uninsured populations are more likely to suffer from adverse medical

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[http://web.archive.org/web/20200422162752/https://optn.transplant.hrsa.gov/data/view-data-reports/national-data/] (stating that there are over 1,200 people in the U.S. currently awaiting lung transplants); Ashley Welsch, *How Do Medical Bills Get so High? The Story Behind One Man's $109,000 Bill After a Heart Attack*, CBS NEWS (Aug. 29, 2018, 3:49 PM), https://www.cbsnews.com/news/how-do-hospital-bills-get-so-high/ [http://web.archive.org/web/20200422163223/https://www.cbsnews.com/news/how-do-hospital-bills-get-so-high/]. Notably, this patient's bill was issued despite his insurance covering some of the cost. *Id.*

190. *United Network for Organ Sharing Data*, U.S. DEPT. OF HEALTH & HUM. SERVS. (Jan. 30, 2019), https://unos.org/data/ [http://web.archive.org/web/20200422163253/https://unos.org/data/] (stating that in 2016 alone, almost 7,000 people died while awaiting organ transplants).

191. Yoshida Toyoda et al., *Heart-Lung Transplantation: Adult Indications and Outcome*s, 6 J. OF THORACIC DISEASE 1138, 1138–42 (Aug. 2014).

192. *Obscene Contracts*, *supra* note 10, at 112 (stating that uninsured patients frequently pay many times more than insured patients do for medical services, in part because insurers negotiate for reasonable prices on behalf of their clients).

193. *Id.* at 118–19.

194. *See* sources cited *supra* note 185.

195. U.S. INST. OF MED. COMM. ON THE CONSEQUENCES OF UNINSURANCE, COVERAGE MATTERS: INSURANCE AND HEALTH CARE 59–80, 96–98 (2001).

196. *See generally Obscene Contracts*, *supra* note 10.

197. *See id.*

198. *See supra* notes 10, 13–14 and accompanying text; *see also* 17 C.J.S. *Contracts* § 3 (2018); 17A AM. JUR. 2D *Contracts* § 272 (2020).

conditions and more likely to have difficulty paying for them.[199] Unfortunately, there has seldom been effective judicial relief for uninsured patients in such circumstances.[200] The scenarios mentioned above satisfy the necessary elements of unconscionability, and accordingly, they should apply to uninsured patients in such predicaments.[201]

B. Plausible Explanations for Courts' Reluctance to Adopt Unconscionability in Medical Billing Contracts

There are two reasons why courts may be reticent to adopt unconscionability in medical billing contexts: the first and most notable of these stems from common law tradition, in that courts have generally abstained from weighing the consideration of contracts.[202] The second explanation is that courts do not want to upend a highly complex and convoluted healthcare market, which may happen as a result of ruling medical billing contracts unconscionable.[203] Both present commonsense explanations for the practice that ultimately fail on their merits.[204]

1. Common Law Principles Against Weighing Consideration Inadequately Explain the Courts' General Reluctance to Find Uninsured Patients' Medical Billing Contracts Unconscionable

Courts have uniformly applied U.C.C. § 2-302 unconscionability and common law unconscionability across a diverse range of cases.[205] This same application would extend to medical billing of the uninsured, which also falls under the common law of contracts.[206] However, for a multitude of reasons, it does not.[207]

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199. *See generally* Charles Marwick, *For the Uninsured, Health Problems Are More Serious*, 94 J. OF THE NAT'L CANCER INST. 967, 967–68 (July 3, 2002); *see also* U.S. INST. OF MED. COMM. ON THE CONSEQUENCES OF UNINSURANCE, *supra* note 195.

200. *See supra* Part II.D (discussing how modern courts have applied unconscionability to medical billing contracts).

201. *See supra* Part II.A; *see also Obscene Contracts*, *supra* note 10.

202. *See infra* Part III.B.1; *see also* 17 C.J.S. *Contracts* §§ 175–78 (2020).

