PRICE TRANSPARENCY AND INCOMPLETE CONTRACTS IN HEALTH CARE

Wendy Netter Epstein[*]

ABSTRACT

Market-based health reform solutions dominate the post-Affordable Care Act landscape. Under these plans, competition is supposed to bring down ballooning prices, and patients are to act more like consumers, refusing low-value, medically unnecessary care. Whether one embraces these solutions, one thing is clear: they cannot work absent price transparency—which the U.S. system lacks. To the contrary, the law explicitly enforces open price term contracts between patients and providers.

This Article is the first to synthesize theories of incomplete contracts from traditional law and economics and recent work in the behavioral sciences and to apply these theories to the price transparency problem. It argues that doctrine is out of step with theory, and proposes a contract law solution: an information-forcing penalty default rule. Courts should impose an undesirable default to force the parties to contract around the default. When providers fail to include a price, and it would have been reasonable to do so, courts should fill the gap with a price of $0. Rather than risk not being paid, providers will include a price in the patient contract. Legislative action has been both slow and ineffective in fixing the crucial price transparency problem. At no other time in recent memory has the importance of contract theory been put into such sharp relief and, remarkably, in an area of law that is at the very core of the emerging political economy.

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[*] Visiting Associate Professor, University of Chicago Law School; Faculty Director, Mary & Michael Jaharis Health Law Institute at DePaul University College of Law. The author wishes to thank Lisa Bernstein, Curtis Bridgeman, Erin Fuse Brown, Christopher Buccafusco, Emily Cauble, Brietta Clark, I. Glenn Cohen, Lawrence Cunningham, Kelly Dineen, Tim Greaney, Jasmine Harris, David Hoffman, Eleanor Kinney, Gregory Mark, Elizabeth McCuskey, Amy Monahan, Nicholson Price, Barak Richman, Jessica Roberts, Christopher Robertson, Zoe Robinson, Rachel Sachs, Nadia Sawicki, Christopher Schmidt, Sidney Watson, William Whitford, and Patricia Zettler. The author also thanks attendees of the Transparency in Health and Health Care: Legal and Ethical Possibilities and Limits conference at Harvard Law School and the Health Law Scholars Workshop at Saint Louis University for their insightful comments.

INTRODUCTION

James, a sixty-five-year-old man, suffers from severe chest pain that is not improving with medication or lifestyle changes. His cardiologist tells him that he needs an angioplasty, a procedure in which a catheter widens a narrowed artery. After discussing the risks of the procedure, James agrees. He arrives at the hospital and signs a series of standard forms, one of which states that he "individually obligates himself . . . to pay the account of the Hospital in accordance with the regular rates and terms of the Hospital."[1] He receives no information about the cost of the procedure, but by signing the form, he enters into a contract to pay whatever the charges end up being.

James later receives the bill for the angioplasty—$67,937. With his $5,000 insurance policy deductible and 20% copay, his portion of the bill amounts to $17,587. Ultimately, he must pay the out-of-pocket limit on his policy, $7,150 for 2017.[2] Before receiving the bill, James had no idea how much the procedure would cost. He also did not know that an angioplasty at another hospital in the same city would have cost only $10,749—*532% less*. Had he had the procedure at the other hospital, James would have owed $6,150—$1,000 less than what he paid.[3] Indeed, large price differentials despite similar quality are common in the U.S. system.[4]

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[1] *See Conditions of Admission*, CEDARS-SINAI MED. CTR., https://www.cedars-sinai.edu/Patients/Programs-and-Services/Pain-Center/Documents/PainCenterConditionsofAdmission-75446.pdf (last visited Sept. 16, 2017).

[2] *See* 42 U.S.C. § 18071 (2012); *FAQs About Affordable Care Act Implementation (Part XXVII)*, CTRS. FOR MEDICARE & MEDICAID SERVS. (May 26, 2015), https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ACA-FAQs-Part-XXVII-MOOP-2706-FINAL.pdf.

[3] The hypothetical angioplasty costs are based on real data compiled by BlueCross BlueShield of the rates actually paid for angioplasties in Los Angeles. BLUECROSS BLUESHIELD ET AL., A STUDY OF COST VARIATION FOR PERCUTANEOUS CORONARY INTERVENTION (ANGIOPLASTIES) IN THE U.S. 4, (2015), https://bluehealthintelligence.com/pdf/Cardiac_Cost_Variation%5B2%5D.pdf. Price differentials are just as stark for common tests. In Ohio, a study found that the price for a standard pregnancy ultrasound varied from $183 to $522. HEALTH CARE COST INST., NATIONAL CHARTBOOK OF HEALTH CARE PRICES–2015 110 (2016), http://www.healthcostinstitute.org/wp-content/uploads/2015/04/HCCI-National-Chartbook-of-Health-Care-Prices-2015.pdf; Jeff Lagasse, *Prices for Healthcare Vary Widely Across States, Even Nearby Cities, Health Care Cost Institute Says*, HEALTHCARE FIN. (Apr. 27, 2016), http://www.healthcarefinancenews.com/news/prices-healthcare-vary-widely-across-states-even-nearby-cities-health-care-cost-institute-says.

[4] *See, e.g.*, OFFICE OF ATTORNEY GEN. MARTHA COAKLEY, INVESTIGATION OF HEALTH CARE COST TRENDS AND COST DRIVERS (2010), http://www.mass.gov/ago/docs/healthcare/prelim-2010-hcctcd.pdf; Ashish K. Jha et al., *Measuring Efficiency: The Association of Hospital Costs and Quality of Care*, 28 HEALTH AFF. 897, 898 (2009); Karen E. Joynt & Ashish K. Jha, *The Relationship Between Cost and Quality: No Free Lunch*, 307 JAMA 1082–83 (2012); CHANGE HEALTHCARE, AFFORDING THE AFFORDABLE CARE ACT: ENGAGING EMPLOYEES IN FINDING LOWER-COST PREVENTIVE CARE 6 (2012) (finding 755% cost variation for

Although James is a hypothetical patient, most real patients who receive medical care in the United States do not know the cost of their care until they receive the bill.[5] By that time, they have already legally committed to pay by entering into what contract scholars have termed "open price term" contracts. Imagine going to buy a car and telling the salesperson that you will take it regardless of the cost, or committing to pay for a hotel or rental car without knowing the cost. It sounds preposterous, but in health care, courts routinely enforce these contracts that lack a price term.

The absence of price transparency in patient-provider contracts is highly problematic.[6] Patients suffer from both an imbalance of information and an imbalance of power. Providers have access to pricing information (working with insurers) and patients generally do not. Providers set prices. Patients have little room to negotiate.[7]

Patients can turn down unnecessary care or seek lower priced care. The industry is counting on them to do just that.[8] There is a significant trend to make patients shoulder more of the economic burden of their health-care decisions—through higher deductibles, copays, and co-insurance[9]—in hopes

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diabetes screenings, 364% cost variation for Pap smears, and 132% cost variation for colonoscopies over a twelve-month period).

[5] Erin C. Fuse Brown, *Resurrecting Health Care Rate Regulation*, 67 HASTINGS L.J. 85, 87–88 (2015); Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy*, 25 HEALTH AFF. 57, 64–66 (2006); DEVON M. HERRICK & JOHN C. GOODMAN, NAT'L CTR. FOR POLICY ANALYSIS, THE MARKET FOR MEDICAL CARE: WHY YOU DON'T KNOW THE PRICE; WHY YOU DON'T KNOW ABOUT QUALITY; AND WHAT CAN BE DONE ABOUT IT. 1 (2007), http://www.ncpa.org/pub/st296/; U.S. GOV'T ACCOUNTABILITY OFF., GAO-11-791, HEALTH CARE PRICE TRANSPARENCY: MEANINGFUL PRICE INFORMATION IS DIFFICULT FOR CONSUMERS TO OBTAIN PRIOR TO RECEIVING CARE 2 (2011).

[6] *See* Wendy Netter Epstein, *A Contract Solution to the Price Transparency Problem*, *in* TRANSPARENCY IN HEALTH AND HEALTH CARE: LEGAL AND ETHICAL RESPONSIBILITIES AND LIMITS (I. Glenn Cohen, Barbara Evans & Holly Lynch eds., forthcoming 2018); *see generally* Daryl M. Berke, Note, *Drive-by-Doctoring: Contractual Issues and Regulatory Solutions to Increase Patient Protection From Surprise Medical Bills*, 42 AM. J.L. & MED. 170, 189 (2016).

[7] Although sometimes uninsured patients can negotiate after receiving the bill.

[8] Paul B. Ginsburg, *Shopping for Price in Medical Care*, 26 HEALTH AFF. 208, 209 (2007).

[9] A "deductible" is the amount an insured pays out of pocket for covered health care services before the plan starts to pay. *Deductible*, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/deductible/ (last visited July 3, 2017). For instance, an insured might have to pay the first $2,000 of health expenses before the plan starts to make payments. *Id.* "Copay" is short for the term "copayment," a typically small per-office visit fee that an insured must pay after satisfying the deductible. *Copayment*, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/co-payment/ (last visited July 3, 2017). "Coinsurance" describes the percentage of costs that an insured must pay out of pocket for a covered health service after satisfying the deductible. *Coinsurance*, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/co-insurance/ (last visited July 3, 2017). For instance, an insured might have to pay 20% of the fee for a procedure and the plan will pay the other 80%. *Id.*

that it will prompt patients to act more like traditional consumers.[10] Indeed, consumer-driven medicine is certain to be a hallmark of any replacement of the Affordable Care Act (ACA).[11]

But it is hard for patients to price shop, reduce overtreatment, or even put pressure on the industry to justify pricing in relation to quality when patients do not know prices before they enter into binding contracts to pay.[12] In a country where one in five Americans still struggles to pay medical bills and three in five bankruptcies are attributed to medical costs, it is troubling that patients lack necessary information to make smart financial decisions, when possible, about their care.[13] Indeed, it is hard to imagine patients doing many of the things that advocates of consumer-driven health care hope they will do if patients have no visibility into price at decision-time.[14] It is also hard to see how providers will be incented to compete on the value of care they offer absent transparency.

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[10] *See, e.g.*, Rachel Dolan, Health Affairs, *Health Policy Brief: High-Deductible Health Plans* 1 (2016), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=152 (describing high deductible plans where "other than certain preventive services, all medical care must be paid for out of pocket until the deductible is met").

[11] *See, e.g.*, H.R. 1628, 115th Cong. (2017); H.R. 3762, 114th Cong. (2015); Ashlea Ebeling, *Trump Calls For Expanding Health Savings Accounts; A Golf Driver On Uncle Sam's Dime?*, FORBES (Mar. 1, 2017, 9:10 AM), https://www.forbes.com/sites/ashleaebeling/2017/03/01/trump-calls-for-expanding-health-savings-accounts-a-golf-driver-on-uncle-sams-dime/#265422bd62ce.

[12] Consider the hypothetical patient Michele. Michele had breast cancer, but completed her treatment and has been deemed cancer free. At her one-year check-up, Michele has no symptoms. But her doctor suggests that she have a PET scan to be sure there are no metastases elsewhere in her body. Michele and her physician discuss the risk of the additional radiation from the scan. They never, however, discuss the cost of the procedure. Michele agrees to undergo the scan, which confirms she is cancer free. She later receives the bill and learns for the first time that the scan cost $7,000. Given that the scan was not strictly necessary, and that her doctor could have monitored her in other ways, she knows she would have declined the scan had she known the cost beforehand. *See* Peter Ubel, *Are High Out-of-Pocket Costs Forcing Patients to Settle for Substandard Care?*, FORBES (May 13, 2016, 9:00 AM), http://www.forbes.com/sites/peterubel/2016/05/13/are-high-out-of-pocket-costs-forcing-patients-to-settle-for-substandard-care/#49325c30713a (discussing a patient's choice between a more accurate but more costly PET scan and a less costly and probably good enough full body CT scan).

[13] This is not to say that a patient who must undergo a procedure to survive but cannot afford the cost should turn it down. But patients consent to much costly medical care that is not necessary. *See*, *e.g.*, Sana M. Al-Khatib et al., *Non-Evidence-Based ICD Implantations in the United States*, 305 JAMA 43, 44 (2011); Aaron L. Schwartz et al., *Measuring Low-Value Care in Medicare*, 174 JAMA INTERNAL MED. 1067 (2014); Atul Gawande, *Overkill, An Avalanche of Unnecessary Medical Care Is Harming Patients Physically and Financially. What Can We Do about It?*, NEW YORKER (May 11, 2015), http://www.newyorker.com/magazine/2015/05/11/overkill-atul-gawande.

[14] Consumer-driven health care is controversial for many reasons. *See infra* Section II.B. This Article does not defend the principles of consumer-driven health care. Rather, it recognizes that the industry has strongly embraced market principles that cannot work absent price transparency.

Questions concerning incomplete contracts—of which open price term contracts are one variant[15]—have dominated contracts scholarship for the last several decades.[16] Scholars have pondered why incomplete contracts arise,[17] whether they should be enforceable,[18] and how courts should fill gaps left by the parties.[19] There has also been much scholarly debate on the desirability of relative completeness in contract drafting.[20] Despite this scholarly attention, however, a coherent legal framework for analyzing incomplete contracts and a theoretical basis for understanding existing doctrine have been elusive.

In part, this is due to competing conceptions of what values matter most. The law and economics account has mostly focused on the role of transaction costs. While it may be more or less costly to detail a deal up front, depending in large part on the level of complexity and uncertainty in the deal, doing so may reduce expenditures down the line because parties are clear about their obligations.[21] In general, law and economics scholars assume that detailed

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[15] *See infra* Section I.C for a discussion of why these agreements should be considered open price term contracts.

[16] *See, e.g.*, Ian Ayres & Robert Gertner, *Filling Gaps in Incomplete Contracts: An Economic Theory of Default Rules*, 99 YALE L.J. 87, 91–95 (1989); Scott Baker & Kimberly D. Krawiec, *Incomplete Contracts in a Complete Contract World*, 33 FLA. ST. U. L. REV. 725, 728 (2006); Omri Ben-Shahar, *"Agreeing to Disagree": Filling Gaps in Deliberately Incomplete Contracts*, 2004 WIS. L. REV. 389, 390 (2004); Nellie Eunsoo Choi, *Contracts with Open or Missing Terms Under the Uniform Commercial Code and the Common Law: A Proposal for Unification*, 103 COLUM. L. REV. 50, 51 (2003); Yuval Feldman & Doron Teichman, *Are All Contractual Obligations Created Equal?*, 100 GEO. L.J. 5 (2011); Mark P. Gergen, *The Use of Open Terms in Contract*, 92 COLUM. L. REV. 997, 997 (1992); Charles J. Goetz & Robert E. Scott, *The Limits of Expanded Choice: An Analysis of the Interactions Between Express and Implied Contract Terms*, 73 CALIF. L. REV. 261, 268–71, 311 (1985); Jeffrey M. Lipshaw, *Metaphors, Models, and Meaning in Contract Law*, 116 PENN ST. L. REV. 987, 1009 (2012); Richard A. Posner, *The Law and Economics of Contract Interpretation*, 83 TEX. L. REV. 1581, 1583 (2005); Robert E. Scott, *A Theory of Self-Enforcing Indefinite Agreements*, 103 COLUM. L. REV. 1641, 1644–45 (2003); Robert E. Scott & George G. Triantis, *Anticipating Litigation in Contract Design*, 115 YALE L.J. 814, 818 (2006) (examining the choice to use vague terms when precise provisions could have been employed).

[17] Ayres & Gertner, *supra* note 16, at 92–94; Baker & Krawiec, *supra* note 16, at 729; George S. Geis, *An Embedded Options Theory of Indefinite Contracts*, 90 MINN. L. REV. 1664, 1668–70 (2006) (discussing several theories of incomplete contracts).

[18] Gergen, *supra* note 16, at 1062 (1992) (arguing for court enforcement of open contracts); Scott, *supra* note 16, at 1644–45 (discussing self-enforcement of incomplete contracts).

[19] *See generally* Ayres & Gertner, *supra* note 16, at 91–92 (providing a theory for how courts and legislatures should set default rules for contracts absent essential terms); Ben-Shahar, *supra* note 16, at 391–93 (arguing for a pro-defendant interpretation of incomplete contracts).

[20] *See* Wendy Netter Epstein, *Facilitating Incomplete Contracts*, 65 CASE W. RES. L. REV. 297, 302 (2014) (arguing "good" contracts are not necessarily detailed and specific); Jody Freeman, *Extending Public Law Norms Through Privatization*, 116 HARV. L. REV. 1285, 1351 (2003); Oliver Hart, *Incomplete Contracts and Public Ownership; Remarks, and an Application to Public-Private Partnerships*, 113 ECON. J. 70 (2003); Scott, *supra* note 16, at 1663 (summarizing studies).

[21] *See* Posner, *supra* note 16, at 1584; Goetz & Scott, *supra* note 16, at 268–71.

contracts reduce the likelihood that litigation will ensue later.[22] On the other hand, a level of incompleteness is preferable in the law and economics account when the cost of detailed up-front drafting exceeds expected gains.[23]

More recent work in the behavioral sciences takes a different approach. Rather than viewing incompleteness only as a cost that makes eventual litigation more likely, this work has identified benefits to incompleteness in building relational capital between the parties.[24] Incompleteness, particularly regarding task specificity, can prompt feelings of trust and foster collaboration between the parties.[25] Completeness, on the other hand, can crowd out an agent's intrinsic motivation.[26] This work has also identified negative cognitive implications of specification—namely, that specification prompts agents to adhere to the enumerated contractual requirements and to lose sight of the overall purpose of the deal.[27]

These two strands of scholarship inform a set of criteria for analyzing contractual completeness. In particular, this analytical framework addresses the question of how best to determine the desirability of relative completeness in drafting. It argues that when transaction costs of detailing are low, information asymmetry is high, and incompleteness is unlikely to build relational capital between the parties, a more complete contract is desirable. But when a deal is complex and uncertain, making transaction costs of drafting high, both parties are adequately informed, and there is a significant need for trust and collaboration to develop, a less detailed contract is desirable.[28]

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[22] Epstein, *supra* note 20, at 305–06.

[23] Scott & Triantis, *supra* note 16, at 816, 823 (2006) (explaining that parties invest in transaction costs until they exceed the expected benefit to be gained by the contract).

[24] *See infra* Section III.A and accompanying notes 222–227.

[25] Michal Shur-Ofry & Ofer Tur-Sinai, *Constructive Ambiguity: IP Licenses as a Case Study*, 48 U. MICH. J.L. REFORM 391, 392, 412–15 (2015). *See also* Karen Eggleston, Eric A. Posner & Richard Zeckhauser, *The Design and Interpretation of Contracts: Why Complexity Matters*, 95 NW. U. L. REV. 91, 126 (2000) ("[D]etail makes for complexity, and complexity can sow distrust, overwhelm the cognitive capacities of the parties, [and] absorb resources . . . ."). Note, however, that medical pricing opacity does not seem likely to produce trust. *See infra* Section III.C at pages 44–47 and accompanying notes.

[26] *See* Edward Deci, *Effects of Externally Mediated Rewards on Intrinsic Motivation*, 18 J. PERSONALITY & SOC. PSYCHOL. 105, 109–10 (1971) (finding that college students will stop playing puzzles for free after being paid to solve them); Epstein, *supra* note 20 (summarizing the literature on crowd-out effects).

[27] *See* Christina E. Shalley et al., *The Effects of Personal and Contextual Characteristics on Creativity: Where Should We Go from Here?*, 30 J. MGMT. 933, 935–36 (2004); *see also* Gideon Parchomovsky & Alex Stein, *Catalogs*, 115 COLUM. L. REV. 165, 185–86 (2015).

[28] In past work, I explored the doctrinal roadblocks to less complete contract drafting and argued that in certain circumstances, these roadblocks stymied the use of efficient *in*complete contracts. Epstein, *supra* note 20, at 299–300. But that is only half the story. At the other end of the spectrum, courts enforce (and thereby incentivize) incomplete contracts where they should not, as the health-care example illustrates.

