

DETERMINING THE FAIR AND REASONABLE VALUE OF MEDICAL  
SERVICES: THE AFFORDABLE CARE ACT, GOVERNMENT INSURERS,  
PRIVATE INSURERS AND UNINSURED PATIENTS

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## I. INTRODUCTION

In a free market, businesses may usually set their prices as they see fit. Of course, potential customers may refuse to accept the prices set by a particular business if they perceive them as too high. These customers may choose instead to purchase goods or services from a lower-priced competitor. In fact, most price regulations aim to insure that the customer has complete price information before a contract is created.<sup>1</sup> The business of healthcare, however, has certain characteristics that distinguish it from most other businesses, and which, in some cases, should limit the ability of healthcare businesses to freely set prices.

One important characteristic of healthcare is that medical services, especially those provided by hospitals, are usually purchased by consumers who do not know at the time of purchase how much the services will cost.<sup>2</sup> In the case of hospital-provided care, even the hospital does not know the exact amount it will bill the patient at the time of purchase. Patients sign an “Authorization for Treatment,” a “Statement of Financial Responsibility,” and/or another similar open-ended agreement pursuant to which the patient purports to agree to pay for all medical goods and services provided by the hospital at the hospital’s list (chargemaster) prices.<sup>3</sup> In reality, however, this

<sup>1</sup> See, e.g., New Jersey Consumer Fraud Act, N.J. STAT. ANN. § 56:8–151(a)(3) (West 2012); N.J. ADMIN. CODE § 13:45A-16.2(a)(12)(ii–iii) (2013) (requiring a general contractor in New Jersey to provide full disclosure in advance of labor and material costs).

<sup>2</sup> See *infra* notes 7–19.

<sup>3</sup> See, e.g., *Cape Reg’l Med. Ctr. v. Sanchez*, No. CPM DC 109-11, at \*2 (N.J. Super. Ct. Law Div. Mar. 26, 2012) (on file with the Baylor Law Review). This case involved a patient who received Emergency Room services at Cape Regional following a car accident. *Id.* at \*1. The patient was not covered by her auto insurer for medical care but was covered by her Medicaid

type of agreement amounts to a blank check given by the patient to the hospital with the amount to be unilaterally filled in by the hospital at a later date.<sup>4</sup> This situation would, perhaps, be tolerable if hospitals or other healthcare providers used their discretion in these cases to charge (fill in) a fair and reasonable price for the medical goods and services provided.<sup>5</sup> After all, the problem of inexact price information at the time of contracting is not unique to the sale of healthcare. For example, when a client hires a lawyer, the client and lawyer know the lawyer's hourly billing rate, but neither party can know how much time the matter will ultimately take. Or for instance, in the case of auto repair, often neither party knows at the time of contracting the exact amount of the ultimate repair bill. In the case of healthcare, however, the amount ultimately charged by the hospital or other provider, when based on the provider's list or chargemaster price, is not reasonable. It is exorbitant and grossly unfair.<sup>6</sup>

A chargemaster is an extensive price list created and maintained by hospitals and other providers.<sup>7</sup> A hospital's chargemaster lists a price for each good and service provided by the hospital (20,000 or more separate items may be included).<sup>8</sup> Hospitals update, that is increase, these list prices

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carrier. *Id.* at \*3. However, by the time Cape Regional submitted their claim to the Medicaid carrier, the claim was too late and thus denied. *Id.* at \*2. Cape Regional sued Sanchez for the total billed charges, \$1,495, even though it would have accepted \$494.85 from Medicaid as full payment. *Id.* at \*5. The court notes that Cape Regional based its claim against Sanchez on the "authorization for treatment signed by the Defendant and the authorization for financial responsibility also signed by the Defendant." *Id.* at \*2. The court noted that these documents routinely form the basis of a hospital's collection effort. *Id.*

<sup>4</sup>*Id.* at \*9 ("The patient or one of his or her loved ones signs the authorization form for payment which is in reality a blank check with the numbers to be filled in by the hospital billing department.").

<sup>5</sup>See generally George A. Nation III, *Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured*, 94 KY. L.J. 101 (2005–2006) (using the doctrine of unconscionability to determine if price is reasonable). In fact, one may argue that hospitals should not be permitted to collect their chargemaster or list prices from any patient based on an agreement signed at the hospital at the time of treatment. See *id.* at 112, 127, 130.