203. *See* discussion *infra* Part III.B.2.

204. *See* discussion *infra* Parts III.B.1, III.B.2.

205. *See* discussion *infra* Part III.B.1; *see also* Larry A. DiMatteo, *supra* note 19, at 1085, 1115.

206. *See* discussion *infra* Part III.B.1; *see also* App. A.

207. *See* App. A.

Weighing consideration is a necessary step in determining whether a medical billing contract is substantively unconscionable[208]—essentially, the court must weigh the value of medical services rendered against the actual cost charged to an uninsured patient.[209] This is something that courts are exceedingly reluctant to do for contracts, as it contradicts centuries of common law precedent.[210] U.C.C. § 2-302 provides a statutory mechanism for circumventing this precedent.[211] However, under the common law, no such mechanism exists, aside from invalidating contracts against public policy interests—something that is infrequently applied and usually disfavored by the courts.[212] Accordingly, it would make sense if courts favored the common law practice of refusing to weigh consideration over the comparatively new doctrine of common law unconscionability.[213] Because medical billing contracts fall under the common law, and not the U.C.C., this reasoning should also extend to medical billing unconscionability cases.[214]

However, if the courts' ardent preference for common law consideration accurately explained unconscionability's inapplicability to medical billing contracts, it should follow that *all* common law unconscionability cases are under-applied.[215] In other words, U.C.C. § 2-302 unconscionability claims should be affirmed more frequently than common law unconscionability contracts because *all common law unconscionability cases—not just medical billing ones—contradict common law principles against weighing consideration*.[216] Comparatively, the statutory construction of U.C.C. § 2-302 permits circumvention of common law principles against weighing consideration,[217] resulting in a more frequent application of statutory unconscionability.[218]

Regrettably, this is not the case.[219] Courts have uniformly applied unconscionability under the U.C.C. and common law.[220] However, for

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208. *See* DiMatteo, *supra* note 19, at 1091 (stating that "per se unconscionability" occurs where consideration for a contract is imbalanced).

209. *See* discussion on substantive unconscionability *supra* Parts II.A, II.B.

210. *See supra* notes 35–37 and accompanying text.

211. *See* U.C.C. § 2-302 (AM. LAW INST. & UNIF. LAW COMM'N 1977).

212. *See, e.g.*, G. Richard Shell, *Contracts in the Modern Supreme Court*, 81 CALIF. L. REV. 431 (1993).

213. *See* cases cited *supra* Part II.D.

214. *Id.*

215. *See* App. A.

216. *See id.*

217. *See supra* note 209 and accompanying text.

218. *See* App. A.

219. *See id.*

220. *See id.*; *see also* DiMatteo, *supra* note 19, at 1115–16.

one particularized subset of the common law—in medical billing of the uninsured—they have uniformly under-applied it.[221] This means that courts' refusal to adopt unconscionability for uninsured patients does not stem from the common law practice of refusing to weigh consideration, as they regularly weigh consideration in other contexts of common law unconscionability.[222]

2. Maintaining the Status Quo of the Healthcare Market Is an Inadequate Justification for Refusing to Utilize Unconscionability on Inequitable Billing Contracts

A typical maneuver for courts addressing unconscionability in the medical billing context is to avoid rocking the boat.[223] They frequently offer dismissive justifications for their decisions, citing a "complex" healthcare marketplace,[224] judicial deference to the legislature,[225] or insufficient understanding to make an informed decision.[226]

Looking at a microcosm of these cases seems to confirm this judicial reticence.[227] In the Supreme Court of Indiana, for instance, the court noted how "courts have generally tolerated low levels of specificity in medical contracts."[228] Furthermore, the court rationalized the status quo: imprecise dollar amounts are "the only practical way in which the obligations of a patient to pay can be set forth . . . ."[229] Ultimately, the court affirmed chargemasters as "not indefinite" and claimed such a decision "recognized the uniqueness of the market for health care."[230]