In this conception, a simple sales contract for widgets would probably not benefit from less complete drafting. Drafting a complete contract is a low-cost endeavor, and there is little to be gained relationally from leaving it incomplete. The sole purpose of entering into a binding contract in a transaction like that is to ensure compliance.[29] But the contract in which a firm partners with another to co-develop new technology might be a good candidate for less complete drafting.[30]

Applying these criteria to the health-care example suggests that enforcing open price term patient-provider contracts is out of step with theory.[31] Transaction costs of detailing would, for the most part, be low. Many health services would be both easy and inexpensive to price *ex ante*. For instance, a hospital should easily be able to price a standard x-ray, even with the minor complication that different insurers have negotiated different rates.[32] The same is true even for more complicated, but still highly standardized procedures like a colonoscopy or cataract surgery.[33] Certain emergency-room treatment and inherently uncertain procedures like complicated surgeries provide exceptions, but do not account for the bulk of medical care.[34] Information asymmetry is high. Providers have far superior access to price information than patients, particularly in a world where health pricing varies tremendously in unpredictable ways and where it is so dependent on understanding a complex numerical code for medical procedures.[35] Finally, it is hard to imagine that behavioral benefits (like increased trust) would follow from a provider's failure to include a price term. While the doctor-patient relationship is important, and the provision of medical care is not exactly akin to the sale of a

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[29] *See, e.g.*, Aditi Bagchi, *Parallel Contract*, 75 U. PITT. L. REV. 139, 140 (2013) (describing a classical, dyadic account of contract law).

[30] Epstein, *supra* note 20, at 299–300.

[31] When there is a mismatch between theory and doctrine, it does not necessarily mean that the doctrine is incorrect. For the reasons discussed more fully in section III.C, however, it is the case here that the doctrine is flawed.

[32] A computer database could clearly spit out an accurate price once a patient's insurance information is input into the system.

[33] *Cf.* HEALTHCARE FIN. MGMT ASSOC., RECONSTRUCTING HOSPITAL PRICING SYSTEMS: A CALL TO ACTION FOR HOSPITAL FINANCIAL LEADERS 22–23 (2007) (calling for standardized pricing throughout health-care organizations).

[34] *See* Michael H. Lee et al., *Owning the Cost of Emergency Medicine: Beyond 2%*, 62 ANNALS EMERGENCY MED. 498, 498 (2013); *see also Cost of Emergency Care Fact Sheet*, AM. COLL. EMERGENCY PHYSICIANS, http://newsroom.acep.org/fact_sheets?item=29928 (last visited Sept. 13, 2017).

[35] The trend toward bundled payment for episodes of care may make it somewhat easier to determine prices, but this method of pricing is still in its infancy. *See, e.g.*, *Bundled Payments for Care Improvement Initiative*, CMS.GOV, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2013-Fact-sheets-items/2013-01-31.html (last updated Sept. 30, 2013).

widget, leaving out the price term does not seem likely to foster that relationship in the same way that a more open-ended contract for innovation would foster collaboration between two innovating entities.

Contract doctrine should encourage patients and providers to enter into more complete contracts that contain a price term, not enforce contracts that lack a material term. The law getting it wrong in this context has important and severe consequences for an industry that makes up one quarter of the federal budget.[36] This Article is the first to turn to contract law as the source of a solution. To this point, policymakers have focused on legislative solutions to the price transparency problem.[37] Despite some legislative success, price transparency remains a problem.

Courts should fill price gaps with an information-forcing penalty default. Penalty defaults select terms that at least one party would *not* want to force parties to contract around the default.[38] In this case, if a provider did not include a contractual price where it would have been reasonable to do so, a penalty default rule would fill the open price term with a price of $0. This approach is analogous to how the Uniform Commercial Code (U.C.C.) finds contracts to be unenforceable if they lack a quantity term (essentially filling those contracts with a quantity of zero). While $0 may seem like a harsh penalty, filling the gap with the reasonable value or *quantum meruit* would be insufficient to induce requisite changes in the market.

In practice, assume that our hypothetical patient, James, signs the standard contract consenting to bear financial responsibility for his angioplasty. That contract must include the price of the procedure. If it does not, and James does not pay, the hospital could not successfully recover damages for breach of contract. Rather, the court would find that the contract lacks a material term that must be filled, and would fill that gap with an amount of $0.[39] With this

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[36] *See Where Did Every Dollar in Spending Go?*, HERITAGE FOUND. (Dec. 4, 2014), http://origin.heritage.org/multimedia/infographic/2014/12/where-did-every-dollar-in-spending-go.

[37] *See, e.g.*, *Transparency and Disclosure of Health Costs and Provider Payments: State Actions*, NAT'L CONF. ST. LEGISLATURES, http://www.ncsl.org/research/health/transparency-and-disclosure-health-costs.aspx#Legislation (last updated Mar. 2017) (listing enacted state legislation for transparency and disclosure of health care costs).

[38] For a discussion of penalty default rules, see *infra* Section IV.A. Although penalty defaults have not been employed in this context, they are currently used in other areas of contract law and doctrine. *Id.*

[39] Alternatively, a court may find a quasi-contract exists by virtue of James consenting to treatment and treatment being provided. For further discussion, see *infra* Section IV.B.2.

change to the common law, providers would be forced to fill the price term at contract execution to avoid this result.[40]

Part I describes the incomplete contracts that result when patients consent to pay for medical procedures without knowing the cost. It then explores the current doctrinal approach to open price term contracts, in which patient-provider contracts lacking price terms are almost universally enforced.

Part II then explores the problems that lack of price transparency causes in the modern health-care marketplace. Policymakers argue that making patients bear more of the cost of health care should prompt them to turn down high-cost, low-value care, and should weed out the vast price differentials caused by market failures.[41] Consumer-driven health care, however, will not work absent price transparency.[42]

Part III takes up the theoretical debate on incomplete contracts, exploring both the law and economics and behavioral sciences literatures. From those literatures, it creates a theoretical framework for assessing the desirability of completeness in various contract settings. Applying that framework to the health-care problem, it suggests that the current doctrinal approach is a mismatch with theory.

Finally, Part IV provides a solution to the price-transparency problem in health-care provider contracts: an information-forcing penalty default rule. If providers omit a price term in cases in which it would have been reasonable to provide one, courts should fill the gap with a price of $0. This penalty to providers should incentivize them to, instead, include a price in the contract. Other areas of contract law have employed similar penalty defaults, but perhaps no area is as ripe for one to be employed as this one.

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[40] Courts would only employ the penalty default where it would have been reasonable to include a price. *See infra* Section III.B (discussing the analytical framework).

[41] Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 674 (2008).

[42] Quality metrics are also essential to prevent a race to the bottom based solely on price. *See, e.g.*, William M. Sage, *Assembled Products: The Key to More Effective Competition and Antitrust Oversight in Health Care*, 101 CORNELL L. REV. 609, 635 n.108, 690 (2016).

I. THE ENFORCEABILITY OF INCOMPLETE CONTRACTS IN HEALTH CARE

Patients become obligated to pay for their care by entering into contracts.[43] If a patient is uninsured, the patient signs an agreement accepting full financial responsibility for the cost of treatment, whatever it ends up being.[44] If a patient is insured, the patient contracts with an insurance company; the insurance company contracts with providers (who become "in-network"); and the patient also contracts directly with the provider. In a hospital setting, these patient-provider contracts are typically titled "Conditions of Admission" forms. They almost always contain language binding the patient to pay whatever the cost of treatment ends up being. Terms vary, but the Cedars Sinai Conditions of Admission Form is a typical example of the language used:

> FINANCIAL AGREEMENT The undersigned agrees . . . that in consideration of the services to be rendered to the Patient, he / she hereby individually obligates himself / herself to pay the account of the Hospital *in accordance with the regular rates and terms of the Hospital* . . . .[45]

These agreements almost never specify the cost that the patient is agreeing to bear.

A. *Open Price Term Contracts Between Patients and Providers*

Indeed, there is abundant evidence that patients do not know the cost of care before they consent to treatment. Authors have written articles with provocative titles like: "I tried to find out how much my son's birth would cost. No one would tell me.";[46] "How much will surgery cost? Good luck finding

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[43] In an emergency, it may be that a quasi-contract is formed, but for the most part patients contract for health care. *See* Mark A. Hall, *The Legal and Historical Foundations of Patients as Medical Consumers*, 96 GEO. L.J. 583, 595 (2008) ("Emergencies require that quasi-contracts substitute for actual agreements; otherwise, providers might be less willing to respond to emergencies.").

[44] Mikey Rox, Wise Bread, *7 Smart Ways to Negotiate Your Medical Bills*, TIME: MONEY (June 29, 2015), http://time.com/money/3938748/7-smart-ways-to-negotiate-your-medical-bills/. Although, practically, there may be post-treatment negotiation for uninsured patients.

[45] *Conditions of Admission*, *supra* note 1 (emphasis added). Such an agreement is typical among healthcare systems. *See, e.g.*, *Patient Financial Agreement and Responsibilities*, PIEDMONT HEALTHCARE, http://www.piedmont.org/media/file/PPG-Patient-Financial-Agreement-Responsibilities.pdf (last visited Sept. 16, 2017). Independent physician offices also tend to use similar language in their agreements. *See, e.g.*, *Office Policies & Consent to Treat*, DUPAGE PEDIATRICS, LTD., http://www.dupagepediatrics.com/docs/Office-Policies-Consent-to-Treat.pdf (last visited Aug. 15, 2016) (stating patients must "pay any outstanding charges not covered by their insurance carrier").

[46] Johnny Harris, *I Tried to Find Out How Much My Son's Birth Would Cost. No One Would Tell Me.*, VOX (May 5, 2016), http://www.vox.com/2016/5/5/11591592/birth-cost-hospital-bills.

out";[47] and "The Doctor Will Charge You Now—But You Don't Know How Much."[48]

A recent study found that "63 percent of those who had received medical care during the last two years did not know the cost of the treatment until the bill arrived."[49] And it is not that patients can even guess the general ballpark of expenses. While consumers can estimate the price of a new Honda Accord within $300, those same consumers were off by $8,100 in estimating the cost of a four-day hospital stay.[50]

Systematic studies have also confirmed what many people probably did not need a study for—many health-care providers will not provide reasonable estimates of cost even after specific requests.[51] One group of scholars attempted to determine prices for hip replacement and found nearly 40% of providers would not provide a complete estimate.[52] Indeed, 15% of the top-ranked hospitals surveyed "were not able to provide any price whatsoever."[53]

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[47] Steve James, *How Much Will Surgery Cost? Good Luck Finding Out*, NBC NEWS (Feb. 11, 2013 10:32 AM), http://www.nbcnews.com/id/50748682/ns/health-health_care/t/how-much-will-surgery-cost-good-luck-finding-out/#.WVsAUxPyvBI; *see also* Lisa Aliferis, *How Much for a Hip Replacement? Good Luck Trying to Finding Out*, KQED: NEWS (Feb. 11, 2013), http://ww2.kqed.org/stateofhealth/2013/02/11/how-much-for-a-hip-replacement-good-luck-trying-to-find-out/; Martha Bebinger & Sacha Pfeiffer, *Trying to Find the Cost of a Medical Procedure? Good Luck*, WBUR (Aug. 2, 2012), http://legacy.wbur.org/2012/08/02/health-care-shopping.

[48] Cody Fenwick, *The Doctor Will Charge You Now—But You Don't Know How Much*, PATCH (May 23, 2016, 2:32 PM), http://patch.com/us/across-america/doctor-will-charge-you-now-you-dont-know-how-much-0.

[49] HERRICK & GOODMAN, *supra* note 5. Like other sources, the Kaiser Institute's survey shows that a majority of people find it difficult to access health-care costs. Bianca DiJulio et al., *Kaiser Health Tracking Poll: 2015*, KAISER FAM. FOUND. (Apr. 21, 2015), http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-april-2015/.

[50] Kathy Gurchiek, *Consumers Savvier About Cost of a New Car Than a Hospital Stay*, SOC'Y FOR HUM. RESOURCE MGMT. (Aug. 2, 2005, 8:00 AM), http://www.shrm.org/hrnews_published/CMS_013559.asp; *see also* Tracey M. Budz, *Great-West Healthcare Consumer Health Care Survey Reveals Mixed Bag of Results; Participants Average Prediction Price of a Honda Accord Within $300 But Are Off by $8,100 on a Four-Day Hospital Stay*, BUSINESS WIRE (July 28, 2005, 8:57 AM), http://www.businesswire.com/news/home/20050728005536/en/Great-West-Healthcare-Consumer-Health-Care-Survey-Reveals.

[51] Patients may have better luck obtaining this information from insurers, but for most procedures, insurers need to know the billing code the provider intends to use to generate accurate cost information, absent a preapproval process. Patients can try to match the procedure name to a billing code, but there are often multiple codes associated with a procedure name. *E.g.*, *That CT Scan Costs How Much? Health-Care Prices Are All Over the Map, Even Within Your Plan's Network*, CONSUMER REP. (July 2012), http://www.consumerreports.org/cro/magazine/2012/07/that-ct-scan-costs-how-much/index.htm; *Frequently Asked Questions*, FAIR HEALTH CONSUMER, https://www.fairhealthconsumer.org/#faq (last visited Sept. 16, 2017.).

[52] Jamie A. Rosenthal, Xin Lu & Peter Cram, *Availability of Consumer Prices from U.S. Hospitals for a Common Surgical Procedure*, 173 JAMA INTERNAL MED. 427, 428 (2013).

[53] *Id.* At least providers have *chosen* not to find out the price. Providers clearly have access to this information. For further discussion, see *infra* Section IV.B.1.

Another study hypothesized that pricing may be more easily obtained for common services like diagnostic tests.[54] But they found that while 95% of hospitals could provide parking prices, only 15% could provide pricing information for electrocardiograms, which they describe as a "simple and uniform medical service."[55] Physical and behavioral scientist Peter Ubel conducted a study and determined that physicians and patients failed to discuss health care expenses in almost two-thirds of clinical interactions.[56]

There are many reasons that patients may not be finding out about prices before they commit to pay. First, some patients simply do not ask, perhaps because some (probably rightly) assume that the information will be difficult if not impossible to obtain.[57] Patients also may not ask because it is culturally taboo to do so.[58] For others, insurance coverage may still mean that cost information is not relevant (although the size of this group seems to be decreasing).[59] Some may believe that price information is immaterial to decisions about care because health care is not a traditional consumer good.

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[54] Jillian R.H. Bernstein & Joseph Bernstein, *Availability of Consumer Prices from Philadelphia Area Hospitals for Common Services: Electrocardiograms vs. Parking*, 174 JAMA INTERNAL MED. 292, 293 (2014) ("We also discovered that hospitals almost invariably could provide the price of parking and that parking was often discounted. This demonstrates not only that hospitals are able to provide cost information by telephone but, we infer, that they can respond to consumers' concern about cost.").

[55] *Id.*; *see also* Sarah Kliff, *Nearly All Hospitals Will Give You the Price of Parking. Barely Any Will Give You the Price of Health Care.*, WASH. POST: WONKBLOG (Dec. 3, 2013), https://www.washingtonpost.com/news/wonk/wp/2013/12/03/nearly-all-hospitals-will-give-you-the-price-of-parking-barely-any-will-give-you-the-price-of-care/.

[56] Peter A. Ubel et al., *Study of Physician and Patient Communication Identifies Missed Opportunities to Help Reduce Patients' Out-of-Pocket Spending*, 35 HEALTH AFF. 654, 660 (2016) (citing Wynn G. Hunter et al., *What Strategies Do Physicians and Patients Discuss to Reduce Out-of-Pocket Costs? Analysis of Cost-Saving Strategies in 1755 Outpatient Clinic Visits*, MED. DECISION MAKING (2016)).

[57] *See* Amelia Laing, *Most Patients Don't Ask Doctors About Cost, but They Should*, ITRIAGE (Mar. 5, 2014), https://blog.itriagehealth.com/patients-dont-doctors-cost/ (highlighting the difficulty of receiving a cost estimate).

[58] *See generally Cultural Competence in Health Care: Is It Important for People with Chronic Conditions?*, GEO. U. HEALTH POL'Y INST. (Feb. 2004), https://hpi.georgetown.edu/agingsociety/pubhtml/cultural/cultural.html (noting the importance of providers being able to provide culturally competent services that meet the social, cultural, and linguistic needs of patients).

[59] *See infra* Section II.B.

You pay for health care without concern for price.[60] But studies suggest that this group is also likely small.[61]

Second, patients may not know about cost because doctors and hospitals rarely offer such information without prompting. Medical societies and trade associations have traditionally discouraged price disclosure to avoid price competition among their members.[62] Many providers benefit from price opacity, particularly if their pricing is high and so is their demand.[63] Doctors and hospitals traditionally have not competed for patients based on price because much of the cost of healthcare was covered by third parties such as employers, insurance companies, or government.[64] To some physicians, medical ethics counsel against price discussions because a physician should not withhold beneficial treatments because of cost.[65]

Third, sometimes patients ask and providers still do not provide the information.[66] Some cannot provide pricing because it is unclear at the time a patient consents to a procedure exactly what will be required.[67] A surgery may go smoothly or there may be complications. It may be hard to predict how many hospital days will be required after the procedure for recovery. But this seems unlikely to account for a high percentage of cases, particularly as more of medicine becomes standardized and evidence-based.[68] It may be hard to price the care of the ER patient hit by a car, but it should be much simpler to

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[60] Patients may not see medical care as something for which they would comparison shop, particularly if they assume (often incorrectly) that price is correlated with quality. Sarah Kliff, *Half of Americans Think Expensive Medical Care Is Better. They're Wrong*, VOX (July 21, 2014, 12:30 PM), https://www.vox.com/2014/7/21/5922835/half-of-americans-think-expensive-medical-care-is-better-theyre-wrong.

[61] It is possible that more patients may seek cost information given the incentives of Consumer Driven Health Plans (CDHPs). But even if they ask for price, the current system generally does not require that they be told. *See infra* Section I.C.

[62] HERRICK & GOODMAN, *supra* note 5; Barak D. Richman et al., *Overbilling and Informed Financial Consent—A Contractual Solution*, 367 NEW ENG. J. MED. 396 (Aug. 2, 2012), http://www.nejm.org/doi/full/10.1056/NEJMp1205225#t=article ("Long-standing professional norms prevent discussion of fees before a physician cares for the sick . . . .").

[63] *See* Reinhardt, *supra* note 5.

[64] HERRICK & GOODMAN, *supra* note 5.

[65] Kevin R. Riggs & Peter A. Ubel, *Overcoming Barriers to Discussing Out-of-Pocket Costs with Patients*, 174 JAMA INTERNAL MED. 849, 849 (2014) ("Medical ethics has traditionally held that the physician should not withhold beneficial treatments because of cost.").

[66] HERRICK & GOODMAN, *supra* note 5 ("Typically, neither the hospital nor the doctor will know the cost until the procedure is completed.").

[67] *See* Elisabeth Rosenthal, *American Way of Birth, Costliest in the World*, N.Y. TIMES (June 30, 2013), http://www.nytimes.com/2013/07/01/health/american-way-of-birth-costliest-in-the-world.html.

[68] For a discussion on evidence-based medicine, see Stefan Timmermans & Aaron Mauck, *The Promises and Pitfalls of Evidence-Based Medicine*, 24 HEALTH AFF. 18, 25–26 (2005).

price a diagnostic test.[69] Today, many surgeries are relatively routine, and at least an estimate should be accessible beforehand.

Some providers have difficulty providing price information because billing practices are complicated and decentralized. For hospital procedures, many individual practitioners will still send separate bills.[70] And as a purely technical matter, many facilities bill patients separately for every service they provide.[71] Additionally, there is not a single price for each procedure, but rather a different price negotiated with each insurer (which differs from the price charged to uninsureds).