<sup>6</sup>See *infra* notes 22–43.

<sup>7</sup>See Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy*, 25 HEALTH AFF. 57, 58 (2006) [hereinafter *U.S. Hospital Services*] ("A hospital's chargemaster is a lengthy list of the hospital's prices for every single procedure performed in the hospital and for every supply item used during those procedures.").

<sup>8</sup>*Id.* at 58–59 (noting that a sample chargemaster posted on the website of California's state government contains close to 20,000 items).

frequently.<sup>9</sup> From 1984 to 2004, for example, chargemaster prices increased 10.7% per year, which was much faster than Medicare allowable costs (6.3%) or hospital net revenues (6.6%).<sup>10</sup> Thus, as later discussed in Part III.E., while increases in list prices do not add dollar-for-dollar to the net revenues a hospital receives, higher chargemaster prices do, for a variety of reasons, result in an increase in net revenues.<sup>11</sup> In addition, there are other reasons for a hospital to continually set higher list prices<sup>12</sup> and no reason for them not to constantly increase list prices.<sup>13</sup> Hospitals, in general, do not provide prospective patients with a copy of the chargemaster.<sup>14</sup> However, even if a copy of the hospital's chargemaster were provided to each potential patient prior to treatment, it would mean very little to the patient.<sup>15</sup> With regard to healthcare, the patient does not know what he is purchasing in a way that would allow the patient to use the chargemaster to calculate the price.<sup>16</sup> A patient may know, for instance, that he needs a hernia repair procedure, and he may have discussed the various procedures in detail with his doctor in order to determine which one is best for him. But, even if the patient is very well informed regarding hernia-repair options, he has no idea how many pairs of surgical gloves, operating room hours, or suture materials, etc. are needed to perform this procedure. Moreover, in some

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<sup>9</sup> *Id.* at 59.

<sup>10</sup> See Gerard F. Anderson, *From 'Soak the Rich' to 'Soak the Poor': Recent Trends in Hospital Pricing*, 26 HEALTH AFF. 780, 783 (2007).

<sup>11</sup> See Christopher P. Tompkins et al., *The Precarious Pricing System for Hospital Services*, 25 HEALTH AFF. 45, 50 (2006) (individual items in the chargemaster are subject to smaller or larger than average increases based on the advice of an "arsenal of consultants and computer software . . . used to determine optimal increases in charges for various services. Optimality implies a higher payoff for a given rate of increase . . .").

<sup>12</sup> See *infra* notes 245–255.

<sup>13</sup> There is no downside to high list or chargemaster prices; rather, there is only potential reward. See Anderson, *supra* note 10, at 785 ("[T]he chargemaster file is generally not accessible to the public.").

<sup>14</sup> See Reinhardt, *U.S. Hospital Services*, *supra* note 7, 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.").

<sup>15</sup> *Id.* ("If the sample chargemaster posted by California's state government is any guide, prospective patients would be hard put to make sense of these price lists.").

<sup>16</sup> See Anderson, *supra* note 10, at 786 (noting the reasons chargemaster information will not allow self-pay patients to negotiate lower prices: patients do not know in advance the services they need from the hospital, chargemasters contain on average 25,000 items, chargemasters are written in billing code that most patients would not understand, and hospitals may change chargemaster rates at any time).

cases, such as those for emergency services, a patient may not even know in a general way what treatment he is seeking.<sup>17</sup> In other words, while a hospital's chargemaster is like a menu or pricelist, it is not something that (even if it were available) most patients could read in a meaningful way to calculate in advance how much they will owe for their treatment.<sup>18</sup>

This is not to say that consumers may not be effective advocates for lower prices; in this case, I am simply recognizing the reality that, as long as hospitals use á la carte pricing based on chargemasters, consumers will not be able to effectively negotiate price.<sup>19</sup> But, neither government insurers nor most private insurers accept á la carte pricing; rather, they demand procedure-based pricing, which is based either on DRGs (diagnostic related groups) for inpatient care or on APCs (ambulatory payment classification) for outpatient services.<sup>20</sup> It should be noted, however, that even in the case of Medicare reimbursement, higher chargemaster rates result indirectly in higher net revenues for hospitals.<sup>21</sup> If hospitals published procedure-based prices and applied them to individual consumers, consumers could effectively compare prices among providers.