This thinking has curiously worked its way into other courts as well.[231] In the Third Circuit, the court deferred on the issue by affirming a district court opinion that stated "*courts are ill-equipped to determine what reasonable hospital costs are.*"[232] Seemingly agreeing with this statement, the Third Circuit did not even attempt to compare prices between insured patients and uninsured patients.[233] This is despite the

221. *See* App. A.
222. *See* discussion *supra* Parts II.A, II.D.
223. *See* discussion and cases *supra* note 142.
224. *See, e.g.*, Allen v. Clarian Health Partners, Inc., 980 N.E.2d 306, 310–11 (Ind. 2012).
225. *See, e.g.*, Dicarlo v. Saint Mary Hosp., 530 F.3d 255, 259–60 (3d Cir. 2008).
226. *See, e.g.*, *id.* at 264.
227. *See* cases cited *supra* Parts II.A, D.
228. *Allen*, 980 N.E.2d at 310 (quoting Hall & Schneider, *supra* note 101, at 674).
229. *Id.* (quoting *Dicarlo*, 530 F. 3d at 264).
230. *Id.* at 311.
231. *See* cases cited *supra* notes 224–30.
232. Dicarlo v. Saint Mary Hosp., 530 F.3d 255, 259 (3d Cir. 2008).
233. *See generally id.*

fact, as discussed above, that unconscionability is suitable for many of these cases.[234] Courts *regularly* impute reasonable prices on contracts they know nothing about, such as "gap-fillers" in U.C.C. § 2-305.[235]

Similarly, the Michigan Court of Appeals has held that reference to a chargemaster (in a patient billing contract) is a sufficiently unambiguous price term for a valid contract.[236] According to the court, "patients' expectations are reasonably based on [a hospital's chargemaster]."[237] Notably, the court failed to inquire into whether these charges were objectively reasonable or not.[238]

All the foregoing cases either dismissed unconscionability or failed to address it entirely,[239] and it is this Note's contention that the preceding justifications are uncompelling.[240]

The healthcare market is undoubtedly complex;[241] but so too is the automotive supply chain, the tech industry, and the pharmaceutical industry—all of which are markets the courts regularly entertain.[242] Where these contracts fall under the U.C.C., § 2-305 dictates that courts may impute a reasonable price term into a contract.[243] Although medical billing contracts do not fall under the U.C.C., explicit price terms are usually *required* at common law to demonstrate the existence of a contract.[244] Here, in medical billing contracts, they are definitionally inexplicit.[245] The complexity of a given market should not be dispositive of whether a court can handle the case;[246] rather, it is the explicit province of the courts to do the exact opposite of that.[247] Courts are

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234. *See* discussion *supra* Part III.A.

235. *See, e.g.*, Pulprint, Inc. v. Louisiana-Pacific Corp., 477 N.Y.S.2d 540 (N.Y. Sup. Ct. 1984); *see also* U.C.C. § 2-305 (AM. LAW INST. & UNIF. LAW COMM'N 1977).

236. Holland v. Trinity Health Care Corp., 791 N.W.2d 724, 729 (Mich. Ct. App. 2011).

237. *Id.* at 730.

238. *See generally id.*

239. *See* cases cited *supra* Part II.A.2.

240. *See* discussion *supra* Part II.A.2.

241. *See* Hall & Schneider, *supra* note 101.

242. *See, e.g.*, Exxon Corp. v. Middleton, 613 S.W.2d 240, 249 (Tex. 1981) ("The complexity of the oil and gas industry makes it difficult to establish a formula to determine the market value of gas in each field in Texas."). The court went on to reverse and remand the case with particular determinations on oil market value. *Id.* at 252.

243. U.C.C. § 2-305 (AM. LAW INST. & UNIF. LAW COMM'N 1977).

244. Nellie Eunsoo Choi, Note, *Contracts with Open or Missing Terms Under the Uniform Commercial Code and the Common Law: A Proposal for Unification*, 103 COLUM. L. REV. 50, 50–51 (2003).