However, there is a movement to simplify billing practices, as well as a big trend away from fee-for-service compensation and toward bundled payment systems in which hospitals will get one payment from Medicare or a private insurer for an entire course of treatment.[72] And because hospitals negotiate rates with private insurers, they should only need a patient's insurance information to determine a negotiated rate.[73]

While health-care costs remain opaque, that is not to say that there has been no progress on price transparency. In recent years, Medicare has started

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[69] *See, e.g.*, David Belk, *Diagnostic Tests*, TRUE COST OF HEALTH-CARE, http://truecostofhealthcare.net/diagnostic-tests/ (last visited Sept. 16, 2017) (listing the prices of commonly ordered medical tests including various blood, cardiology, and radiology tests). *But see* Ryan Flinn, *E.R. Visit Costs Hard to Predict with $4 to $24,000 Swings*, BLOOMBERG (Feb. 28, 2013, 12:01 AM), https://www.bloomberg.com/news/articles/2013-02-27/er-visit-costs-hard-to-predict-with-4-to-24-000-swings.

[70] *See* HERRICK & GOODMAN, *supra* note 5; Julie Appleby, *Ask 3 Hospitals How Much a Knee Operation Will Cost . . . And You're Likely to Get a Headache: Telling Patients to Be Better Shoppers Just Isn't Working*, USA TODAY (May 9, 2006), http://usatoday30.usatoday.com/educate/college/healthscience/articles/20060514.htm; *see also* Maura Calsyn, *Shining Light on Health Care Prices*, CTR. FOR AM. PROGRESS (Apr. 3, 2014, 8:45 AM) ("[D]octors make referrals without knowing the prices charged by other providers; they select medical devices for use in procedures without knowing the costs of the products or whether less-expensive alternatives may produce similar or even better outcomes. A recent study found that orthopedic surgeons correctly estimated the cost of a device only 21 percent of the time.").

[71] Richman et al., *supra* note 62 (discussing that "enormous accounting complexity causes both providers and patients to lack the capacity to negotiate and assent to a bill"); Gina Kolata, *What Are a Hospital's Costs? Utah System Is Trying to Learn*, N.Y. TIMES (Sept. 7, 2015) http://www.nytimes.com/2015/09/08/health/what-are-a-hospitals-costs-utah-system-is-trying-to-learn.html?_r=0.

[72] *See* Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 1395cc-4 (2012); Wendy Netter Epstein, *Public-Private Contracting and the Reciprocity Norm*, 64 AM. UNIV. L. REV. 1, 10, 12 (2014) (noting incentive mismatches can result in higher costs).

[73] Technologically speaking there are some hurdles. For instance, hospitals and doctors' offices would need to be able to obtain real-time information on insureds' benefits and eligibility. Hospitals would need to know a doctor's negotiated billing rate to give a patient a complete picture of the expense. *See generally* ANNE B. CASTO & ELIZABETH FORRESTAL, PRINCIPLES OF HEALTHCARE REIMBURSEMENT (5th ed. 2015). Building out these capabilities is not without cost, but it can certainly be done. *Id.*

releasing information on what it pays providers.[74] Some states have passed price transparency laws.[75] Some websites offer fair market prices for physician services and diagnostic tests according to geographic region.[76] Further, some employers and insurers have started providing information to patients, particularly in the form of online calculators that patients may use in an attempt to predict how much a procedure will cost, although this trend has not yet become widespread among private insurers.[77]

But often laws require that patients request the information, not that it be disclosed absent a request.[78] And when information is available, it is either not in a form that is useful to consumers (e.g., list prices rather than negotiated insurance rates)[79] or it is inaccurate (many online calculators).[80] Despite some movement, report cards on state transparency laws suggest that patients are still struggling to gain access to accurate pricing information.[81]

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[74] *See Medicare Unmasked*, WALL STREET J. (May 19, 2016), http://graphics.wsj.com/medicare-billing/ (last visited July 4, 2017). These releases are done in bulk and are not individual specific. *See id.*

[75] For example, Massachusetts has a medical price transparency law that requires physicians and hospitals to provide cost information for procedures and services. *See* Martha Bebinger, *The Price of Health Care Is Finally Public (in One State)*, TIME: MONEY (Oct. 11, 2014), http://time.com/money/3484955/health-care-prices-massachusetts/. Notably, New Hampshire, Colorado, and Maine received an A according to the Catalyst for Payment Reform Report Card due to the quality of their price reporting and transparency websites. Stephanie Van Vreede, *2016 State Price Transparency Report Card Is Released*, CATALYSIS (July 27, 2016), https://createvalue.org/articles_and_news/2016-state-price-transparency-report-card-is-released/.

[76] *See generally* CASTLIGHT HEALTH, http://www.castlighthealth.com (last visited July 4, 2017) (providing price data for healthcare services); FAIR HEALTH, http://www.fairhealth.org (last visited July 4, 2017) (providing price data for healthcare services); HEALTHCARE BLUEBOOK, http://www.healthcarebluebook.com (last visited July 4, 2017) (providing price data for healthcare services).

[77] Elana Gordon, *Patients Want to Price-Shop for Care, but Online Tools Unreliable*, NPR (Nov. 30, 2015, 4:54 AM), http://www.npr.org/sections/health-shots/2015/11/30/453087857/patients-want-to-price-shop-for-care-but-online-tools-unreliable; *see also* Calsyn, *supra* note 70. California's Department of Insurance recently released a new tool for consumers to look up health care costs, but most of the website does not work. *California Healthcare Compare*, CONSUMER REPORTS, http://www.consumerreports.org/cro/health/california-health-cost-and-quality-consumer-reports/index.htm (last visited Aug. 15, 2016).

[78] *See, e.g.*, CAL. HEALTH & SAFETY CODE §§ 1339.55, .56, .58, .585 (West 2016).

[79] Erin C. Fuse Brown, *Irrational Hospital Pricing*, 14 HOUS. J. HEALTH L. & POL'Y 11, 14 (2014); *U.S. Health Care Reform*, OPEN PHILANTHROPY PROJECT (May 2015), http://www.openphilanthropy.org/research/cause-reports/health-care-reform ("For example, listed prices are not the same as a patient's out-of-pocket costs, and the listed price most likely reflects only one part of a patient's treatment.").

[80] Online calculators are unreliable and not legally binding. Gordon, *supra* note 77.

[81] CATALYST FOR PAYMENT REFORM – HEALTH CARE INCENTIVES IMPROVEMENT INST., REPORT CARD ON STATE TRANSPARENCY LAWS (2015), http://www.hci3.org/wp-content/uploads/files/files/2015_Report_PriceTransLaws_06.pdf; Beth Kutscher, *45 States Get an F on Healthcare Price Transparency*, MOD. HEALTHCARE (July 8, 2015), http://www.modernhealthcare.com/article/20150708/NEWS/150709929; *Transparency and Disclosure of Health Costs and Provider Payments: State Actions*, *supra* note 37.

In general, health-care costs remain opaque to patients and vary considerably in highly unpredictable ways. In most cases, providers have far superior information on pricing than individual patients have, and they readily have the resources to provide a price.

B. Doctrinal Approach to Open Price Term Contracts

Open price term agreements are not uncommon.[82] They arise when parties cannot agree on price, intentionally leave the price to be set later,[83] or agree to a variable price term that does not later fill the gap (e.g., when a reference market collapses or other methods to determine a price do not materialize).[84] For instance, agreements to renew a lease often do not name a price at the time of drafting.[85] Similarly, franchise agreements typically leave the product price term open because of the need to frequently adjust the price of goods over time.[86] In general, contracts for the sale of goods in which the product price fluctuates do not reference a specific price (but may refer to a method for calculating a price).[87] In addition, service contracts, such as a brokerage contract, also commonly leave the price term open at the time of drafting.[88]

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[82] *See, e.g.*, Gergen, *supra* note 16, at 1026 (noting open price terms are preferable because they align the parties' risks in entering the contract).

[83] It is possible to have an agreement to agree on price when the parties have made it clear that they intend to be legally bound and the court nonetheless finds the contract enforceable. William L. Prosser, *Open Price in Contracts for the Sale of Goods*, 16 MINN. L. REV. 733, 736 (1932).

[84] *Id.* at 734 ("[T]o make a binding agreement, and at the same time to avoid . . . the risks of a changing market as between the parties, . . . in a contract for the sale of goods, the price is left open for future determination.").

[85] *See, e.g.*, Moolenaar v. Co-Build Companies, Inc., 354 F. Supp. 980, 984 (D.V.I. 1973) (noting a retail lease included a renewal clause that left rate to be later determined).

[86] Douglas C. Berry et al., *Open Price Agreements: Good Faith Pricing in the Franchise Relationship*, 27 FRANCHISE L.J. 45, 45 (2007); Gillian K. Hadfield, *Problematic Relations: Franchising and the Law of Incomplete Contracts*, 42 STAN. L. REV. 927, 927–28 (1990).

[87] For example, oil and gas companies may prefer to use open price terms due to the fluctuating availability of the resource. *See* Berry et al., *supra* note 86, at 46 ("[P]rice increases would be disastrous to any long-term supply contract between a gasoline refiner and dealer that had fixed prices at the time of execution of the contract . . . ."); Gergen, *supra* note 16, at 1036 (noting oil and gas leases may use open price terms due to uncertainty); *see, e.g.*, United Energy Distribs., Inc. v. ConocoPhillips Co., No. 1:07-CV-2644-RBH, 2008 WL 4458991, at *8 (D.S.C. Sept. 30, 2008) (noting that U.C.C. § 2-305(3) (AM. LAW INST. & UNIF. LAW COMM'N 1977) was drafted to address open price term industries such as the oil and gas industries).

[88] By custom within the brokerage industry, the seller contracts to pay the broker 6% commission. Like a patient contracting for health care, the seller does not know exactly how much he will have to pay. *See* Bruce M. Owens, *Kickbacks, Specialization, Price Fixing, and Efficiency in Residential Real Estate Markets*, 29 STAN. L. REV. 931, 947–48 (1977).

Courts have struggled over time with whether agreements that lack a price term should be deemed enforceable. At common law, a legally enforceable contract required offer, acceptance, consideration, and reasonably definite terms.[89] A price term was essential to the formation of a binding contract.[90] Without specification of price, courts held agreements too indefinite to be enforceable. The comments to the First Restatement of Contracts § 32 summarize the prevailing view in 1932:

> The law cannot subject a person to a contractual duty or give another a contractual right unless the character thereof is fixed by the agreement of the parties. A statement by A that he will pay B what A chooses is no promise.[91]

The comments to § 32 further illustrated unenforceable contracts:

> A promises B to sell to him and B promises A to buy of him goods "at cost plus a nice profit." The promise is too indefinite to form a contract.[92]
>
> A promises B to do a specified piece of work and B promises A to pay a price to be thereafter mutually agreed. As the only method of settling the price is dependent on future agreement of the parties, and as either party may refuse to agree, there is no contract.[93]

Cases from the first half of the twentieth century were consistent on the point, with some exceptions, that the lack of a price term rendered a contract unenforceable.[94] Courts reasoned that without having set a price, parties did

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[89] *See, e.g.*, RESTATEMENT (FIRST) OF CONTRACTS § 32 (AM. LAW INST. 1932) ("An offer must be so definite in its terms, or require such definite terms in the acceptance, that the promises and performances to be rendered by each party are reasonably certain."); Choi, *supra* note 16, at 51 ("Under traditional contract doctrine, contracts with any indefiniteness were not legally binding . . . ."); Prosser, *supra* note 83, at 734–35 ("The price is an essential term of the contract; without it there is no sufficient consideration for the seller's promise, and no measure of the buyer's obligation to perform."). Note that § 32 of the First Restatement later became § 33 of the Second Restatement, with significant changes. *Compare* RESTATEMENT (FIRST) OF CONTRACTS § 32 (AM. LAW INST. 1932) (requiring certainty in the terms of the offer), *with* RESTATEMENT (SECOND) OF CONTRACTS § 33 (AM. LAW INST. 1981) (permitting contract formation as long as the terms "provide a basis for determining the existence of a breach and for giving an appropriate remedy").

[90] See Prosser, *supra* note 83, at 734–35.

[91] RESTATEMENT (FIRST) OF CONTRACTS § 32 cmt. a (AM. LAW INST. 1932).

[92] *Id.* at cmt. c, illus. 6.

[93] *Id.* at cmt. c, illus. 10.

[94] *See, e.g.*, Jordan v. Buick Motor Co., 75 F.2d 447, 449 (7th Cir. 1935) (finding an agreement unenforceable when the number and price of cars to be handled was not fixed in the purported contract); Tribble v. J. W. Greer Co., 83 F. Supp. 1015, 1022 (D. Mass. 1949) (finding a contract unenforceable when there was no certainty as to price or a formula for fixing price); Sun Printing & Publ'g Ass'n v. Remington Paper & Power Co., 139 N.E. 470, 471–72 (N.Y. 1923) (stating that a contract without an agreed upon price is

not convey intent to be legally bound. Rather, those parties merely entered into non-binding agreements to agree.[95]

This doctrinal approach had a number of benefits. It was a bright-line rule that gave parties a clear directive: agree on price or the contract will not be enforceable. Parties wishing to be able to fall back on court sanction knew that their agreements must contain a price. Forcing parties to agree on price *ex ante* usually required expending fewer resources than a court would have to spend later to determine a price in litigation, assuming that the parties could more efficiently make such decisions than the courts. Also, courts may find it difficult to fill a contractual price gap with a reasonable price term based on limited information.[96] Courts do not have expertise to rewrite contracts in which the parties did not agree at the outset. Some scholars also believed that giving parties the incentive to agree on price translated to a higher probability of deal success and a lower likelihood that litigation would later ensue.[97] Put another way, if price were not agreed to at deal execution, it would more likely than not become a point of contention later on. As such, the rule that no price term meant no enforceability also conserved judicial resources by reducing likelihood of litigation and reducing factual inquiry if litigation does occur.[98] Finally, courts reasoned that failing to enforce a contract in which the parties had not agreed to a price honored the intention of the parties.[99]

But there were also downsides to the traditional, bright-line rule. For example, it provided little flexibility to parties that were starting to structure more and more complicated and uncertain deals. Sometimes, it also had the effect of thwarting the intent of the parties that did actually intend to be bound to a deal despite the lack of a price. In 1951, the U.C.C. responded to these concerns with § 2-305.[100]

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merely an agreement to agree); Machesky v. Milwaukee, 253 N.W. 169, 169 (Wis. 1934) (finding a contract unenforceable when there was no certainty as to price or a formula for fixing price). *But see, e.g.*, Augeri v. C.F. Wooding Co., 378 A.2d 538, 540 (Conn. 1977) (finding that an agreement too indefinite for enforcement may be made definite by entire or partial performance); ROBERT E. SCOTT & DOUGLAS L. LESLIE, CONTRACT LAW AND THEORY 259 (1988) (explaining instances of contracts in which there was partial performance).

[95] *See* Lawrence A. Cunningham, *Cardozo and Posner: A Study in Contracts*, 36 WM. & MARY L. REV. 1379, 1393 (1995) (discussing the requirement of certainty in classical contract theory).

[96] Courts filling such gaps with little basis also raise equity concerns.

[97] *See, e.g.*, Posner, *supra* note 16, at 1583–84.

[98] *See* Ronald J. Gilson et al., *Text* and *Context: Contract Interpretation as Contract Design*, 100 CORNELL L. REV. 23, 42 (2014).

[99] *See, e.g.*, Posner, *supra* note 16, at 1583–84.

[100] *See* U.C.C. § 2-305 (AM. LAW INST. & UNIF. LAW COMM'N 1977) (replacing Uniform Sales Act §§ 9–10).

Consistent with the general goals of the U.C.C. to take a more flexible approach to contract formation and to prioritize the intent of the parties, the U.C.C. explicitly permits the formation of binding contracts that lack a price term, as long as there is evidence that the parties intended to be bound and a reasonable price could be set by the court *ex post*.[101] In general, under the modern approach to contract law, courts are more willing to fill gaps left by the parties.[102]

The U.C.C. approach stemmed from a recognition that complex contingencies affect supply and demand of products and that markets for products may be volatile. These uncertainties can make it difficult, if not impossible, for parties to specify a price for goods at the time a contract is signed.[103] However, parties desire assurances that deals will hold the force of law. Consistent with the general U.C.C. commitment to facilitating commerce, § 2-305 provides parties with flexibility and options for how to structure their agreements. It contemplates that parties can leave the price term open to be filled later by agreement (or, alternatively, with a reasonable price determined by the court if no agreement is reached). It also contemplates reference to a market price and provides a default for filling the open price term if that reference becomes unavailable.

Whereas the common law read an open price term to mean that the parties did not intend to be bound, the U.C.C. assumes the opposite—that parties *do* intend to be bound despite lack of prior agreement on price.[104] This is a standard, not a rule, but for the most part, courts deciding cases under the U.C.C. approach are much more likely to find that parties intended to be bound to the agreement. Courts will err on the side of saving a contract and filling a missing price term (to the extent possible) rather than simply finding agreements unenforceable.

The U.C.C. approach has several benefits. It facilitates the formation of contracts in situations in which parties find it hard or impossible to agree to a price, but nonetheless want to enter into a deal. It may therefore better

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[101] *See* Prosser, *supra* note 83, at 736–37; *see also* John R. Browning et al., Project, *A Comparison of California Sales Law and Article Two of the Uniform Commercial Code*, 10 UCLA L. REV. 1087, 1134 (1963) (arguing uncertainty due to failure to set a price should not invalidate a contract because parties contemplated uncertainty and nonetheless agreed to be bound).

[102] *See* Goetz & Scott, *supra* note 16, at 267–73.

[103] *See id.*; *see also* Robert E. Scott, *Conflict and Cooperation in Long-Term Contracts*, 75 CALIF. L. REV. 2005, 2013 (1987).

[104] Scott, *supra* note 16, at 1650.

effectuate the intent of the parties. It also permits parties to spend fewer resources negotiating a price at a time when it would be both difficult and costly to do so.[105] It might actually be more efficient to permit parties to defer price negotiation until after contract execution depending on the circumstances.

But as the bright-line common law rule provided the parties with more certainty and with incentive to negotiate price *ex ante*, the U.C.C. standard does the opposite. It also has the downside of stretching the resources of the courts if litigation later occurs because courts filling open price terms must consider extrinsic evidence and evidence of industry custom and practice to fill those gaps.

But the U.C.C. only governs the sale of goods,[106] and in modern times, courts have been inconsistent in their approach to open price terms in service contracts, with some following the more liberal, contextualist approach of the U.C.C., and others continuing to strike down as unenforceable agreements that lack an explicit price term.[107] Yet courts addressing patient-provider contracts have been surprisingly uniform in their approach. The next section discusses case law treatment of this issue.

C. The Enforceability of Patient-Provider Contracts That Lack Price Terms

Courts almost always enforce agreements between patients and providers that lack a specific price term. They do so partially under the fiction that these actually are not open price term agreements at all. In addition, courts have tended to rely on the historical justification that it would be impossible for providers to commit to a price before the procedure.

First, contracts between patients and providers usually incorporate by reference the hospital chargemaster. The chargemaster is a file maintained by hospitals that lists, by code, everything a hospital might charge for and the

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[105] *See* Haslund v. Simon Prop. Grp., Inc., 378 F.3d 653, 655 (7th Cir. 2004) (noting that "[c]ontracts can be shorter and simpler and cheaper when courts stand ready to fill gaps and resolve ambiguities").

[106] U.C.C. § 2-201 cmt. (AM. LAW INST. & UNIF. LAW COMM'N 1977) (clarifying that this section is "restricted to sale of goods"); Choi, *supra* note 16, at 55 (stating the U.C.C. "explicitly governs sale-of-goods contracts").

[107] *See* Choi, *supra* note 16, at 55 (noting that courts are split in how to deal with service contracts that lack a price term).