Another important characteristic of healthcare is that chargemaster or list prices are not fair or reasonable.<sup>22</sup> They are grossly inflated because they are set to be discounted rather than paid.<sup>23</sup> Hospitals, in general, do not expect to recover these inflated prices, but for reasons discussed in Part III.E., they are very reluctant to reduce them for self-pay patients. Nevertheless, hospitals and other providers maintain that the grossly inflated list prices contained in their chargemasters are "reasonable and customary," in part because every patient, insured or uninsured, receives a detailed itemized bill reflecting chargemaster prices.<sup>24</sup> As a result, hospitals

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<sup>17</sup> See *id.*

<sup>18</sup> See *id.*

<sup>19</sup> See *id.*

<sup>20</sup> See Reinhardt, *U.S. Hospital Services*, *supra* note 7, at 60–61 (discussing various billing/price-setting methods for various payers).

<sup>21</sup> *Id.* at 60 (noting that the DRG weights used by Medicare are "recalibrated regularly on the basis of average standardized, billed charges for all cases falling into each DRG in the most recent Medicare file").

<sup>22</sup> See *infra* Part IV.B.

<sup>23</sup> See Reinhardt, *U.S. Hospital Services*, *supra* note 7, at 57 ("[Chargemaster rates] are much higher than the prices U.S. hospitals are actually paid. In 2004, for example, U.S. hospitals were actually paid only about 38 percent of their 'charges' by patients or their insurers.").

<sup>24</sup> *Id.* at 59 ("Typically, a hospital will submit, for all of its patients, detailed bills based on its chargemaster, even to patients covered by Medicare."); *id.* at 63 ("It might be argued that because

sometimes claim that all patients are billed at chargemaster rates.<sup>25</sup> However, while all patients are billed chargemaster rates, all patients are not expected to pay the billed charges.<sup>26</sup> As later discussed in Part III.E., for insured patients, the billed (chargemaster based) amount is dramatically (at least 50%) discounted. Thus, while hospitals claim that the chargemaster rates reflect their usual and customary *charge* for services, they certainly do not represent the usual price actually *paid* for the listed goods and services.<sup>27</sup> Self-pay patients, who represent a small portion of a hospital's patients, are the only patients expected to actually pay the full hospital bill based on chargemaster rates.<sup>28</sup> Self-pay patients include: the uninsured;<sup>29</sup> international visitors who receive medical care here; and people insured by health plans lacking contracts with hospitals (out of network patients subject to so called "balance billing" or those who self-insure via reliance on a health-savings account).<sup>30</sup> In addition, in this article, the term self-pay patient also includes patients covered by automobile insurance for healthcare and patients covered by workers compensation because, in these cases, hospitals also expect full payment of or an amount very close to the billed charges.

A third important characteristic of healthcare sales is that hospitals and other providers engage in extensive and significant price discrimination.<sup>31</sup> As discussed in Part III.E., providers of medical services routinely and significantly discount their chargemaster prices pursuant to

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hospitals initially bill all of their patients at their chargemaster prices, they do not engage in 'price discrimination' [an argument Reinhardt finds unpersuasive].").

<sup>25</sup> See *id.* at 63.

<sup>26</sup> *Id.* at 57 (noting that in 2004, U.S. hospitals were actually paid only about 38% of their charges); *id.* at 59–62 (discussing the specifics of discounting chargemaster prices for government and private insurers).

<sup>27</sup> See Reinhardt, *U.S. Hospital Services*, *supra* note 7, at 57.

<sup>28</sup> See Anderson, *supra* note 10, at 780 ("Hospitals often present [self-pay patients] with bills that reflect the hospital's full charge . . ."); Tompkins et al., *supra* note 11, at 52 (self-payers are usually forced to accept the full charges set by the hospital).

<sup>29</sup> It is important to note that, even with the Patient Protection and Affordable Care Act (ACA) (aka "ObamaCare"), there will still be a significant number of Americans without health insurance. See Heather R. Higgins & Hadley Heath, Op-Ed., *Informed Independents Cool to ObamaCare*, WALL ST. J., Oct. 5, 2012, at A13. For example, it is estimated that, ten years after the ACA becomes fully operational, there will be 30 million Americans uninsured. *Id.*

<sup>30</sup> Anderson, *supra* note 10, at 781 (listing the various groups of self-pay patients who were required to pay for care at chargemaster rates).