245. *See* discussion on chargemasters *supra* Part II.C.

246. *See, e.g.*, *Middleton*, 613 S.W.2d at 249.

247. Marbury v. Madison, 5 U.S. 137, 177 (1803) ("It is emphatically the province and duty of the judicial department to say what the law is.").

supposed to interpret the law, regardless of any underlying complexity.[248] Plus, if courts find an issue too complex, how can they reasonably expect uninsured patients to understand it any better?[249]

There is legitimate concern that judicial rulings to the contrary could potentially upend the medical marketplace.[250] Perhaps, as a consequence of ruling that certain medical billing contracts are unreasonable, the whole medical billing system would unravel.[251] Perhaps it would completely change insurance premiums and quality of care.[252] But in any case, it is not the courts' job to reverse engineer decisions on speculative doomsday scenarios.[253] It is the courts' job to apply the law as given,[254] and the law of unconscionability seems to fit many medical billing contexts quite well.[255] Additionally, hospitals claim that uninsured patients rarely pay full chargemaster pricing.[256] If so, invalidity of the few contracts that do pay full price would hardly threaten the sanctity of the healthcare market.[257]

Certainly, not all medical billing contracts are so exorbitant as to be unconscionable.[258] However, for the ones that are arbitrary in nature, that have no justification other than the decrees of a chargemaster, or that are only discernible after a patient receives treatment, unconscionability should preclude the enforceability of such contracts.[259]

IV. CONCLUSION

Unquestionably, unconscionability should apply to many exorbitant medical billing contracts. The requisite elements of both procedural and substantive unconscionability are surely satisfied where indigent, uninsured patients (1) need medical treatment out of necessity; (2) cannot easily ascertain prices from public chargemasters; (3) are not informed of the final cost until after the hospital administers its services; and (4) are contractually bound to medical contracts with astronomical costs. Courts should not address such cases with reluctance for fear of causing tumult in the medical marketplace—such fear is not unique or inherent to the

248. *Id.*
249. *See generally Obscene Contracts*, *supra* note 10, at 115–24.
250. Allen v. Clarian Health Partners, Inc., 980 N.E.2d 306, 310 (Ind. 2012).
251. *Id.* at 311.
252. *See id.*
253. *See Marbury*, 5 U.S. at 177–78.
254. *See id.*
255. *See supra* Part III.A.
256. *See Obscene Contracts*, *supra* note 10, at 120.
257. *See id.*
258. *See supra* Part III.A.
259. *Id.*

healthcare market, as court decisions in all markets fundamentally reshape respective market landscapes. Accordingly, the courts' reticence to adopt unconscionability in medical billing contexts is not only misplaced, but it also disregards the fundamental requirements of common law.

APPENDIX A: STATISTICAL ANALYSIS ON U.C.C. AND COMMON LAW APPLICATION OF UNCONSCIONABILITY

A two population-proportion statistic tests a randomly selected proportion of a population and thereafter extrapolates this proportion across the rest of the presumably uniformly distributed population.[260] By taking a large enough sample size, the test effectively reduces the possibility of an unrepresentative sample.[261] The first population-proportion is then compared to another population-proportion, thereby assessing causal relationships between the two.[262] In essence, the statistical test determines a percentage chance that two population-proportions causally differ.[263]

Importantly, the "null hypothesis" is that the two population proportions are equivalent (H_0: $p_1 = p_2$), while the "alternative hypothesis" is that the two population proportions are statistically different (H_A: $p_1 \neq p_2$). The "alternative hypothesis" is only true if the "null hypothesis" can be rejected, and the "null hypothesis" is only rejected where the two population-proportion test yields statistical significance. The statistical significance level is frequently set at 5%, or $p = 0.05$.[264] If a two population-proportion test yields a value less than 5%, then there is sufficient evidence to reject the null hypothesis and accept the alternative hypothesis. However, if the population-proportion test yields a value greater than 5%, then the null hypothesis is true (that is, the two populations are statistically equivalent).[265]