"standard" price for that item.[108] While a "typical hospital bill contains between ten to fifty items, the chargemaster contains an average of 25,000 [different] items."[109] Items are listed by code numbers, not by procedure name, diagnosis, or any other descriptor that would be recognizable to a patient.[110] Hospitals are permitted to change their chargemaster rates at any time without notice.[111] And in most jurisdictions, there is no requirement that the chargemaster be posted publicly or otherwise made available to patients.[112] The chargemaster does not reflect the rates negotiated by insurance companies.[113] On average, the chargemaster rates are considerably higher than the rates charged to insureds, but there is much variability.[114]

While some agreements explicitly incorporate by reference the chargemaster, others use vaguer language that merely obligates patients to pay the account or the charges, without further specification. Most courts nonetheless read in an implied term referencing the chargemaster anyway.[115]

As a practical matter, however, agreements between patients and providers are open or indefinite as to price. They are, in real terms, agreements to simply

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[108] *See* Brown, *supra* note 79, at 17; Carrie Pallardy, *Deconstructing the Enigmatic Hospital Chargemaster*, BECKER'S HOSPITAL CFO REP. (Sept. 4, 2015), http://www.beckershospitalreview.com/finance/deconstructing-the-enigmatic-hospital-chargemaster.html.

[109] Gerard F. Anderson, *From "Soak the Rich" to "Soak the Poor": Recent Trends in Hospital Pricing*, 26 HEALTH AFF. 780, 786 (2007).

[110] Anderson, *supra* note 109, at 786; Brown, *supra* note 79, at 16; Brown, *supra* note 5, at 101, 105.

[111] Brown, *supra* note 79, at 17.

[112] Reinhardt, *supra* note 5, at 59 ("With the exception of California, . . . hospitals are not required to post their chargemasters for public view.").

[113] Further, Erin C. Fuse Brown notes that "[h]ospitals readily concede that chargemaster prices do not represent the costs of providing the service, or the price any insurer pays, referring to them instead as starting points . . . ." Erin C. Fuse Brown, *Fair Hospital Prices Are Not Charity: Decoupling Hospital Pricing and Collection Rules from Tax Status*, 53 U. LOUISVILLE L. REV. 509, 517–18 (2016).

[114] *See id.* ("Unlike the prices reached through negotiation between hospitals and health plans, the prices charged by hospitals to uninsured or underinsured self-pay patients are not the result of *bona fide* bargaining . . . ."); Pallardy, *supra* note 108 ("It is unlikely a hospital chargemaster will ever become available to the public given the gap between charges and what patients and payers will actually pay. Patients are concerned with their out-of-pocket expenses, not the convoluted backend of healthcare cost structure.").

[115] *See, e.g.*, DiCarlo v. St. Mary's Hosp., 530 F.3d 255, 264 (3d Cir. 2008) (finding price term not open because "all charges" unambiguously referred to chargemaster rates); Allen v. Clarian Health Partners, Inc., 980 N.E.2d 306, 308 (Ind. 2012) (reading in reference to chargemaster rates in which contract merely "guarantee[d] payment of the account" with no other reference to rate); Holland v. Trinity Care Corp., 791 N.W.2d 724, 726 (Mich. Ct. App. 2010) (referring to "usual and customary charges" in financial agreement reasonably referenced hospital's "Charge Master" prices). *But see* Doe v. HCA Health Servs. of Tenn., Inc., 46 S.W.3d 191, 197 (Tenn. 2001) (declining to name a definite price term where standard form stated: "I understand I am financially responsible to the hospital for charges not covered by this authorization." (emphasis omitted)).

let the provider set the price later. Patients usually cannot reference the chargemaster.[116] And even if they are able to obtain a copy, they cannot make sense of it. Without knowing which codes the hospital intends to bill for (also not noted in the standard agreement), it would be impossible for a patient to calculate cost at the time they enter into the agreement. Hospitals can change their chargemaster prices at any time they choose. It would also be literally impossible for an insured patient to know the negotiated rate he or she will be charged by referencing the chargemaster since it does not list negotiated rates. A hospital essentially reserves the right to later charge whatever it wants as long as it puts the charge into its chargemaster.[117]

Interestingly, however, courts tend *not* to analyze cases challenging the enforceability of these contracts (or the reasonableness of the price terms) as open price term cases. Because of the reference (or imputed reference) to the chargemaster, courts analyze these cases as contracts that incorporate pricing by reference to an external source. This, however, is fiction.

Whereas there is doctrinal inconsistency in how to approach service contracts that lack a price term more generally, the doctrine surrounding patient-provider contracts that lack a price has developed rather uniformly. Courts almost always enforce such contracts and allow hospitals to fill the price gap with the chargemaster rates for uninsured patients. As Professors Mark Hall and Carl Schneider have noted, "[C]ourts have generally tolerated low levels of specificity in medical contracts."[118] This means that even where contracts fail to specify a price for the services to be provided, courts find them enforceable.

Courts provide one primary reason: providers cannot know in advance what procedures will be necessary when a patient signs the contract obligating payment. The New Jersey District Court, in *DiCarlo v. St. Mary's Hospital*, explained:

> The price term "all charges" is certainly less precise than price term of the ordinary contract for goods or services in that it does not

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[116] *Doe*, 46 S.W.3d at 194 (noting the chargemaster contains confidential, proprietary information that patients cannot access); *see* Reinhardt, *supra* note 5, at 59 ("With the exception of California, which now requires hospitals to make their chargemasters public, hospitals are not required to post their chargemasters for public view."). The contractual reference to a chargemaster is therefore meaningless to a patient desiring to actually be informed of the price to which he or she is consenting.

[117] In the case of insured patients, the provider's price must be subject to the provider's negotiated rates with the insurance company.

[118] Hall & Schneider, *supra* note 41, at 674.

> specify an exact amount to be paid. It is, however, the only practical way in which the obligations of the patient to pay can be set forth, given the fact that nobody yet knows just what condition the patient has, and what treatments will be necessary to remedy what ails him or her.[119]

This reasoning is pervasive in court opinions[120] and is bolstered by the sentiment that it is reasonable to assume that whatever the cost, patients will be willing to pay for necessary treatment.[121]

Also common, although less so, is the concern that no entity other than the hospital could reasonably be tasked with supplying a rate *ex post* due to the complexity of both the underlying medicine and the market conditions that affect such rates. According to the *DiCarlo* court: "A court could not possibly determine what a 'reasonable charge' for hospital services would be without wading into the entire structure of providing hospital care and the means of dealing with hospital solvency."[122]

Courts do not seem to consider the possibility that providers may be required to provide a price (or a cost estimate) *ex ante*, perhaps because they do not believe it is possible to do so, or maybe because courts only decide these issues once a test or procedure has already occurred without price disclosure.

Finally, some courts may be concerned that providers may not agree to treat patients if providers are worried about later compensation.[123] "Patients'

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[119] *DiCarlo*, 530 F.3d at 264.

[120] *See, e.g.*, Shelton v. Duke Univ. Health Sys., Inc., 633 S.E.2d 113, 116 (N.C. Ct. App. 2006) ("It is common, almost expected, that a course of treatment embarked upon will, through unforeseen circumstances, be amended, altered, enhanced, or terminated altogether, and a completely new course of treatment begun. In light of this, it would be impossible for a hospital to fully and accurately estimate all of the treatments and costs for every patient before treatment has begun.").

[121] *Id.*; *see also* Allen v. Clarian Health Partners, Inc., 980 N.E.2d 306, 310 (Ind. 2012); Nolte v. Cedars Sinai Med. Ctr., 187 Cal. Rptr. 3d 737, 744 (Cal. Ct. App. 2015).

[122] *DiCarlo*, 530 F.3d at 264; *see also* Nygaard v. Sioux Valley Hosps. & Health Sys., 731 N.W.2d 184, 193 (S.D. 2007) (quoting Cox v. Athens Reg'l Med. Ctr., Inc., 631 S.E.2d 792, 797 (Ga. Ct. App. 2006) ("[I]n a hospital setting, it is not possible to know at the outset what the cost of the treatment will be, because it is not known what treatment will be medically necessary."). Courts do, however, engage in this analysis in other similar contexts. *See, e.g.*, RESTATEMENT (SECOND) OF CONTRACTS § 356(1) (AM. LAW INST. 1981) (requiring courts to assess reasonableness of liquidated damages); Kristin Harlow, *Applying the Reasonable Person Standard to Psychosis: How Tort Law Unfairly Burdens Adults with Mental Illness*, 68 OHIO ST. L.J. 1733, 1738 (2007) (describing the reasonable person standard of negligence law).

[123] *See generally* Hall, *supra* note 43, at 585–86 (discussing how the law views those who receive medical care more as patients than consumers).

and physicians' contractual obligations are forged in the context of someone who is sick and vulnerable seeking care in a therapeutic relationship that entails special responsibility for the patient's welfare."[124] If a physician must take on that burden, they must also be ensured payment.[125]

Most lawsuits that are brought challenging the enforceability of these contracts come from uninsured patients who argue that the chargemaster prices the hospital imputes are unreasonable. Presumably, insured patients do not often sue because even if the court finds that there is no enforceable contract, if the patient already had the procedure, the hospital would still be entitled to recovery in *quantum meruit* and the rate negotiated between the insurer and the provider would surely be a reasonable rate.[126]

The next Part discusses the practical implications of this doctrinal choice. The implicit permission that courts give to providers to charge patients only after they have consented to treatment impedes progress toward price transparency, both as to individual patient choices and as to the functioning of the market writ large.

II. INCOMPLETE CONTRACTS AND THE UNINFORMED PATIENT PROBLEM

That courts enforce contracts between patients and providers lacking price terms yields a number of significant, negative consequences. For instance, it squanders the potential of consumer-driven health care to repair market pricing and mitigate overtreatment. It also means that some patients will unwittingly continue to incur costs that they cannot afford, which creates negative systemic consequences.[127]

A. Moral Hazard in Health Care Increases Costs; Consumer-Driven Health Care Is Supposed to Fix the Problem

The United States significantly outspends all other industrialized, high-income nations in health spending. Yet the United States does worse in most

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[124] *Id.*

[125] *Id.* at 591.

[126] See *infra* Section IV.B.1 for a discussion of why insured patients should sue and how doctrine could incentivize providers to disclose rates *ex ante*.

[127] Without universal health care, there will always be patients who receive care they cannot pay for, but as section I.D.2 describes, lack of cost information exacerbates these problems.

measures of quality compared to peer countries.[128] Although some dispute the magnitude of the problem, few would argue that spending more for lower quality is a winning equation.[129] Health economists and policymakers have myriad theories for why the U.S. health-care market is so flawed.[130] One contributing factor that has generated a lot of attention, particularly in recent decades, is that insured patients have little incentive to make cost-conscious decisions because, to some extent, they are not spending their own money. Their monthly premiums are a sunk cost and they spend little out-of-pocket (at least historically) for the care they consume. Consumer-driven health care, which is an umbrella term referring to methods to make patients act more like traditional consumers entrusted with decision-making power, has emerged as a key industry solution.[131] As Republicans look to "repeal and replace" the ACA, consumer-driven health care is certain to grow in importance.[132]

Prior to the advent of health insurance, patients who sought medical care paid providers directly on a fee-for-service basis. Health insurance, largely a product of the middle to late twentieth century, changed the model.[133] Both

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[128] 155 CONG. REC. S11132-05 (daily ed. Nov. 5, 2009) (statement of Sen. Hagan) ("[T]he United States spends $2.3 trillion each year on health care—the most per capita of all industrialized nations. Yet we still have higher infant mortality and lower life expectancy than many of the other industrialized nations."). Some have argued that health care costs more in the United States because we are a wealthier country and are buying better quality, but data should disabuse us of that notion. *See* Adam Candeub, *Contract, Warranty, and the Patient Protection and Affordable Care Act*, 46 WAKE FOREST L. REV. 45, 51 (2011) ("There is little to no data linking total health care expenditures with positive health care outcomes . . . .").

[129] *See generally* David Squires & Chloe Anderson, *U.S. Health Care from a Global Perspective: Spending, Use of Services, Prices, and Health in 13 Countries*, COMMONWEALTH FUND, Oct. 2015, http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/oct/1819_squires_us_hlt_care_global_perspective_oecd_intl_brief_v3.pdf. The New England Institute of Health estimates nearly 30% of health care spending is due to overuse. JULES DELAUNE & WENDY EVERETT, NEW ENGLAND HEALTHCARE INST., WASTE & INEFFICIENCY IN THE U.S. HEALTH CARE SYSTEM 23 (2008), http://www.nehi.net/writable/publication_files/file/waste_clinical_care_report_final.pdf; *see also* Eve A. Kerr & John Z. Ayanian, *How to Stop the Overconsumption of Health Care*, HARV. BUS. REV. (Dec. 11, 2014), https://hbr.org/2014/12/how-to-stop-the-overconsumption-of-health-care ("[U]nnecessary, even harmful, services . . . represent about 10% of all U.S. health care spending—nearly $300 billion a year.").

[130] *See generally* Uwe Reinhardt, *The Many Different Prices Paid to Providers and the Flawed Theory of Cost Shifting: Is It Time for a More Rational All-Payer System?*, 30 HEALTH AFF. 2125, 2127 (2011) (discussing market imperfections in the health care market).

[131] *See, e.g.*, Hall, *supra* note 43, at 586–87; James C. Robinson & Paul B. Ginsburg, *Consumer-Driven Health Care: Promise and Performance*, 28 HEALTH AFF. 272, 272 (2009).

[132] Timothy Jost, *Examining the House Republican ACA Repeal and Replace Legislation*, HEALTH AFF. BLOG (Mar. 7, 2017), http://healthaffairs.org/blog/2017/03/07/examining-the-house-republican-aca-repeal-and-replace-legislation/.

[133] In 1940, less than 10% of the employed population had health insurance coverage. By 1955, that number had increased to nearly 70%, and further grew in the 1960s with the enactment of Medicare and Medicaid. *See* PETER R. KONGSTVEDT, ESSENTIALS OF MANAGED HEALTH CARE 5 (6th ed. 2013).

traditional private health insurance and government-sponsored health benefits were designed to cover most of the cost of an individual's incremental health care consumption. With private insurance, patients typically pay insurance companies fixed monthly premiums. These premiums entitle patients to coverage, which means that if they see a provider who is "in-network"—who has entered into a contract with the insurer—the patient incurs no (or very little) additional out-of-pocket expense for the care. These in-network providers are reimbursed by the insurance company on a fee-for-service basis[134] and the insurance company in turn sets patient premiums to account for the fees they pay to providers.[135]

Under this model, the purely economic incentives for physicians are to deliver as much high cost care as possible, increasing their personal compensation. Patients have little incentive to turn down costly care because their insurance premiums are a sunk cost, and they pay little to nothing for the office visits and treatments they receive that are covered by insurance. As a result, rational consumers purchase far more than the efficient level of health care services. This is often referred to as moral hazard.[136]

Unsurprisingly, these incentives have created an over-utilization problem in the United States.[137] Americans consume too much care known to provide minimal clinical benefit.[138] According to the Institute of Medicine, overtreatment—too many tests and too many procedures that do not improve health—is costing the United States at least $210 billion per year.[139]

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[134] For private insurers, the fee schedule is negotiated between the provider and the insured. Government insurers (e.g., Medicare and Medicaid) set payment rates for providers who agree to see those patients. *See* Michael E. Porter & Elizabeth Olmsted Teisberg, *Redefining Competition in Healthcare*, HARV. BUS. REV., June 2004, at 1, 5.

[135] Individual health care expenditures make premiums higher, but one individual's behavior does little to effect premium prices, so there is a collective action problem. *See, e.g.*, Robert D. Cooter & Neil S. Siegel, *Collective Action Federalism: A General Theory of Article I, Section 8*, 63 STAN. L. REV. 115, 144–50 (2010) (describing the collective action problem in health care).

[136] *See* Christopher Robertson, *The Split Benefit: The Painless Way to Put Skin Back in the Health Care Game*, 98 CORNELL L. REV. 921, 939 (2013). Although the insurer still negotiates rates.

[137] The tax laws also help to create an environment where patients spend more on health care than might be efficient. *See, e.g.*, Clark C. Havighurst & Barak D. Richman, *Distributive Injustice(s) in American Health Care*, 69 LAW & CONTEMP. PROBS. 7, 36 (2006).

[138] *See, e.g.*, Aaron L. Schwartz et al., *Measuring Low-Value Care in Medicare*, 174 JAMA INTERNAL MED. 1067 (2014) (discussing a study of Medicare claims data that found that in a single year, 42% of Medicare beneficiaries had received care known to provide minimal clinical benefit).

[139] *See* Annie Lowrey, *Study of U.S. Health Care System Finds Both Waste and Opportunity to Improve*, N.Y. TIMES (Sept. 11, 2012), http://www.nytimes.com/2012/09/12/health/policy/waste-and-promise-seen-in-us-health-care-system.html. Notably, those without insurance probably consume too little care. *Id.*

"Consumerism" has become a buzzword for free market aficionados.[140] The premise is basic economics: a patient who must spend more of his or her own money (rather than the insurance company's money)[141] should consume less care, particularly if it is unnecessary care.[142]

There are several ways to make patients act more like consumers in the economic sense. The first is to increase patient cost-sharing obligations through adding copays and co-insurance.[143] Both create an incremental cost to patients of consuming care. In theory, if a patient really needs to see a doctor, the patient will be willing to incur the cost, but if the office visit may not be necessary, the patient may hold off.[144]

The second way to make a patient act more like a consumer is by increasing deductibles, which are the amount a patient has to pay out-of-pocket before insurance benefits kick in.[145] Patients with high deductibles should be more cost conscious. Essentially, high deductibles make patients act more like uninsured patients until the deductible is met.[146]

A famous experiment conducted between November 1974 and January 1982—the RAND Health Insurance Experiment—provided support for the theory that increasing patient cost-sharing reduces health care spending.[147] The

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[140] Hall, *supra* note 43, at 586 (noting that consumer-driven principles have been discussed as early as the 1930s).

[141] *See id.* (describing the consumer-directed health-care movement); Robertson, *supra* note 136, at 946 (describing giving patients more "skin in the game" to deter costly consumption).

[142] *See, e.g.*, CLARK C. HAVIGHURST, HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM (1995). Lindsay F. Wiley notes that consumerism can reframe the health care market to a patients' rights model. Lindsay F. Wiley, *From Patient Rights to Health Justice: Securing the Public's Interest in Affordable, High-Quality Health Care*, 37 CARDOZO L. REV. 833, 851 (2016).

[143] Coinsurance is the "percentage of costs of a covered health care service you pay (20%, for example) after you've paid your deductible." *Coinsurance*, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/co-insurance/ (last visited Sept. 17, 2017).

[144] One criticism of the consumerism model is the reliance it yields to patients to make these sorts of decisions when patients generally are not well-educated in medical decision making.

[145] Ifrad Islam, *Trouble Ahead for High Deductible Health Plans?*, HEALTH AFF. BLOG (Oct. 7, 2015), http://healthaffairs.org/blog/2015/10/07/trouble-ahead-for-high-deductible-health-plans/ ("[O]ne motor driving cost control opportunity in high deductible plans is the empowerment of patients to make better choices about the medical care they seek.").

[146] A third, and most extreme option, is to take insurance out of the equation entirely. Uninsured patients are the most cost conscious of all. But this extreme choice prices many out of health care and is really at the fringe of what would be considered consumer-driven health care. *See, e.g.*, Timothy Stoltzfus Jost, *Is Health Insurance a Bad Idea? The Consumer-Driven Perspective*, 14 CONN. INS. L.J. 377, 379–80 (2008).

[147] *See* Robert H. Brook et al., RAND Corp., *The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate* 1, RAND HEALTH (2016), https://www.rand.org/pubs/research_briefs/RB9174.html.

study randomly assigned about 2,750 families in six U.S. cities to insurance plans with varying amounts of patient cost sharing.[148] It sought to assess whether cost sharing influenced overall spending and what the correlation was with health outcomes. It found that high deductible plans with high cost sharing led to much lower average spending—on average 25% to 30% less—than plans with no out-of-pocket expenses aside from the premiums.[149] In general, health outcomes were similar despite differences in health spending.[150]

The consumer-driven health-care movement first gained serious momentum with the passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[151] The Act provides tax incentives to those who enroll in consumer-driven health plans. So-called Consumer Driven Health Plans (CDHPs), which have dual features of a high deductible paired with a health savings account (HSA), grew exponentially with the passage of the law.[152] Proponents of these plans argued that the use of HSAs—which are consumer-controlled accounts and not fixed health insurance benefits—would ultimately foster market competition, which would in turn lower health care prices and stimulate improvements in service.[153]

Critics were concerned, however, that less wealthy and less educated patients would suffer under the new model. Less wealthy patients might avoid necessary health care because of the cost burden. And less educated patients might lack the ability to make informed, appropriate choices.[154] Even educated patients may have difficulty evaluating high value care because of the difficulty in obtaining quality data alongside pricing data. But even after the

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[148] *Id.*

[149] *Id.* at 2.

[150] A notable exception is that individuals of lower socioeconomic status saw greater improvements in high blood pressure and vision care with lower cost-sharing. *Id.* at 3.

[151] Pub. L. No. 108-173, 117 Stat. 2066 (2003); *see also* Wiley, *supra* note 142, at 851–52; Mark A. Hall & Clark C. Havighurst, *Reviving Managed Care with Health Savings Accounts*, 24 HEALTH AFF. 1490, 1491 (2005); *How Consumer-Directed Health Plans Work*, UNIV. WASH., http://hr.uw.edu/benefits/health-insurance/compare-plans/how-consumer-directed-health-plans-work/ (last visited Sept. 17, 2017).

[152] *See* 26 C.F.R. § 601.602 (Westlaw through 2017) (providing IRS definition of high-deductible plan); 26 U.S.C. § 223 (2006) (defining health savings account).

[153] *See* Juliana Darrow, Opinion, *Health Savings Accounts Essential to Build a Vibrant Healthcare System*, THE HILL (Mar. 10, 2017, 7:40 AM), http://thehill.com/blogs/pundits-blog/healthcare/323279-health-savings-accounts-essential-part-of-building-a-vibrant.

[154] *See* Ubel *et al.*, *supra* note 56, at 654.

ACA put some limits on these plans,[155] they have grown exponentially in popularity.[156]

A 2015 survey by the Kaiser Family Foundation found that in the employer-provided insurance market, almost one quarter of workers are now enrolled in a HDHP, up from 4% in 2006.[157] That number is even higher—almost 50%—for workers whose insurance plans have a general annual deductible of at least $1,000 for individual coverage.[158] In general, deductibles in employer-sponsored plans have increased 67% since 2010.[159] In the individual market, almost 90% of enrollees in a marketplace plan have a deductible above the level necessary to qualify as a HDHP.[160]

If one thing is clear, it is that techniques to make patients act more like consumers in making medical decisions are taking over the marketplace.[161] Even before repeal of the ACA became a policy focus, Professor Mark Hall called consumer-driven health care "the emerging centerpiece of health care policy."[162] It means that now even insured patients have reason to care about health care prices.

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[155] *See* 42 U.S.C. § 18071 (2012); *Out-of-Pocket Maximum/Limit*, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/ (last visited Sept. 17, 2017).

[156] Pat Tiberi, *Consumer Directed Health Plans with HSAs Are Growing in Popularity*, U.S. CONGRESS: JOINT ECON. COMMITTEE (Mar. 22, 2017), https://www.jec.senate.gov/public/index.cfm/republicans/2017/3/consumer-directed-health-plans-with-hsas-are-growing-in-popularity. Notably, even if you are a skeptic of consumer-driven health care, as many are, there are other very good reasons to want price transparency in the health care market. *See, e.g.*, Brown, *supra* note 5, at 104.

[157] KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TR., EMPLOYER HEALTH BENEFITS: 2015 ANNUAL SURVEY 1 (2015), http://files.kff.org/attachment/report-2015-employer-health-benefits-survey [hereinafter KAISER FAMILY FOUND.].

[158] *Id.* at 118. ("Over the last five years, the percentage of covered workers with a general annual deductible of $1,000 or more for single coverage has grown substantially, increasing from 27% to 46%."); Dolan, *supra* note 10.

[159] KAISER FAMILY FOUND., *supra* note 157, at 4.

[160] Dolan, *supra* note 10, at 1.

[161] *Id.*

[162] Hall, *supra* note 43, at 587; *see also* HERRICK & GOODMAN, *supra* note 5, at 9; *National Health Expenditures Data: Historical*, CMS.GOV, https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html (last visited Sept. 17, 2017) (noting United States health care spending rose by 5.8% in 2015).

B. Market-Based Reform Solutions Fail If Patients Do Not Know Prices

For consumer-driven market reform mechanisms to work, patients must know how much a procedure will cost before they consent to it.[163] They must be able to perform the cost-benefit analysis that cost-sharing presumes. More globally, price transparency is required if market competition is going to force improvements in the value of care offered. Perhaps not surprisingly, improving price transparency has been listed in almost every major expert's plan to reduce health costs—across the political spectrum.[164]

There are two ways in which larger patient cost-sharing obligations may reduce health-care costs. Patients may turn down unnecessary care, or they may price shop for better value[165] care.

Many studies have now found that patients with larger cost-sharing obligations or higher deductibles do reduce the amount of health care they consume[166] and do change their care habits in ways that reduce expenditures. For instance, patients reduce their use of brand name prescription drugs and visit the emergency room less frequently.[167]

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[163] Christopher T. Robertson & David V. Yokum, *Cost Sharing as Choice Architecture*, *in* NUDGING HEALTH: HEALTH LAW AND BEHAVIORAL ECONOMICS, at 146, 146–48 (I. Glenn Cohen et al. eds. 2016).

[164] Morgan A. Muir et al., *Clarifying Costs: Can Increased Price Transparency Reduce Healthcare Spending?*, 4 WM. & MARY POL'Y REV. 319, 320 (2013) (citing Ezekiel Emanuel et al., *A Systemic Approach to Containing Healthcare Spending*, NEW ENG. J. MED. (Aug. 1, 2012), http://www.nejm.org/doi/full/10.1056/NEJMsb1205901 ("In August 2012, several of the nation's top healthcare experts who helped write the Affordable Care Act (ACA) included 'price transparency' in an eleven-point plan to reduce health costs.")); *see supra* note 11; *see also* Judith H. Hibbard et al., *An Experiment Shows That a Well-Designed Report on Costs and Quality Can Help Consumers Choose High-Value Health Care*, 31 HEALTH AFF. 560 (2012).

[165] The term "value" is defined to mean health outcomes achieved per dollar spent and hence reflects cost relative to quality. *See* Michael E. Porter, *What Is Value in Health Care?*, 363 NEW ENG. J. MED. 2447, 2447 (2010).

[166] Dolan, *supra* note 10, at 3; Anna D. Sinaiko et al., *Cost-Sharing Obligations, High-Deductible Health Plan Growth, and Shopping for Health Care: Enrollees with Skin the Game*, 176 JAMA INTERNAL MED. 395, 395 (2016); Amelia M. Haviland et al., *Do "Consumer-Directed" Health Plans Bend the Cost Curve Over Time?* 3 (Nat'l Bureau of Econ. Research, Working Paper No. 21031, 2015), http://www.nber.org/papers/w21031.pdf. *But see* Michael Hiltzik, *The Myth of "Consumer-Driven Healthcare" Comes to Life Again*, L.A. TIMES (Dec. 14, 2015, 3:30 PM), http://www.latimes.com/business/hiltzik/la-fi-mh-the-myth-of-consumer-directed-healthcare-20151214-column.html.

[167] PAUL FRONSTIN, EMP. BENEFIT RESEARCH INST., WHAT DO WE REALLY KNOW ABOUT CONSUMER-DRIVEN HEALTH PLANS? 22 (2010), https://www.ebri.org/pdf/briefspdf/ebri_ib_08-2010_no345_cdhps.pdf (discussing a study finding that emergency room use declined under higher deductibles); Sinaiko et al., *supra* note 166, at 395 (finding that high deductible plans are associated with lower health care spending).

Consider the patient with clinically stable cancer who is asked to decide between a positron emission tomography (PET) scan ($6,000) and whole-body computerized tomography (CT) imaging ($1,000). The PET scan offers modest added accuracy. A patient responsible for 20% of the cost would have to pay an extra $1,000 out of pocket for the PET scan and may choose to go with the probably just as good CT scan instead.[168] Cost data may be particularly impactful in the area of preference-sensitive care, where clinical evidence does not clearly support one treatment option and patients are typically asked to decide treatment based on personal values.

More data is needed to assess the role that price transparency specifically plays in patient treatment choices.[169] It makes intuitive sense that knowing the (high) cost of a test or procedure makes it even more likely that a patient will opt out of the procedure if it is not really necessary. Studies have found that CDHPs reduce care consumption, but some show that reductions in use are relatively low magnitude.[170] Perhaps reduction in unnecessary care would be even more apparent paired with price transparency.

Nonetheless, there are concerns. With more price transparency, patients might turn down *necessary* care because of cost.[171] The preliminary evidence on this point is mixed. Some studies that have looked at health status implications of higher cost-sharing have found that health status is, for the most part, not affected, suggesting that necessary care continues to be delivered.[172] Others have, however, noted an adverse impact on low-income patients and those with chronic conditions.[173] If price information is provided

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[168] This hypothetical is based on Peter Ubel's depiction of Rosemary Myers's cancer treatment story. *See* Ubel, *supra* note 12.

[169] For a start, see Ethan M.J. Lieber, *Does It Pay to Know Prices in Health Care?*, 9 AM. ECON. J.: ECON. POL'Y 154, 154–55 (2017) (showing that price transparency reduced average prices paid for health care).

[170] *See generally* J. Frank Wharam et al., *Emergency Department Use and Subsequent Hospitalizations Among Members of a High-Deductible Health Plan*, 297 JAMA 1093 (2007).

[171] This possibility is particularly problematic if low-income patients are disproportionately drawn to high-deductible plans because of lower premium costs.

[172] RACHEL EFFROS, RAND CORP., INCREASE COST-PARTICIPATION BY EMPLOYEES (E.G., THROUGH HIGH-DEDUCTIBLE HEALTH PLANS) (2009), https://www.rand.org/pubs/technical_reports/TR562z4.html (finding that HDHPs reduce effective and less effective care, but with no measurable impact on health status for most patients).

[173] *See, e.g.*, Amitabh Chandra et al., *The Impact of Patient Cost-Sharing on Low-Income Populations: Evidence from Massachusetts*, 33 J. HEALTH ECON. 57, 57–58 (2014) (finding that some low-income patients subject to higher cost-sharing cut back on use entirely). In general, there are difficulties associated with counting on patients to make medical decisions that are in their own best interests. *See, e.g.*, Wendy Netter Epstein, *Nudging Patient Decision Making*, 92 WASH. L. REV. (forthcoming 2017) (manuscript at 2) (on file

and comparative quality information is unavailable, there is a risk that patients will over-emphasize price in the decision calculus. In other words, policymakers would not want patients to make decisions based *solely* on price.

These concerns are real and deserve additional study. Indeed, the problem of how to provide patients with salient quality data is already receiving much attention from policymakers, and progress is being made.[174] But a key piece of the consumer-driven argument is that patients have not been cost-sensitive because of moral hazard, and making them bear more cost will prompt patients to turn down unnecessary care. If patients do not know cost, that simply will not happen.[175]

Experts also believe that patients who have pricing information will be able to shop around to find higher-value (lower-cost and higher-quality) care. Preliminary data also supports this hypothesis. For instance, a recent study found that patients who researched (and obtained) pricing information spent less on average on their care than those who did not.[176]

There is much concern among policymakers that this point is overstated because patients are not price sensitive when it comes to health care.[177] At least some evidence, however, seems to counsel otherwise. We know that patients do "shop" for the price of health-care procedures because they become medical tourists, jumping through major hurdles to travel to other countries to have procedures at a lower cost than they could have those procedures in the United States.[178]

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with author); Ubel et al., *supra* note 56, at 660 (noting that there needs to be a happy medium between patient decision and physician engagement).

[174] *See, e.g.*, CTRS. FOR MEDICARE & MEDICAID SERVS., CMS QUALITY STRATEGY (2016), https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/CMS-Quality-Strategy.pdf; *Physician Compare*, MEDICARE.GOV, https://www.medicare.gov/physiciancompare/ (last visited Sept. 18, 2017).

[175] *See* Peter A. Ubel et al., *supra* note 56, at 655.

[176] Christopher Whaley et al., *Association Between Availability of Health Service Prices and Payments for These Services*, 312 JAMA 1670, 1674–75 (2014); *see also* Andrew M. Seaman, *Knowing Prices Tied to Lower Healthcare Spending*, REUTERS, Oct. 23, 2014, http://www.reuters.com/article/us-healthcare-costs-spending-idUSKCN0IC2K420141023 (discussing Whaley et al.'s research).

[177] Some data supports this concern. *See, e.g.*, Jason Shafrin, *Is Health Care Demand Elastic?*, HEALTHCARE ECONOMIST (July 22, 2009), http://healthcare-economist.com/2009/07/22/is-health-care-demand-elastic/.

[178] *See generally* I. Glenn Cohen, *Protecting Patients with Passports: Medical Tourism and the Patient-Protective Argument*, 95 IOWA L. REV. 1467, 1472–73 (2010) ("For U.S. patients, medical tourism promises significant cost savings."); I. Glenn Cohen, *Transplant Tourism: The Ethics and Regulation of International Markets for Organs*, 41 J.L. MED. & ETHICS 269, 269 (2013) (noting patients travel internationally for

The cosmetic surgery market provides an interesting data point as well. Cosmetic procedures are only provided to those who can pay. In contrast to the rest of the health-care market, prices *are* typically provided in advance. The market for cosmetic surgery seems to function much more as a typical economic market than the market for the rest of health care. From 1992 through 2001, the consumer price index rose 26%, and in comparison, costs for medical services rose 47%. Costs for cosmetic surgery increased only 16%.[179] While there may be many other reasons that costs have risen more slowly, including the elective nature of cosmetic surgery, it at least suggests that there is price pressure in a market with price transparency.[180]

Another concern is that price transparency will not prompt comparison shopping because quality data is hard to obtain and patients may equate higher prices with higher quality.[181] Again, evidence is somewhat mixed. But at least some studies, including a recent Robert Wood Johnson Foundation and Public Agenda survey, found that patients do not correlate high prices with better medical care.[182]

Price transparency is not only a necessary component in influencing individual patient behavior. Market reform proponents also look to transparency to improve the health-care market more generally.[183] In other words, even if price transparency does not affect the choices of each individual patient, improving price transparency should produce a public good in bringing prices down to competitive levels.[184]

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treatment). Much is unknown about price sensitivity. It may be that the stage IV cancer patient is not terribly price sensitive, but those consenting to either elective or more routine procedures would be.

[179] Kenneth T. Bowden, *Determining a Reasonable Price for Health Care in the United States: Is This Possible?*, 34 BRIEF 26, 27 (2005); *see also* Devon Herrick, *Why Health Costs Are Still Rising*, NAT'L CTR. POL'Y ANALYSIS (Nov. 18, 2010), www.ncpa.org/pub/ba731.

[180] HERRICK & GOODMAN, *supra* note 5; Mark J. Perry, *What Economic Lessons About Medical Costs Can We Learn from the Market for Cosmetic Procedures?*, AEIDEAS (Mar. 12, 2016, 9:37 AM), https://www.aei.org/publication/what-economic-lessons-about-medical-costs-can-we-learn-from-the-market-for-cosmetic-procedures/.

[181] *See* Marina N. Bolotnikova, *The Changing Consensus on Healthcare Cost-Sharing*, HARV. MAG. (May 4, 2016), http://harvardmagazine.com/2016/05/harvard-medical-study-price-comparison-health-care-prices (noting that "[p]atients may also be skeptical of lower-cost care, (even though research has shown little relationship between cost and quality)," but nonetheless calling price transparency a "piece of the puzzle"); *see also* Sunita Desai et al., *Association Between Availability of a Price Transparency Tool and Outpatient Spending*, 315 JAMA 1874 (2016).

[182] *See* PUB. AGENDA, HOW MUCH WILL IT COST?: HOW AMERICANS USE PRICES IN HEALTH CARE 2, (2015), http://www.publicagenda.org/pages/how-much-will-it-cost.

[183] Richman et al., *supra* note 62.

[184] *Id.*

Currently, there is a vast pricing spectrum in the American health-care market that does not clearly correlate with quality differences (or with market cost differentials).[185] For instance, one study found that low-risk births could range in cost from $1,189 to $11,986 just for the hospital facilities (hospital room and supplies).[186] More expensive cities do not necessarily have higher health-care prices than less expensive ones.[187] Part of the cause may be lack of price transparency.[188] Indeed, one study estimates that the system's lack of price transparency adds about $36 billion in system-wide costs each year.[189]

There is also a vast differential between rates charged to insured patients and those charged to uninsured patients for the same procedures. This has been flagged for years as a market failure that is highly problematic.[190] Policymakers believe that price transparency has the possibility to remedy the problem, at least in part.[191] But the current model, in which providers have only limited legislative pressure to make any sort of price disclosures,[192] makes it highly unlikely that market improvements will happen.

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[185] Zack Cooper et al., *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, HEALTH CARE PRICING PROJECT 5, 11, 21 (2015), http://www.healthcarepricingproject.org/sites/default/files/pricing_variation_manuscript_0.pdf.

[186] Xiao Xu et al., *Wide Variation Found in Hospital Facility Costs for Maternity Stays Involving Low-Risk Childbirth*, 34 HEALTH AFF. 1212, 1214 (2015).

[187] *See generally* Alison Kodjak, *That Surgery Might Cost You a Lot Less in Another Town*, NPR (Apr. 27, 2016, 4:20 PM), http://www.npr.org/sections/health-shots/2016/04/27/475880565/that-surgery-might-cost-you-a-lot-less-in-another-town. In general, the health care market is flawed. *Id.*

[188] *See, e.g.*, Gail R. Wilensky, *Consumer-Driven Health Plans: Early Evidence and Potential Impact on Hospitals*, 25 HEALTH AFF. 174, 176, 183–84 (2006). Note, however, that the biggest driver of price variations may be the market power of the provider. *See, e.g.*, OFFICE OF ATTORNEY GEN. MARTHA COAKLEY, EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS PURSUANT TO G.L. C. 118G, § 6½ (b) 1–5, 27, 43–44 (2010), http://www.mahp.com/assets/pdfs/attorney-general-report.pdf.

[189] Bobbi Coluni, *Save $36 Billion in U.S. Healthcare Spending Through Price Transparency*, THOMSON REUTERS 1–2 (Feb. 2012), http://64.64.16.103/wp-content/uploads/2012/12/thomsonreuters_savings_from_price_transparency.pdf. Interestingly, this has not in itself spurred hospital disclosure of price.

[190] Glenn A. Melnick & Katya Fonkych, *Hospital Pricing and the Uninsured: Do the Uninsured Pay Higher Prices?*, 27 HEALTH AFF. 116, 119 (2008) (describing how uninsured patients pay higher prices than insured patients).

[191] The imbalance in power between providers and uninsured patients will, however, continue to exist even if pricing is disclosed, and insurance companies will still be able to negotiate better rates than individuals. It would be progress, however, if the gap could at least be narrowed.

[192] Russ Mitchell, *29 States Get F on Disclosure Laws for Health Care Prices*, NPR (Mar. 18, 2013, 4:26 PM), http://www.npr.org/sections/health-shots/2013/03/18/174660050/29-states-get-f-on-disclosure-laws-for-health-care-prices.

C. Unexpected Medical Bills Contribute to High Personal Bankruptcy Rates and Unrecoverable Hospital Debt

Other undesirable results follow from price opacity. Americans who receive unexpected medical bills are more likely to file for bankruptcy, and hospitals have heavy unrecoverable debt loads, increasing systemic costs.