In comparing the population of U.C.C. § 2-302 case law with the population of common law unconscionability case law, the null hypothesis is that courts apply common law unconscionability with the same frequency as U.C.C. § 2-302 unconscionability, largely because common law principles prevent courts from weighing consideration.[266]

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260. *See* PETER GOOS & DAVID MEINTRUP, STATISTICS WITH JMP: HYPOTHESIS TESTS, ANOVA, AND REGRESSION 205–28 (John Wiley & Sons, Ltd. 2016).
261. *Id.*
262. *Id.*
263. *Id.*
264. *Id.*
265. *Id.*
266. *See* discussion *supra* Part III.B.1.

Effectively, the null hypothesis is that population 1 (U.C.C. unconscionability) equals population 2 (common law unconscionability).

The statistical test for comparing two population proportions is as follows: $Z = \frac{p_1 - p_2}{\sqrt{\hat{p}(1-\hat{p})(\frac{1}{n_1} + \frac{1}{n_2})}}$ where p_1 = the proportion of U.C.C. § 2-302 cases that affirmed unconscionability, p_2 = the proportion of common law cases that affirmed unconscionability, n_1 = sample size of U.C.C. § 2-302 cases, n_2 = sample size of common law unconscionability cases, $\hat{p} = \frac{p_1 + p_2}{n_1 + n_2}$, and Z = the test statistic.[267] A test statistic less than or equal to -1.6 (or a p-value of less than 0.05—in other words, a less than a 5% chance that the null hypothesis is true) is considered statistically significant, meaning that the two population proportions very likely differ due to causal correlation.[268]

Out of ninety U.C.C. § 2-302 cases sampled for this study,[269] thirty-three of them affirmed unconscionability as a defense against contract enforcement (36.67%).[270] Out of ninety common law unconscionability cases sampled, thirty-six of them affirmed the unconscionability defense (40%).[271] These proportions are noticeably similar, and the statistics agree: where $p_1 = 33$, $p_2 = 36$, $n_1 = 90$, and $n_2 = 90$, the test statistic, Z = -0.4599, *resulting in a p-value of approximately 0.64552. This fails to demonstrate statistical significance, meaning the null hypothesis—that*

267. *See* GOOS & MEINTRUP, *supra* note 260.

268. *Id.*

269. Cases were randomly sampled using Westlaw and Boolean search terms. Following the search, cases were screened and included or excluded from the query by the following method: for U.C.C. § 2-302 cases, the search terms "(U.C.C. 2-302) OR (Uniform Commercial Code 2-302)" were used. Cases were sorted by relevance. Cases that were overturned, fell under U.C.C. article 2A or only referenced U.C.C. § 2-302 by analogy were excluded. The search was then repeated using various combinations of the above terms, and duplicative cases were disregarded. For common law unconscionability cases, the search "('restatement second contracts' /s 208) AND (unconscionability OR unconscionable)" were used. This search was similarly repeated using various combinations of the above terms and others, to first narrow, then broaden, the search. Again, cases were sorted by relevance. Cases that concerned sale of goods under the U.C.C., that were overturned, or were non-dispositive rulings were excluded from the query (for instance, Hill v. Sisters of St. Francis Health Servs, Inc., No. 06-C-1488, 2006 WL 3783415, at *6 (N.D. Ill. Dec. 20, 2006) states that plaintiff pled a "sufficient" unconscionability claim but did not go so far as to say the plaintiff's medical bills were definitively unconscionable). Cases that discussed unconscionability in medical billing contexts were collected by a variety of keyword searches, such as "unconsc!," "med!," "hospital," "bill or billing," and "uninsured or "patient," as the body of case law was not extensive.

270. *See supra* note 269 for a discussion on how cases were searched, selected, and screened.