An uninsured patient may receive an unexpected medical bill because she is surprised by hospital chargemaster (or physician) rates.[193] Insured patients can also receive unexpected bills that they must pay. Balance billing, for instance, occurs when a patient sees an out-of-network provider not bound to the negotiated in-network billing rates.[194] That out-of-network provider can, generally speaking, bill the patient for the part of the total cost that the insurer does not cover. For example, assume that the hospital bills $2,000, but the rate that insurance pays is $800, and a patient's plan only covers 50% of out-of-network care. A patient might assume that insurance will pay $400 and the patient will then owe $400. But really the patient will likely be billed $1,600 (which is $2,000 less the $400 that insurance paid). Patients often do not know when they are receiving care from out-of-network physicians (e.g., an out-of-network physician who assists on a surgery) and often do not know the chargemaster rate before consenting.[195]

Some states have passed legislation that prevents some of these practices.[196] But balance billing is still quite common. "An estimated 1 in 3 American adults with private health insurance falls victim every two years to

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[193] *See, e.g.*, Michael Winerip, *Set Back by Recession, and Shut Out of Rebound*, N.Y. TIMES (Aug. 26, 2013), http://www.nytimes.com/2013/08/27/booming/for-laid-off-older-workers-age-bias-is-pervasive.html (describing the case of a former corporate executive who lost his insurance upon job termination and incurred over $171,000 in medical bills for a six-night hospital stay); *see generally* LIZ HAMEL ET AL., KAISER FAMILY FOUND., THE BURDEN OF MEDICAL DEBT: RESULTS FROM THE KAISER FAMILY FOUNDATION / *NEW YORK TIMES* MEDICAL SURVEY, SECTION 1: WHO HAS MEDICAL BILL PROBLEMS AND WHAT ARE THE CONTRIBUTING FACTORS (2016), http://kff.org/report-section/the-burden-of-medical-debt-section-1-who-has-medical-bill-problems-and-what-are-the-contributing-factors/ (noting that 53% of uninsured have difficulty paying bills and two-thirds of those report that the bills resulted from one-time or short-term medical expense).

[194] Erin C. Fuse Brown, *Resurrecting Health Care Rate Regulation*, 67 HASTINGS L.J. 85, 125 (2015).

[195] *See* Haley Sweetland Edwards, *The Hidden Cost of "Surprise" Medical Bills*, TIME (Mar. 3, 2016), http://time.com/4246077/medical-bills-hidden-cost/; Elisabeth Rosenthal, *After Surgery, Surprise $117,000 Medical Bill from Doctor He Didn't Know*, N.Y. TIMES (Sept. 20, 2014), http://www.nytimes.com/2014/09/21/us/drive-by-doctoring-surprise-medical-bills.html?_r=1.

[196] New York recently enacted legislation protecting patients against "surprise billing" in emergency room services. *See* N.Y. PUB. HEALTH § 24 (McKinney 2015). Other states including California, Texas, and Colorado have done the same, but problems persist. Olga Khazan, *The Agony of Medical Bills*, THE ATLANTIC (May 21, 2015), http://www.theatlantic.com/health/archive/2015/05/the-agony-of-surprise-medical-bills/393785/.

what are known, aptly, as 'surprise medical bills,' according to a 2015 survey by Consumer Reports."[197]

Insured patients may also be surprised by medical bills they receive for in-network services that they must pay in full before meeting their (frequently high) deductibles. While these bills reflect a negotiated rate for in-network providers, many patients are still unaware of the impact of their high-deductible insurance plans. A 2014 study found that 63% of American adults had received medical bills that cost more than they anticipated.[198]

Perhaps it is unsurprising that unpaid medical bills are the primary cause of U.S. bankruptcies, outpacing credit-card bills or late mortgage payments.[199] And bankruptcy filers tend to be individuals who are insured and who are not chronically disadvantaged. Many would be considered middle class by income standards.[200] Even outside of the bankruptcy context, there is much evidence of medical indebtedness, including among insured patients.[201]

Patients who do not know the cost of medical procedures cannot make good financial decisions about seeking that care before they experience the negative impact of crushing medical bills. While some spending beyond means is unavoidable in a system without universal health-care coverage, and some

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[197] Edwards, *supra* note 195. A related problem is that patients unintentionally receive a type of medical device or drug that their insurance company does not cover—also resulting in an unanticipated, high bill. *Id.*

[198] Christina Lamontagne, *NerdWallet Health Study: Medical Debt Crisis Worsening Despite Policy Advances*, NERDWALLET (Oct. 8, 2014), https://www.nerdwallet.com/blog/health/managing-medical-bills/medical-bills-debt-crisis/.

[199] Daniel A. Austin, *Medical Debt as a Cause of Consumer Bankruptcy*, 67 ME. L. REV. 1, 2, 21–22 (2014) (noting that medical debt is the predominant factor in 18% to 26% of all bankruptcies); *see* David U. Himmelstein et al., *Marketwatch: Illness and Injury as Contributors to Bankruptcy*, HEALTH AFF. W5–63, W5-66–67 (Feb. 2, 2005), http://content.healthaffairs.org/content/early/2005/02/02/hlthaff.w5.63.full.pdf+html, David U. Himmelstein et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED. 741, 741, 744–45 (2009); Christopher Tarver Robertson et al., *Get Sick, Get Out: The Medical Causes of Home Mortgage Foreclosures*, 18 HEALTH MATRIX 65, 90–94 (2008). Note that this finding is not without controversy. *See, e.g.*, Megan McArdle, Opinion, *The Myth of the Medical Bankruptcy*, BLOOMBERG VIEW (Jan. 17, 2017, 8:46 AM), https://www.bloomberg.com/view/articles/2017-01-17/the-myth-of-the-medical-bankruptcy.

[200] Melissa B. Jacoby & Elizabeth Warren, *Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress*, 100 NW. U. L. REV. 535, 552 (2006) ("Our study of bankruptcy filers, however, reveals that *it is common for people with health insurance to develop medical-related financial problems*." (emphasis added)).

[201] *Id.* at 553–54 (noting that several studies "have observed significant financial vulnerability and medical indebtedness" among both insured and uninsured patients); KAREN POLLITZ ET AL., KAISER FAMILY FOUND., MEDICAL DEBT AMONG PEOPLE WITH HEALTH INSURANCE (2014), http://kff.org/private-insurance/report/medical-debt-among-people-with-health-insurance/.

patients would continue to make poor decisions even with disclosure,[202] lack of price transparency almost certainly exacerbates the problem.

Relatedly, when patients consent to care that they ultimately cannot afford, they leave hospitals with high rates of unrecoverable debt. Uninsured patients contribute to the problem, but co-pays and deductibles among insured patients can also be a significant part of a hospital's bad debt.[203] In 2014, community hospitals provided $42.8 billion in uncompensated care.[204] Two-thirds of the costs that hospitals bill to patients are not recovered.[205]

While there is some public funding to reimburse hospitals,[206] the effect on the overall system is still higher health-care costs. When patients consent to procedures without knowing the price, a host of negative consequences follow, from personal financial ramifications to larger systemic problems.

The next Part explains how these issues are really ones of incomplete contracts. The vast incomplete-contracts literature, which addresses the benefits and challenges of the strategic use of incompleteness in drafting, should inform doctrinal choices. In health care, theory suggests that the use of incomplete contracting mechanisms is likely a poor fit with systemic goals.

III. CONTRACT THEORY AND THE INCOMPLETE CONTRACTING PARADIGM

Open price term contracts are one type of a larger category of "incomplete contracts."[207] Incomplete contracts—which range from those that are missing material terms to those that do not anticipate contingencies or address possible

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[202] Epstein, *supra* note 173 (manuscript at 38); Susanna Kim Ripken, *The Dangers and Drawbacks of the Disclosure Antidote: Toward a More Substantive Approach to Securities Regulation*, 58 BAYLOR L. REV. 139, 160–61 (2006) (noting that information overload can result in poorer decision making); Peter Ubel, *How Price Transparency Could End Up Increasing Health-Care Costs*, ATLANTIC (Apr. 9, 2013), http://www.theatlantic.com/health/archive/2013/04/how-price-transparency-could-end-up-increasing-health-care-costs/274534/ (arguing that patients will unreasonably equate higher costs with better quality).

[203] Jacoby & Warren, *supra* note 200, at 553–54.

[204] This number includes both their cost of bad debt and charity care. *Uncompensated Hospital Care Cost Fact Sheet*, AM. HOSP. ASS'N 1, 2–3, (2016), http://www.aha.org/content/16/uncompensatedcarefactsheet.pdf.

[205] *Id.*

[206] TERESA A. COUGHLIN ET AL., KAISER FAMILY FOUND., UNCOMPENSATED CARE FOR THE UNINSURED IN 2013: A DETAILED EXAMINATION (2014), http://kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination/.

[207] *See generally* Scott, *supra* note 16, at 1643–45.

future states of the world, among other categories—[208] have been the focus of intense scholarly inquiry over the last several decades.[209]

Scholars wonder what motivates incompleteness. A contract may be *un*intentionally incomplete due to negligence or laziness,[210] or a contract may be intentionally incomplete.[211] Perhaps the parties failed to agree to terms or rationally assessed the costs in detailing the contract *ex ante* and chose not to bear those costs.[212] Better-informed parties may have chosen to leave a contract incomplete for the purpose of withholding information from a less-informed transacting partner,[213] or parties may have left contracts incomplete as a conscious choice to build relational capital.[214]

Just as scholars have queried why parties choose relative completeness or incompleteness, they have also pondered when incompleteness is desirable and when it is undesirable.[215] Because the law gives incentives to parties in their drafting choices, the difficult task of distinguishing good incompleteness from bad incompleteness is particularly important to legal doctrine.

A. Theories of Incomplete Contracts

There are many variables that affect the efficiency and general desirability of contractual incompleteness. The law and economics account focuses on transaction costs.[216] The behavioral science literature focuses on the effect of drafting choices on party behavior and motivation.[217] To a large extent, these

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[208] *Id.* at 1641 ("All contracts are incomplete. There are infinite states of the world and the capacities of contracting parties to condition their future performance on each possible state are finite.").

[209] *See, e.g.*, Ayres & Gertner, supra note 16, at 92–94; Scott, *supra* note 16, at 1644–45.

[210] *See, e.g.*, Gregory M. Duhl, *Conscious Ambiguity: Slaying Cerberus in the Interpretation of Contractual Inconsistencies*, 71 U. PITT. L. REV. 71, 76 n.29 (2009) ("Of course, sloppiness is another cause of ambiguous drafting.").

[211] Robert E. Scott, *The Law and Economics of Incomplete Contracts*, 2 ANN. REV. L. & SOC. SCI. 279, 280 (2006).

[212] *See, e.g.*, Scott, *supra* note 16, at 1642.

[213] *See, e.g.*, Ian Ayres & Robert Gertner, *Strategic Contractual Inefficiency and the Optimal Choice of Legal Rules*, 101 YALE L.J. 729, 760 (1992).

[214] *See, e.g.*, Epstein, *supra* note 20, at 300–02; Florian Herold, *Contractual Incompleteness as a Signal of Trust*, 68 GAMES & ECON. BEHAV. 180, 181 (2010).

[215] Epstein, *supra* note 20, at 300–02; Epstein, *supra* note 72, at 28; Ronald J. Gilson et al., *Contracting for Innovation: Vertical Disintegration and Interfirm Collaboration*, 109 COLUM. L. REV. 431, 451 (2009); Scott, *supra* note 16, at 1644–45.

[216] *See* Ayres & Gernter, *supra* note 213.

[217] *See, e.g.*, Bruno S. Frey & Reto Jegen, *Motivation Crowding Theory*, 15 J. ECON. SURVS. 589, 590 (2001).

literatures exist side by side, and very little attempt has been made to build bridges between them.[218]

In the traditional law and economics account, "the complete contingent contract that specifies the obligations of the parties in each possible future state of the world" is the gold standard.[219] More specifically, transaction costs motivate the decision about how complete of a contract to draft. Parties must expend resources to draft a contract. Drafting a more detailed contract generally means spending more resources. But in the law and economics depiction, a detailed contract dissuades parties from acting opportunistically during contract performance, reduces the likelihood that litigation will ensue, and reduces the cost of litigation if it does occur.[220]

Whether it is efficient to bear the cost of detailed drafting can be determined by a cost-benefit analysis.[221] When the cost of detailed drafting is less than expected gains, detailed drafting is the efficient choice.[222] In most situations, this is assumed to be the case.[223] There may be situations in which it is costly to detail the contract because of how complicated the deal is or how uncertain future states of the world are. Then, it may be more efficient to draft a more *in*complete contract. There may also be other reasons, such as reputational sanctions[224] or operating within a network[225] that make litigation

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[218] *See* Alan Schwartz & Robert E. Scott, *Contract Theory and the Limits of Contract Law*, 113 YALE L.J. 541, 549 (2003).

[219] George G. Triantis, *The Efficiency of Vague Contract Terms: A Response to the Schwartz-Scott Theory of UCC Article 2*, 62 LA. L. REV. 1065, 1068 (2002).

[220] Ayres & Gertner, supra note 16, at 92–93.

[221] Judge Richard Posner is the most prominent supporter of this view. *See* ANTHONY T. KRONMAN & RICHARD A. POSNER, THE ECONOMICS OF CONTRACT LAW 1–7 (1979); RICHARD A. POSNER, ECONOMIC ANALYSIS OF LAW 12–16 (4th ed. 1992); *see also* Ayres & Gertner, supra note 16, at 92 ("Scholars have primarily attributed incompleteness to the costs of contracting."); Adam B. Badawi, *Interpretive Preferences and the Limits of the New Formalism*, 6 BERKELEY BUS. L.J. 1, 25 (2009) (noting that in the traditional view, detailed drafting increases the certainty that the judiciary will get it right in litigation).

[222] *See, e.g.*, Keith J. Crocker & Kenneth J. Reynolds, *The Efficiency of Incomplete Contracts: An Empirical Analysis of Air Force Engine Procurement*, 24 RAND J. ECON. 126, 135 (1993) (noting that parties incorporate the potential for future disputes into their contracting).

[223] Louis Kaplow & Steven Shavell, *Fairness Versus Welfare*, 114 HARV. L. REV. 961, 1135 (2001). For two parties to reach an optimally efficient agreement, information asymmetries may need to be mitigated. *See, e.g.*, Eric H. Franklin, *Mandating Precontractual Disclosure*, 67 U. MIAMI L. REV. 553, 563 (2013).

[224] Claire A. Hill, *Bargaining in the Shadow of the Lawsuit: A Social Norms Theory of Incomplete Contracts*, 34 DEL. J. CORP. L. 191, 212–16 (2009).

[225] *See* Lisa Bernstein, *Beyond Relational Contracts: Social Capital and Network Governance in Procurement Contracts*, 7 J. LEGAL ANALYSIS 561, 563 (2015).

and opportunism unlikely, in which case there might be little reason to bear the cost of contract specification.[226]

The law and economics account of incomplete contracts is based on certain assumptions. For instance, given contractual ambiguity, it assumes parties will act opportunistically in their own self-interests.[227] In addition, it assumes that detailed drafting prompts desirable compliance. However, the behavioral literature has tested these assumptions and found that individual behavior often deviates from the model.[228]

First, in terms of cognitive effects, there is solid evidence suggesting that detailed drafting can prompt compliance.[229] However, there is also evidence that specification causes agents to focus on what is enumerated in the contract, sacrificing the larger goals of the endeavor; for example, an agent might comply with each item on a checklist with little regard for delivering an overall quality service.[230] Specification hampers the exercise of discretion, and, for this reason, it is important to distinguish between situations in which simple contractual compliance is the goal from those in which something more is needed.[231]

Second, detail can sometimes motivate agents, but it can also signal distrust and hamper cooperation and collaboration. Some studies have found that specific, challenging goals make agents desire to perform better and exert higher levels of effort.[232] But many studies have also found that task specificity

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[226] Even so, parties may still choose to draft detailed governance documents. *See id.*

[227] Deepak Malhotra & J. Keith Murnighan, *The Effects of Contracts on Interpersonal Trust*, 47 ADMIN. SCI. Q. 534, 534–59 (2002).

[228] *See, e.g.*, Daniel Kahneman & Amos Tversky, *Prospect Theory: An Analysis of Decision Under Risk*, 47 ECONOMETRICA 263, 284–86 (1979); Richard Thaler, *Toward a Positive Theory of Consumer Choice*, 1 J. ECON. BEHAV. & ORG. 39, 39 (1980); Amos Tversky & Daniel Kahneman, *The Framing of Decisions and the Psychology of Choice*, 211 SCI. 453, 457–58 (1981).

[229] *See, e.g.*, Erik A. Mooi & Mrinal Ghosh, *Contract Specificity and Its Performance Implications*, J. MARKETING, Mar. 2010, at 105, 106; Kenneth H. Wathne & Jan B. Heide, *Opportunism in Interfirm Relationships: Forms, Outcomes, and Solutions*, J. MARKETING, Oct. 2000, at 36, 48.

[230] Eileen Y. Chou et al., *The Goldilocks Contract: The Synergistic Benefits of Combining Structure and Autonomy for Persistence, Creativity, and Cooperation*, 113 J. PERSONALITY & SOC. PSYCHOL. 393, 397 (2017); *see also* Laura Poppo & Todd Zenger, *Do Formal Contracts and Relational Governance Function as Substitutes or Complements?*, 23 STRATEGIC MGMT. J. 707, 708, 711 (2002) (discussing the importance of lack of specificity to increase trust); Armin Falk & Michael Kosfeld, *The Hidden Costs of Control*, 96 AM. ECON. REV. 1611, 1611 (2006).

[231] Epstein, *supra* note 20, at 318.

[232] *See* Gerard H. Seijts & Gary P. Latham, *The Effect of Distal Learning, Outcome, and Proximal Goals on a Moderately Complex Task*, 22 J. ORGANIZATIONAL BEHAV. 291, 302, 304 (2001).

can signal distrust and crowd out rapport and cooperation.[233] It can also dampen an agent's intrinsic desire to perform well.[234] In particular, task specification has been shown to decrease motivation when the task is complex.[235]

Whereas the law and economics literature tends to favor completeness in drafting,[236] much of the behavioral literature touts the virtues of incompleteness.[237] But it does not necessarily consider the types of costs on which the law and economics literature is so focused.

The next section attempts to synthesize these two seemingly disparate literatures. It suggests an analytical tool to differentiate between situations when contractual completeness is desired from when it is not.

B. An Analytical Framework for Judging Desirability of Completeness

Incompleteness exists on a spectrum. No contract can be entirely *in*complete or there would be nothing to enforce, and no contract can be entirely complete because no two parties could ever fully anticipate every future state of the world.[238] Some agreements are better off being toward one end of the spectrum or another. Drawing on the literature, I suggest a balancing test of three factors to help courts determine if, in any particular set of circumstances, more complete or incomplete contracting is desirable. This

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[233] *See* Eileen Y. Chou et al., The Relational Costs of Complete Contracts 4 (June 25, 2011) (unpublished manuscript), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1872569 (noting that complete contracts can discourage cooperation).

[234] In a famous study testing the motivational effects of implicit versus explicit contracts, Fehr and Gächter found that principals who chose the explicit contract lost on average nine tokens per contract, compared to a profit of twenty-six tokens per implicit contract and that the difference was attributable to effort levels. Ernst Fehr & Simon Gächter, *Fairness and Retaliation: The Economics of Reciprocity*, J. ECON. PERSP., Summer 2000, at 159, 177; *see also* Ernst Fehr et al., *Reciprocity as a Contract Enforcement Device: Experimental Evidence*, 65 ECONOMETRICA 833, 833 (1997).

[235] *See* Nicholas S. Argyres et al., *Complementarity and Evolution of Contractual Provisions: An Empirical Study of I.T. Services Contracts*, 18 ORG. SCI. 3, 15 (2007).

[236] Notably, however, prominent law and economics scholars have started to accept that different contexts might merit different doctrinal treatment. *See, e.g.*, Ronald J. Gilson et al., *Text* and *Context: Contract Interpretation as Contract Design*, 100 CORNELL L. REV. 23, 75 (2014) (arguing for literalism in interpreting contracts between two sophisticated parties and contextualism for contracts between novices); Lawrence A. Cunningham, *Contextualism in Contract Interpretation: Doctrine, Debate, and Beyond*, 85 GEO. WASH. L. REV. (2017) (compiling work).

[237] Indeed, I have written before about circumstances in which relative incompleteness is likely to engender better results than more complete drafting. *See* Epstein, *supra* 20, at 313.

[238] Scott, *supra* note 211, at 280.

Article suggests an analytical framework that accounts for both the law and economics and behavioral sciences findings.

The first factor concerns transaction costs. When a party would incur only low transaction costs to detail a contract, a court should be more likely to require a detailed contract. When transaction costs for detailing would be high, a court should be less apt to require a more complete contract. Transaction costs will tend to be highest when the subject matter is particularly complex, where the future is highly uncertain, or both. For instance, a simple sales transaction for the sale of a widget would not be costly to detail. On the other hand, a multi-year contract for innovation in which the product does not yet exist would be much costlier to detail. All else being equal, when transaction costs for detailing a contract are high, contractual completeness becomes less desirable.

The second factor requires an assessment of information asymmetry. When one party has ready access to information that the other party does not, often a more efficient contract can be designed when the information is disclosed. This factor does not necessarily consider the costs or incentives for the information-bearer to acquire the information. But, in general, when the more sophisticated party is a repeat player and has access to better information than the less sophisticated party, a more efficient contract will result when that information is disclosed through more complete drafting.[239] The typical example, here, stems from the insurance context. Doctrine encourages sophisticated insurers to share information about coverage with less sophisticated insureds.[240] High degrees of information asymmetry suggest more detailed contracts being desirable.[241]

The third factor concerns the extent to which a deal requires trust and cooperation to develop between the parties. Less complete contracts have been shown to build relational capital.[242] But context matters. For instance, for some contracts, the main goal is compliance. Consider again the sale of the widget. The parties expect that each will simply comply with the terms—for the seller to sell the widget to the buyer at the agreed upon date and time for the agreed

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[239] Ayres & Gertner, *supra* note 16, at 97; Ian Ayres & Robert Gertner, *Majoritarian vs. Minoritarian Defaults*, 51 STAN. L. REV. 1591, 1592 (1999); Shmuel I. Becher, *Asymmetric Information in Consumer Contracts: The Challenge That Is Yet to Be Met*, 45 AM. BUS. L.J. 723, 733 (2008).

[240] *See* Epstein, *supra* note 20, at 323 (2014) (discussing the doctrine of contra proferentem—construe against the drafter).

[241] *See* Ayres & Gertner, *supra* note 213, at 735–36.

[242] *See* Chou et al., *supra* note 233, at 4.

upon price. There is little need for trust to develop or for the parties to learn to collaborate. Building relational capital is low priority. On the other hand, there are some contracting situations in which developing trust and collaboration is essential. Consider the outsourcing of ongoing services or the previously mentioned example of contracts for joint innovation.[243] When the development of relational capital is, relatively speaking, important and relative contractual incompleteness is likely to foster that development, courts would want to tolerate incompleteness. But when simple compliance is the goal, courts would want to prompt more complete drafting.

Together, these three factors—degree of transaction costs to detail, extent of information asymmetry, and desirability of forming relational capital—form an analytical tool that courts may employ to determine the desirability of contractual completeness. Balancing these factors will result in clear answers for many cases. Other cases will prove more difficult.

Anytime courts engage in balancing tests, there are costs associated, both in the resources dedicated to the endeavor and in the possibility that the court will get it wrong. This is the sort of task, however, that modern contract law, with its focus on contextualism, has embraced. It is commonly expected that courts will dive into the facts of a given case to get to the right result.[244]

In addition, there is some evidence that courts are doing at least a part of this assessment already, even if not explicitly. Professor Robert Scott conducted an empirical study of contemporary case law on indefinite contracts.[245] In a sample of eighty-nine cases in which a court was asked to determine whether a contract was too indefinite to be enforced, courts enforced the contracts in thirty-four cases and denied enforcement in fifty-five. Scott hypothesized that courts enforcing agreements were following the more modern U.C.C. approach, whereas those not enforcing were following the more traditional common law rule.[246] The data, however, did not confirm that hypothesis.[247]

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[243] These are an update on the criteria that I introduced in past work. *See* Epstein, *supra* note 20, at 299–313; Epstein, *supra* note 72, at 12.

[244] *See generally* Larry A. DiMatteo, *Reason and Context: A Dual Track Theory of Interpretation*, 109 PENN. ST. L. REV. 397, 459–61 (2004) (discussing the emergence of contextual contract interpretation).

[245] Scott, *supra* note 16, at 1643.

[246] *Id.* at 1653.

[247] *Id.* at 1643.

Instead, Scott found something interesting. Courts seemed to focus on whether the parties exploited verifiable information in drafting their agreements.[248] When an agreement was incomplete owing to high levels of uncertainty *ex ante*, courts were more prone to fill gaps for the parties. But if parties simply "appear to have discarded verifiable information that they might have used at relatively low cost to condition performance, the courts decline to enforce the agreement."[249] In other words, outside the health context, courts seem to be engaging in a sort of analysis along the lines of the first factor (concerning transaction costs to draft) suggested here.[250] Courts should be able to make the analysis they use more explicit so that parties receive the right signals at the drafting stage. And courts should expand their analysis to be consistent with the teachings of theory more broadly, as this section suggests. But it can be done.

Indeed, examples in which incompleteness is desirable have previously been explored. In contracts for innovation, intellectual property licensing, and public-private contracting over complex government services, to name some, transaction costs to draft are high, information asymmetry low, and there is a great need for relational capital.[251] There, less complete contracts are desirable. The health-care example is, in many ways, opposite.

C. Doctrinal Approach to Incomplete Health Law Contracts Is Mismatched with Theory

Current doctrine permits incomplete contracts between patients and providers, but it is often a mismatch with theory. In most cases, courts should require relative completeness, including as to price.

First, for most medical treatment, transaction costs incurred in providing a fee *ex ante* are relatively low. This is not what traditional case law assumes.[252] It assumes that it would be costly and difficult to provide *ex ante* pricing

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[248] *Id.* at 1654.

[249] *Id.* at 1655.

[250] *Id.* at 1659 ("In the cases falling within each of these prototypes, the courts appear most influenced by the failure of the parties to agree on readily available, verifiable terms.").

[251] *See* Epstein, *supra* note 20, at 321–23.

[252] *See* DiCarlo v. St. Mary's Hosp., No. 05-1665 (DRD-SDW), 2006 WL 2038498, at *4 (D.N.J. July 19, 2006); *see also* Nygaard v. Sioux Valley Hosps. & Health Sys., 731 N.W.2d 184, 193 (S.D. 2007) (quoting Cox v. Athens Reg'l Med. Ctr., 631 S.E.2d 792, 797 (Ga. Ct. App. 2006)).

because of uncertainty.[253] While certain aspects of medical care may indeed be uncertain, the traditional concerns are over-stated as to modern medicine.

Today, providers usually know in advance what code will be used to charge the patient (e.g., for an office visit, an x-ray, a flu shot, etc.).[254] For the uninsured patient, the provider need only access the hospital chargemaster (or physician price list) to then determine the price. For the in-network insured patient, the provider must query the rate the provider has negotiated for the procedure.[255] For the government-insured patient, the provider must determine the rate set by the government for the procedure.[256]

A degree of complexity is potentially introduced depending on what the treatment is. For instance, it might be more difficult to provide a price for the patient who was hit by a car who arrives at an emergency room with multiple injuries or for the oncology surgery in which the surgeon really will not know the extent to which the cancer has spread until she opens up the patient[257] than for the patient who requires a routine flu shot or a routine diagnostic test like an x-ray.

But it would be wrong to assume that all or even the majority of health care falls into the category of being highly complex and difficult to predict. Emergency-room care accounts for a very small proportion of health care expenditures—as little as 2% of expenditures by some measures.[258] And while

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[253] *See DiCarlo*, 2006 WL 2038498, at *4; *see also Nygaard*, 731 N.W.2d at 193 (quoting Cox v. Athens Reg'l Med. Ctr., 631 S.E.2d 792, 797 (Ga. Ct. App. 2006) (stating "in a hospital setting, it is not possible to know at the outset what the cost of the treatment will be, because it is not known what treatment will be medically necessary").

[254] Indeed, trade associations, medical device companies, and others, spend much time educating physicians on what coding choices will maximize their compensation. *See, e.g.*, Am. Ass'n of Neurological Surgeons, *Managing Coding & Reimbursement Challenges in Neurosurgery* (2015), http://www.aans.org/pdf/Education%20and%20Meetings/2015%20Managing%20Coding%20Brochure.pdf; *Reimbursement: Directory of Resources*, MEDTRONIC, http://www.medtronic.com/us-en/healthcare-professionals/reimbursement.html (last visited Sept. 24, 2017).

[255] Riggs & Ubel, *supra* note 65.

[256] This may be an over-simplification of the functioning of hospital billing systems, which are, admittedly, not particularly efficient and effective. But one could easily imagine a system set up to work this way.

[257] It is costlier to provide a price or price range for complex surgery, but that is not to say that it could not be priced. It would require a complex flow chart of potential complications, but there are only so many complications that are really a possibility, and those are already detailed in the informed consent documents.

[258] The Fiscal Times, *Emergency Room Costs Have Skyrocketed to as Much as $151 Billion*, BUSINESS INSIDER (Apr. 30, 2013, 7:04 PM), http://www.businessinsider.com/er-costs-skyrocketed-to-151-billion-2013-4; Louis Jacobson, *Does Emergency Care Account for Just 2 Percent of All Health Spending?*, POLITIFACT (Oct. 28, 2013, 10:58 AM), http://www.politifact.com/truth-o-meter/statements/2013/oct/28/nick-gillespie/

some surgeries are unpredictable and uncertain, many have become more routinized over time and will only continue to be more so. Between the flu shot and the cancer surgery lies a lot of other medical care. For most of it, providers should be able to determine a price or at least a small range for the price prior to the patient undergoing the treatment, and incur little cost for doing so.[259] An office visit usually has a standard charge. There is little uncertainty in the cost of a magnetic resonance imaging (MRI) or a CT scan or a mammogram. And the list goes on.

The second factor to consider is the extent of information asymmetry. Here, the provider clearly has better access to pricing information than the patient.[260] Providers know what codes they will use to bill for their services.[261] And providers are the ones that have either set the rates (uninsured patients), negotiated the rates (privately insured patients), or been informed of the rates (publicly insured patients). While patients do have some options—for instance, they can call their insurance companies and get a sense of cost for various procedures—providers are undoubtedly better situated to do so.[262] Providers are the repeat players, here, with far better and less costly access to information than patients do.

As to the last factor, in most instances, there seems to be limited potential that leaving out a price term will serve to build positive relational capital between the provider and the patient. A provider's refusal to state a price for an x-ray is not going to make the patient trust the provider more or facilitate better collaboration on the patient's care the way that less task specification signals

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does-emergency-care-account-just-2-percent-all-hea/; *see also Medical Expenditure Panel Survey*, DEP'T HEALTH & HUM. SERVS.: AGENCY FOR HEALTHCARE RES. & QUALITY (2008), http://tinyurl.com/489fao6; Lee et al., *supra* note 34 (describing emergency room costs between 5% and 6%, but as high as 10%).

[259] *Medicare Provider Utilization and Payment Data*, CMS.GOV, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/index.html (last modified Aug. 10, 2017); Peter Ubel, *If Costs Are Unknown, Can Doctors Still Talk About Them?*, FORBES (June 17, 2014, 2:06 PM), http://www.forbes.com/sites/peterubel/2014/06/17/if-costs-are-unknown-can-doctors-still-talk-about-them/#6e4c22a63b6f. For a description of technological hurdles that would add to transaction costs, however, see *supra* note 73.

[260] *See generally* John Santa, *Transparency in the Cost of Care*, *in* THE HEALTHCARE IMPERATIVE: LOWERING COSTS AND IMPROVING OUTCOMES: WORKSHOP SERIES SUMMARY 377 (Pierre L. Yong et al. eds., 2010).

[261] *Course 2: The Medical Billing Process*, MED. BILLING & ONLINE CODING http://www.medicalbillingandcodingonline.com/medical-coding-for-billers/ (last visited Sept. 24, 2017).

[262] Berry et al., *supra* note 86, at 46 ("The reasons vary, but in franchising situations, the relative bargaining strengths of the parties often place one side at a disadvantage in contract negotiations. The resulting power disparity often permits the stronger party to retain the right to set important terms, such as price, at a future date.").

trust and a desire to collaborate in other settings. This is particularly true for the parts of medicine in which compliance is the goal: do the diagnostic test, give the vaccine, suture the wound, etc.

There is an argument to be made that keeping discussions of cost out of patient-provider communications does build relational capital, particularly when it comes to long-term relationships involving chronic disease. Bringing cost into the discussion can turn the relationship into one more characterized by its business characteristics than a more traditional doctor-patient relationship. Doctors tend to view their jobs as providing sound medical advice without concern for price.[263] On the other hand, one could imagine that a doctor-patient relationship built on trust could suffer if patients feel they are not being given critical information to make decisions about treatment—like cost.

The balancing test may yield a different result depending on the circumstances of any individual case. But it is unlikely that balancing the factors in the case of a patient seeking an x-ray would ever result in a finding that the contract should be incomplete as to price. The transaction costs a provider would have to bear to provide the fee should be low. Information asymmetry is high. And the goal is simply to take the image—in other words, compliance with the task rather than more complicated relationship building between the patient and the provider. On the other hand, one could imagine a complex and unpredictable procedure, in which information asymmetry may still be high, but there is a significant need to develop a strong, long-term collaborating relationship between the provider and the patient. There, a court could find that a level of incompleteness—including leaving out the price in the contract—is the efficient course.

Although these are not always easy lines to draw, courts are experienced at applying balancing tests.[264] In doing so, courts should be able to determine whether a more detailed or less detailed contract is merited and send the right signals to future parties engaged in similar drafting exercises.

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[263] Peter A. Ubel, Opinion, *Doctor, First Tell Me What It Costs*, N.Y. TIMES (Nov. 3, 2013), http://www.nytimes.com/2013/11/04/opinion/doctor-first-tell-me-what-it-costs.html?mcubz=1; Ubel, *supra* note 259.

[264] And in most situations, parties should be able to view the criteria and get the signal for what end of the spectrum their deal falls on.

The next Part offers a solution to the doctrine-theory mismatch evident in the health care example—a solution that may also be applicable to other areas where courts should be incentivizing completeness in contract drafting.

IV. THE PENALTY DEFAULT RULE SOLUTION TO THE PRICE TRANSPARENCY PROBLEM

Courts have a doctrinal tool at the ready to prompt providers to include a price term in at least most of their contracts: the penalty default rule. The problem has been that when the price term is left open, courts enforce the contract and fill the open term with a reasonable price. For uninsured patients, courts have held that the chargemaster prices are "reasonable," and for insured patients, the negotiated rates are reasonable.[265] Under this scheme, there is little incentive for providers to disclose price and no way for patients to change their behaviors in consideration of price.

Various solutions to this problem have been proposed, from legislative to private solutions to solutions based in tort law. But the current approaches are all flawed. Contract law provides a yet unexplored option—one that can be implemented simply by a change to the common law. This Part explains how penalty default rules work and how a penalty default could be employed in health care.

A. How Penalty Default Rules Work

Professors Ian Ayres and Robert Gertner were the first to describe the concept of a penalty default.[266] They observed that high transaction costs do not always explain why parties draft incomplete contracts.[267] Rather, sometimes contracts are incomplete because one party strategically withholds information from the other party, which reduces the efficiency of the deal.[268] They suggested that lawmakers should reduce this rent-seeking, strategic behavior that leads to inefficient contracts by "sometimes choos[ing] penalty defaults that induce knowledgeable parties to reveal information by contracting around the default penalty."[269]

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[265] *See, e.g.*, Queen's Med. Ctr. v. Kaiser Found. Health Plan, Inc., 948 F. Supp. 2d 1131, 1149–50 (D. Haw. 2013); Allen v. Clarian Health Partners, Inc., 980 N.E.2d 306, 310–11 (Ind. 2012).

[266] Ayres & Gertner, *supra* note 16, at 94.

[267] *Id.* at 92–93.

[268] *Id.* at 94.

[269] *Id.*

Penalty defaults force the sharing of information by selecting a gap-filler term that is undesirable to the party that is strategically withholding the information.[270] As Ayres and Gertner describe: "[P]enalty defaults are purposefully set at what the parties would not want—in order to encourage the parties to reveal information to each other or to third parties (especially the courts)."[271]

"[P]enalty defaults 'operate on precontractual behavior' because it is the potential contractors' aversion to the default penalty that causes them to change their contractual offers."[272] Two examples illustrate: U.C.C. § 2-201, which requires that an agreement include a quantity term to be enforceable;[273] and the contra proferentem rule,[274] which requires ambiguous contract provisions to be construed against the drafting party.[275]

The U.C.C. quantity rule (U.C.C. § 2-201) requires that a quantity be specified in the contract for the contract to be enforceable.[276] It essentially sets a default quantity of zero. If the parties do not specify a quantity, the court will not fill the gap with a reasonable quantity. Instead, the court will find the contract to be invalid.[277]

This zero-quantity rule sends a message to contracting parties: specify a quantity term or you have no contract. In this sense, it is an information-forcing rule. It does not try to fill the gap with what parties would have agreed to at the time of contracting, which is the most common approach to gap-filling in contracts. Rather, it penalizes parties that do not come to agreement on quantity. The effect of the penalty default is that parties are forced to contract

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[270] *Id.* at 103–04.

[271] *Id.* at 91; *see also* Ian Ayres, *Ya-Huh: There Are and Should Be Penalty Defaults*, 33 FLA. ST. U. L. REV. 589, 594 (2006); Michelle Boardman, *Penalty Default Rules in Insurance Law*, 40 FLA. ST. U. L. REV. 305 (2013) (explaining the penalty default theory).

[272] Ayres, *supra* note 271, at 595.

[273] U.C.C. § 2-201 (AM. LAW INST. & UNIF. LAW COMM'N 1977) ("[T]he contract is not enforceable under this paragraph beyond the quantity of goods shown in [the] writing.").

[274] *See* RESTATEMENT (SECOND) OF CONTRACTS § 206 (AM. LAW INST. 1981); Epstein, *supra* note 20, at 323.

[275] *See* Ayres, *supra* note 271, at 594; Ayres & Gertner, *supra* note 16, at 94. *But see* Eric A. Posner, *There Are No Penalty Default Rules in Contract Law*, 33 FLA. ST. U. L. REV. 563 (2006).

[276] U.C.C. § 2-201 cmt. 1 (AM. LAW INST. & UNIF. LAW COMM'N 1977) ("The only term which must appear is the quantity term which need not be accurately stated but recovery is limited to the amount stated.").

[277] This approach is in stark contrast to how the U.C.C. treats contracts for the sale of goods that lack a price term, as discussed earlier, where courts are directed to fill the gap with a reasonable (market) price.

around the default of zero quantity and no enforcement and instead include a quantity term.[278]

Contra proferentem, or "construe against the drafter," is, in many respects, also intended to function as a penalty default.[279] The rule tells courts to construe ambiguous contract provisions against the drafting party.[280] It is most frequently applied in the insurance context to prevent insurers from purposely using vague language to later argue for a favorable interpretation in litigation.[281] Because the drafting party usually has greater bargaining power and is in a position to use clearer language, the rule penalizes parties that do not heed the warning.[282] Viewed from the vantage of drafting parties, the rule is intended to incentivize drafters to use precise language.[283] As these and other examples illustrate,[284] penalty defaults can be used more generally to force parties to enter into more complete contracts when doing so would be efficient.

Part of the difficulty, however, comes in distinguishing situations in which penalty defaults will work as intended from those where they will not. Much of the scholarly criticism of penalty defaults discusses just this. For instance, scholars have argued that parties will not always choose to contract around a penalty default.[285] This is particularly so when the cost of disclosing the information is large and the likelihood of litigation is small.[286] There, the information-bearing party may choose to roll the dice and hope that the deal does not end up in court rather than disclose the valuable information it possesses.[287]

There are other related problems, as well. For instance, consider the operation of contra proferentem in the insurance context. The consumer may not read the contract even if it is more detailed—or perhaps because it is more

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278 Ayres, *supra* note 272, at 609.