271. *See supra* note 269.

U.C.C. § 2-302 and common law unconscionability are equivalently applied—remains true. Accordingly, the alternative hypothesis—that U.C.C. § 2-302 and common law unconscionability are *not* equivalently applied—is rejected.

At a 95% confidence interval, the true population proportion value for p_1 is equivalent to $p_1 \pm z\sqrt{\frac{p_1(1-p_1)}{n_1}}$, where z = 1.96 (and same for p_2, just with the common law cohort).[272] This means that the true value for p_1 is $p_1 \pm 0.10$ cases and the true value for p_2 is $p_2 \pm 0.10$ cases. Even on the outer margins of these confidence intervals, both would still yield statistically insignificant values. Accordingly, it is statistically unlikely that courts are applying U.C.C. § 2-302 unconscionability differently than common law unconscionability. This independent finding appears well-supported by academic literature.[273]

This same experiment can be conducted between common law unconscionability (generally) and common law unconscionability in the medical billing context. Presumably, medical billing contracts are both a subset of common law contracts, *so there should be no substantive difference between how the two are applied*.[274] Therefore, the null hypothesis (H_0: $p_1 = p_2$) underlying the preceding presumption is that the population proportion of common-law unconscionability cases and the population proportion of medical billing unconscionability cases are equivalent (i.e., courts apply the two case populations uniformly). The alternative hypothesis (H_A: $p_1 \neq p_2$) is that the two populations are statistically different and, therefore, not uniformly applied.

Again, out of ninety common law unconscionability cases sampled, thirty-six of them affirmed the unconscionability defense (40%). Comparatively, out of twenty-three medical billing cases concerning the uninsured, only one of them affirmed an unconscionability defense (4.35%). This is a stark discrepancy, and the statistics again support such a finding.

The statistical test for comparing two population proportions is again the same, $Z = \frac{p_1 - p_2}{\sqrt{\hat{p}(1-\hat{p})(\frac{1}{n_1}+\frac{1}{n_2})}}$ where p_1 = the proportion of common law cases that affirmed unconscionability (generally), p_2 = the proportion of medical billing cases that affirmed unconscionability, n_1 = sample size of common law cases, n_2 = sample size of medical billing cases that dealt

272. *See* GOOS & MEINTRUP, *supra* note 260.
273. *See* DiMatteo, *supra* note 19.
274. *See* discussion *supra* Part III.B.2.

with unconscionability, $\hat{p} = \frac{p_1 + p_2}{n_1 + n_2}$, and Z = the test statistic.[275] Notably, any medical billing unconscionability cases in cohort p_1 were excluded to prevent overlap between the two populations, as were overturned rulings. Where p_1 = 36, p_2 = 1, n_1 = 90, and n_2 = 23, the test statistic, Z = 3.25164, resulting in a p-value of 0.00116, or 0.116%. This is a statistically significant result, as $p < 0.05$ and is sufficient grounds to reject the null hypothesis that courts uniformly apply common law unconscionability cases and medical billing unconscionability cases. Accordingly, *the alternative hypothesis is accepted, in that there is a statistically significant difference in how courts apply common law unconscionability generally and common law unconscionability in medical contexts*.

Even using a 95% confidence interval, the true value for p_1 is $p_1 \pm 0.101$ cases, while the true value for p_2 is $p_2 \pm 0.0833$ case. On the outskirts of either confidence interval, there is still sufficient evidence to reject the null hypothesis that courts uniformly apply common law unconscionability and medical billing unconscionability.

Accordingly, *there is a 0.116% chance that the discrepancy between these two population-proportions is due to chance*. This stands in great contrast to the previous experiment, where U.C.C. § 2-302 unconscionability and common law unconscionability were statistically uniform in their application. In other words, there is a statistically significant difference between how courts have applied common law unconscionability generally and common law unconscionability in medical billing of the uninsured.

275. *See* GOOS & MEINTRUP, *supra* note 260.