279 *Id.*

280 RESTATEMENT (SECOND) OF CONTRACTS § 206 (AM. LAW INST. 1981).

281 *See* Michelle E. Boardman, Contra Proferentem*: The Allure of Ambiguous Boilerplate*, 104 MICH. L. REV. 1105, 1107 (2006).

282 *See* RESTATEMENT (SECOND) OF CONTRACTS § 206 cmt. a (AM. LAW INST. 1981) (describing that the rule is intended to prevent party with greater bargaining power from leaving term deliberately obscure).

283 Epstein, *supra* note 20, at 323–24.

284 For a long list of penalty defaults, *see* Ayres, *supra* note 272, at 598–607.

285 *See, e.g.*, Avery W. Katz, *Contractual Incompleteness: A Transactional Perspective*, 56 CASE W. RES. L. REV. 169, 175 (2005).

286 *See, e.g.*, *id.*; Jason Scott Johnston, *Strategic Bargaining and the Economic Theory of Contract Default Rules*, 100 YALE L.J. 615, 617 (1990); Barry E. Adler, *The Questionable Ascent of* Hadley v. Baxendale, 51 STAN. L. REV. 1547, 1589 (1999).

287 *See, e.g.*, Ayres & Gernter, *supra* note 213, at 729.

detailed—and thus the rule only adds transaction costs with no efficiency gain.[288] Indeed, the more sophisticated party may actually harm the less sophisticated party in response to the penalty default by raising insurance rates to cover the added cost (in litigation risk) that the default rule adds.[289]

Professors Omri Ben-Shahar and Lisa Bernstein explore a related problem. They argue that penalty defaults may be inefficient when they force the disclosure of information that would reveal trade secrets valuable beyond the single contract.[290] Finally, Professor Eric Posner has been a vocal critic of penalty defaults, arguing that the analysis required to determine whether a penalty default is necessary is too complicated and indeterminate for judges to use.[291]

The next section addresses these criticisms in exploring how a penalty default would work in the health care context.

B. A Penalty Default Rule to Fix the Health Care Price Transparency Problem

In most contracts between patients and providers, relative completeness in drafting is desirable. Currently, however, most of these contracts are incomplete in the sense of missing a material term—the price. The common law enforces these contracts, even though theory suggests it should not.[292]

1. The Proposed Solution

Courts should find that, at least for low-complexity, relatively predictable health care services, providers must include a price term. If providers leave a contractual gap as to price, courts should fill the gap with a price of $0. If a provider fails to include a price term, and the patient subsequently does not pay, the provider will not be able to recover its rate by bringing a cause of

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[288] Boardman, *supra* note 271, at 330.

[289] *Id.* at 329.

[290] Omri Ben-Shahar & Lisa Bernstein, *The Secrecy Interest in Contract Law*, 109 YALE L.J. 1885, 1886 (2000).

[291] Posner, *supra* at 275, at 586.

[292] Nygaard v. Sioux Valley Hosp. & Health Sys., 731 N.W.2d 184, 192 (S.D. 2007) (noting that "if the charges are ascertainable through reference to outside sources, there is no need to judicially impute a fair and reasonable price term").

action for breach of contract. Courts could implement this penalty default simply with a change to the common law.[293]

If the penalty default works, providers will respond by including pricing in their contracts where it is reasonable to do so. Now, providers require that patients sign agreements stating the patient is responsible for whatever price the provider later assesses.[294] In reaction to a penalty default, that contract would more than likely contain the price (or perhaps a range of prices when appropriate).[295]

Courts, however, would only employ the penalty default when the analytical framework set out in section III.B suggests that more complete contracting is desirable. It is not a costless endeavor to ask courts to engage in this exercise, but neither is it particularly complicated.[296] This would exempt from the pricing requirement emergencies (which are typically assessed under principles of quasi-contract anyway) and particularly complicated and unpredictable procedures. But for health care that is relatively predictable and easy to price, courts would employ the $0 gap-filler.[297]

Consider the case of a patient who seeks medical attention after an injury. His doctor strongly suspects a gastrocnemius muscle tear, so-called "tennis leg," but informs the patient that only MRI can definitively confirm the diagnosis. With a penalty default rule, the hospital performing the MRI would likely choose to include the cost of the test *to the patient*[298] in the patient's contract, and the patient could then make an informed decision about whether to incur the cost of the expensive MRI. The hospital would be well-advised to

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[293] *See* Hall, *supra* note 123, at 596 (suggesting that the law could be more demanding in requiring price terms but that it would conflict with longstanding practices.).

[294] *See, e.g.*, *Conditions of Admission*, *supra* note 1.

[295] Medicare's MS-DRG system and private payers' case-rate and per diem methodologies provide examples. Both provide ways of scaling the rate to account for complications and comorbidities.

[296] One possibility is that the penalty default could be supported by a regulatory framework to guide courts on what procedures could generally be expected to be priced *ex ante*, and which ones could not be. Such a mechanism would mitigate Eric Posner's criticism of penalty defaults as being too indeterminate. *See* Posner, *supra* note 275. But even without a regulatory framework, line-drawing difficulties seem to pale relative to the huge costs of the status quo and in comparison to the potentially huge gains from prompting price transparency.

[297] Even without a supporting regulatory framework, if litigation sends appropriate signals, the market should respond with price disclosure, lessening the burden on the courts.

[298] This will require interaction between the hospital and the insurer, e.g., to ascertain how much of the deductible the insured has already satisfied, how much co-insurance would cover, how much the patient will owe, etc.

provide the lower patient-specific cost that the insured patient will actually be asked to pay—which requires checking insurance details.[299]

Again consider the example of the hypothetical patient, James, who must undergo an angioplasty.[300] James's procedure is scheduled and non-emergent. Under current practice, he would be presented a contract with no price and required to sign. Under the penalty default regime, a rational, informed provider would instead provide James with a contract that includes the price term—and specifically, the amount that James will be asked to pay given insurance benefits. If there is ambiguity as to what James will be charged because of medical unknowns, the provider could at least be expected to provide an estimate.[301]

There are potential issues with timing. If James schedules his procedure, comes in ready to have it done, and is then first presented with the price, disclosure of the price would likely be too late for James to engage in the cost-benefit analysis that market proponents expect. He is already there and ready to undergo the procedure. A better scenario would be if James's physician presents him with the contract before James schedules the procedure. This would give James time to process the information and act accordingly. Once the market reacts to the doctrinal change, market forces should dictate that cost information be produced in patient-accessible forms at the salient time.

In addition to the timing issue, there are other potential concerns. One is that the penalty default regime will mean higher prices for patients. Because it is costlier for providers to put in place the administrative apparatus to provide a price *ex ante*, providers will pass that extra cost onto consumers.[302] However, while it may be true that there is some additional cost to provide pricing *ex ante*, the magnitude is probably not very high for most procedures. And efficiency only requires that the savings from patients having access to cost information exceed the additional cost to providers.

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[299] If a hospital merely includes the cost of the procedure without reference to how much the individual patient will actually owe, the patient will be much more likely to opt out of the procedure in reaction to the higher price. This argument does assume, however, some elasticity of demand for services. Market forces may put less pressure on such disclosures, e.g., for later-stage cancers and other similarly serious ailments where price tends to be a less motivating force for patients.

[300] *See supra* INTRODUCTION.

[301] Note that written estimate laws in other industries require exactly that. *See, e.g.*, Automotive Repair Act, 815 ILL. COMP. STAT. 306 § 15(b) (West 2016) (requiring a written estimate for labor and parts with final bill not to exceed estimate by more than 10%).

[302] *See, e.g.*, Boardman, *supra* note 271, at 330.

Alternatively, if price transparency succeeds in prompting patients to turn down expensive care, physicians may have to raise prices to make up for the lost revenue. However, if patients gain access to relevant quality information, what will more likely happen is that the market will come to more accurately price high-value care relative to low-value care.

Another concern is that the penalty default solution depends on providers reacting to the penalty default and the threat of litigation by including a price term in future contracts. Patients would have to sue to force a change in *ex ante* provider practice.[303] But instead of trying to avoid suit, providers could instead raise their rates to cover the additional litigation costs and lost fees. While this is a possibility, it is muted if the providers stand to lose more in litigation than the cost of including the price term. It is true, though, that patients must sufficiently test the system—refuse to pay and make the provider sue to try to recover damages.[304] Class actions, if not avoided by arbitration clauses, would help.[305]

Another possibility is that instead of raising prices, providers may respond to the new regime by providing worse treatment. If providers must commit to a price in advance of a procedure, but it later turns out that the provider estimated low, the provider may do less for the patient, recognizing that the provider will only be paid the pre-agreed upon rate. For instance, if the doctor and patient agree to a price of $2,000, but during treatment, it turns out that the doctor really has to do $2,500 worth of work, the doctor may not provide full treatment. Alternatively, doctors may estimate prices on the high side to account for this possibility.

Negligence law would presumably address some of these concerns. In addition, this is how other markets work, even for services, and there is no reason to think that medicine is more problematic than building a house. Moreover, we have not seen these effects in other priced markets, such as the market for cosmetic surgery.[306]

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[303] One may be skeptical that patients will be informed enough or have enough resources to bring suit. This is an area where the plaintiffs' bar and patient advocacy groups could make a big difference.

[304] This is similar to concerns about the medical malpractice system not working as intended because not enough aggrieved patients can successfully sue. TOM BAKER, THE MEDICAL MALPRACTICE MYTH 1–14 (2005); *see also* Scott Tenner, & Lillian Ringel, *A Medical Complication Compensation Law: Improving Quality Healthcare Delivery While Providing for Injury Compensation*, 10 J. HEALTH & BIOMEDICAL L. 55, 58 (2014). Also, providers may employ other collection mechanisms with success on uninformed patients.

[305] The penalty default would also need to be non-waivable.

[306] HERRICK & GOODMAN, *supra* note 5.

Additional concerns include that consumers will not read the contract and, therefore, will not change their behavior because of price; or even informed patients, for any number of reasons, will not price shop or they will turn down unnecessary care.[307] These are, of course, problems that could arise with any price transparency regime.

Finally, the purpose of a penalty default rule, primarily, is to target pre-contractual behavior—to give the right incentives to the parties at the drafting stage. When focusing on situations in which the penalty default is actually applied in litigation, however, the result seems harsh. The hospital and doctors who performed James's angioplasty and who later sue to recover their fees would not receive their $67,937. Courts may be tempted to order payment on equitable grounds rather than for breach of contract. Perhaps this remedy would be appropriate for a case that presents a close call, but for the penalty default to function properly, and to send the right signals, some harsh results in one-off cases would be necessary to change industry practices.

2. *A Penalty Default Is Superior to, or Possibly a Necessary Complement to, Alternatives*

A penalty default rule is not the only option for addressing health care's price transparency problems. A multitude of other solutions have been suggested or already implemented. While some of these solutions are promising, none are without fault, and none have yet worked on their own to solve the current price transparency dilemma. The most effective solution will provide price information that is directly relevant to the patient's decision. Because averages, chargemaster rates, and usual and customary charges often vary widely from what an individual patient will be expected to pay, many of the current solutions are of limited utility. The contracts solution presents a better option than existing solutions. It requires that a price be provided that is relevant to the individual patient, and it offers a flexible vehicle that can differentiate between situations when a price should be provided and when it would be too costly and uncertain to require it. At the very least, it would serve as an important complement to the price transparency solutions already in the works.

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[307] Patients who cannot afford care but nonetheless need it will still consent to that care under this regime. This is unavoidable in the current system.

Current solutions meant to address price transparency include (1) state-level legislation and all-payer claims databases, (2) federal legislation, and (3) private insurer pricing mechanisms.

First, many states have now passed legislation meant to address price transparency problems.[308] Although each state has its own approach, in many instances, the information that providers are required to disclose is not user-friendly or patient-specific.[309] For example, most states list only average prices, or even less helpfully, the chargemaster rates.[310] Some states list only in-patient rates.[311]

One clear trend has been that many states have mandated the creation of all-payer claims databases (APCDs), which collect claims and payment information from private and public payers. These databases have the potential to compile very useful information, but that information is still not targeted to the individual patient's situation.

A common problem faced by legislative solutions is that industry players push back on requirements to release pricing information because it is

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[308] *See* ARIZ. REV. STAT. ANN. § 36-125.05 (2016); ARK. CODE ANN. §§ 20-7-301–07 (West 2011); CAL. HEALTH & SAFETY CODE §§ 1339.55, .56, .58, .585 (West 2016); COLO. REV. STAT. ANN. § 6-20-101 (West 2016); DEL. CODE ANN. tit. 16, §§ 2001–2009 (West 2013); FLA. STAT. § 381.026 (West Supp. 2017); 20 ILL. COMP. STAT. ANN. 2215/4-2(d)(6)&(7) (West 2015); IND. CODE ANN. §§ 16-21-6-1–3, 5–11 (West Supp. 2017); KY. REV. STAT. ANN § 216.2929 (West, Westlaw current through 2017 Reg. Sess.); ME. REV. STAT. ANN. tit. 22, §§ 8701–12 (2016); MASS. GEN. LAWS ANN. ch. 111, § 228 (West 2015); MINN. STAT. ANN. §§ 62J.81–.83 (West 2013); MO. ANN. STAT. §192.667 (West Supp. 2017); NEB. REV. STAT. ANN. § 71-2075 (West 2009); NEV. REV. STAT. ANN. § 439B.400 (West 2012); N.H. REV. STAT. ANN. § 420-G:11 (Supp. 2016); N.C. GEN. STAT. ANN. §§ 131E-214.11–.14 (West 2017); OHIO REV. CODE ANN. §§ 3727.42–.44 (West 2017); OR. REV. STAT. ANN. §§ 442.405, .420, .425, .450, .460, .463 (West 2011); 35 PA. STAT. AND CONS. STAT. ANN. §§ 449.1–.19 (West Supp. 2017); 23 R.I. GEN. LAWS ANN. §§ 23-17.17-1–11 (West 2016); S.D. CODIFIED LAWS §§ 34-12E-8, 11–13 (2011); TEX. HEALTH & SAFETY CODE ANN. §§ 324.051, .101 (West 2017); UTAH CODE ANN. §§ 26-33a-101–15 (West, Westlaw through Gen. Sess. 2017); VT. STAT. ANN. tit. 18, § 9410 (West Supp. 2016); VA. CODE ANN. §§ 32.1-276.2–.7 (Westlaw through 2017 Reg. Sess.); WASH. REV. CODE ANN. § 70.41.250 (West 2011); WIS. STAT. ANN. §§153.05, .08, .20–.22, .46, .50 (West 2016).

[309] *See generally* CATALYST FOR PAYMENT REFORM – HEALTH CARE INCENTIVES IMPROVEMENT INST., REPORT CARD ON STATE TRANSPARENCY LAWS 8–17 (2014), http://www.hci3.org/wp-content/uploads/files/files/Report_PriceTransLaws_2014.pdf (indicating that all but five states receive a failing grade on price transparency laws).

[310] *See, e.g.*, CAL. HEALTH & SAFETY CODE § 1339.55 (requiring hospitals to make public their chargemaster prices); CAL. HEALTH & SAFETY CODE § 1339.56 (requiring each hospital to compile a list of the twenty-five most common outpatient procedures and their average charge); *see also Hospital Chargemasters and Charges for 25 Common Outpatient Procedures*, CAL. OFF. STATEWIDE HEALTH PLANNING & DEV., http://www.oshpd.ca.gov/Chargemaster/ (last visited Sept. 25, 2017).

[311] *But see* 20 ILL. COMP. STAT. ANN. 2215/4-2(d)(6)&(7) (requiring hospitals and surgery centers to report costs of various outpatient procedures, as well as success rates).

confidential[312] or protected by trade secret.[313] The contracts solution, however, avoids these problems. It takes the information that was going to be provided to patients anyway and moves it earlier in the process. It does not require public reporting of negotiated rates between providers and insurers. It simply changes the timing for the disclosure.

Second, the federal government has made some strides in addressing price transparency, but its efforts suffer from many of the same problems as the state efforts. For instance, the U.S. Department of Health and Human Services recently released charge data for the 100 most common inpatient hospital services and the thirty most common outpatient hospital services for more than 3,000 hospitals. Medicare now places on its website price comparisons for similar brand name drugs used to treat common conditions. These new requirements offer promise for patients, but strong enforcement has been lacking, and patients are still not receiving information that is timely, complete, and easy to understand.

Third, there have been private efforts. Insurance companies have started to offer tools on their websites for their insureds to estimate the prices of procedures.[314] These tools are well-intended and offer some hope for the future, but they still require that the patient understand the codes for which the physician will ultimately bill. In addition, the calculators are not binding and often inaccurate.[315] Insurance companies should have the incentive to make them accurate, but there nonetheless continue to be problems.

Many other suggestions have also been made.[316] Notably, the concept of requiring financial disclosure as a part of the informed consent process has gained some steam.[317] It would, however, be quite difficult for a patient to

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[312] *See, e.g.*, CATALYST FOR PAYMENT REFORM, *supra* note 81, at app. 1, at 3–4 (discussing "gag clauses" preventing providers from releasing insurer negotiated rates).

[313] *Id.* at 4–5.

[314] *See, e.g.*, Calsyn, *supra* note 70 (discussing Aetna and Anthem policies).

[315] Gordon, *supra* note 77.

[316] *See, e.g.*, Calsyn, *supra* note 70; E. Haavi Morreim, *Consumer-Defined Health Plans: Emerging Challenges from Tort and Contract*, 39 J. HEALTH L. 307, 346–47 (2006) (suggesting changing state consumer protection laws to require price disclosure).

[317] *See, e.g.*, Timothy S. Hall, *Bargaining with Hippocrates: Managed Care and the Doctor-Patient Relationship*, 54 S.C. L. REV. 689, 720–23 (2003); Richman et al., *supra* note 62, at 396; Meghan M. Overgaard, Note, *Balancing the Interests of Researchers and Donors in the Commercial Scientific Research Marketplace*, 74 BROOK. L. REV. 1473, 1499–1500 (2009); Elizabeth Glass Geltman, *Cost Needs to Be Part of the Medical Informed Consent Process*, HUFFINGTON POST (Dec. 8, 2015, 12:45 PM), http://www.huffingtonpost.com/elizabeth-glass-geltman/cost-needs-to-be-part-of-the-medical-informed-consent-process_b_8742926.html (urging providers to practice financial informed consent).

prevail in a tort action alleging lack of financial informed consent, in part because of the requirement of proving causation.[318] If patients are unlikely to sue using this cause of action or unlikely to prevail, providers will, in turn, be unlikely to change their practices. The contractual cause of action has the benefit of being easier for patients to win than a tort cause of action.

In general, a contract law solution may hold the most promise because it requires a price specific to the individual patient, but does not run afoul of gag clauses between insurers and providers. And it allows for more nuance, only requiring price when the balancing test suggests it should be included (low transaction cost, high information asymmetry, and little relational benefit to leaving it blank), so emergencies and highly uncertain procedures may be exempted (although one could imagine at least a range could be provided). Even if the regulatory- and private-sector efforts to improve transparency can change the status quo, these solutions could be augmented by also employing the common law penalty default. While the penalty default is not without risk and may not solve all problems, in an area where legislative action has been slow and ineffective, contract law provides a promising vehicle for change.

CONCLUSION

Current doctrine that enforces contracts between patients and providers that lack a price term is out of step with theory. For many areas of health care, it would not be costly for providers to determine a price *ex ante*; providers have much better access to pricing information than patients, and leaving out the price is unlikely to build relational capital between the parties. Contract law offers a previously unexplored solution to the price transparency problem in health care: penalty defaults. If courts were to fill open price terms in patient-provider contracts with a price of $0, it would incentivize providers to put in a price at the contract execution stage. Given the problems in the legislative and tort solutions on which lawmakers and policymakers have previously focused, a contract solution merits further exploration.

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[318] *See* Joan H. Krause, *Reconceptualizing Informed Consent in an Era of Health Care Cost Containment*, 85 IOWA L. REV. 261, 317 (1999) (citations omitted) (describing hurdles to succeeding in cause of action).