<sup>31</sup> See *infra* Part III.A.

specific contracts with HMOs and private insurance companies. While all insurers pay discounted rates, the amount of the discount—and thus the amount paid by insurers for the same healthcare—varies widely with no two insurers necessarily paying the same price for the same care.<sup>32</sup> Government insurers, such as Medicare and Medicaid, set their own reimbursement rates that hospitals and doctors agree to accept as full payment, and these amounts are usually significantly less than the amounts paid by private insurers and HMOs.<sup>33</sup> Discounts from chargemaster prices given to insurers overall average about 62%,<sup>34</sup> but in specific cases can be 80% or even more.<sup>35</sup> To put it another way, hospitals and other providers typically and routinely accept less than 50% of the chargemaster rates (sometimes a lot less) as full payment from HMOs, private insurers, and government insurers on behalf of insured patients.<sup>36</sup> Overall in 2004, for every \$257 that a hospital charged based on its chargemaster rates, it actually collected \$100.<sup>37</sup> In other words, patients such as the uninsured and other self-pay patients who are charged chargemaster rates are actually being asked to pay *at least* two and a half times the average amount paid by health insurers for the same exact care.<sup>38</sup> All of these discounts are well known in advance by the hospital and are planned for in budgeting.<sup>39</sup> Thus, with regard to medical services, different patients (or more accurately different insurers) pay dramatically different prices for the same medical

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<sup>32</sup> See Reinhardt, *U.S. Hospital Services*, *supra* note 7, at 63 (“The reality is that hospitals accept different payments from different payers for identical services, and that can properly be called price discrimination.”).

<sup>33</sup> See *id.* at 59–61 (outlining payments to various insurers); Tompkins et al., *supra* note 11, at 47.

<sup>34</sup> Reinhardt, *U.S. Hospital Services*, *supra* note 7, at 57 (“In 2004, for example, U.S. hospitals were actually paid only about 38 percent of their ‘charges’ by patients or their insurers.”).

<sup>35</sup> See *infra* notes 65–87 (discussing *Nassau Anesthesia Assocs. PC v. Chin*, 924 N.Y.S.2d 252 (N.Y. Dist. Ct. 2011)); *Nassau*, 924 N.Y.S.2d at 254 (finding discounts among the various payers ranged approximately from 20% to 91%).

<sup>36</sup> See Anderson, *supra* note 10, at 782 (“In 2004, the overall ratio of gross to net revenues was 2.57, which means that for every \$100 the hospital actually collected from all sources, it initially charged \$257.”).

<sup>37</sup> *Id.*

<sup>38</sup> See *id.*

<sup>39</sup> See Tompkins et al., *supra* note 11, at 50 (“Prototypically, pure pricing updates occur once a year, as a component of the budgeting process, which includes constructing an initial revenue model based on expected payer mix, service mix, and expected payer contract specifications, and an initial cost model based on current input costs, expected service volumes, and so forth.”).

care.<sup>40</sup> In healthcare, there is a huge difference between the price charged and the price paid (and accepted as full payment by providers) by, or on behalf of, most patients.<sup>41</sup> The most important factor in determining the amount the hospital or other provider will accept as full payment for its medical care is the identity of the insurer.<sup>42</sup>

If chargemaster prices are not fair or reasonable, the obvious question then becomes: how much should self-pay patients be charged for medical care? In certain situations, courts, or others, are called upon to determine the fair and reasonable value of medical services.<sup>43</sup> For example, in personal injury cases<sup>44</sup> and in self-pay cases (such as those involving uninsured patients<sup>45</sup> or out-of-network patients subject to balance billing<sup>46</sup>) courts are often called upon to make this determination. In these cases the issue is: what is the fair and reasonable value of medical care? If it is not the amount billed by the provider, then is it the amount usually paid by insurers, or some other amount? In all of these cases the question ultimately is: what is the fair and reasonable value of medical care? Answering this question is the focus of this article. Part II provides some background concerning the various contexts in which it is necessary to determine the fair and reasonable value of medical care. Part III briefly discusses hospital pricing practices and price discrimination with particular focus on the likely reasons hospitals charge different prices to different payers, and whether, in fact, it is fair to say that hospitals are engaged in price discrimination. Part IV analyzes various methods for determining the fair and reasonable value of medical services. Part V concludes.

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<sup>40</sup> See Anderson, *supra* note 10, at 780.

<sup>41</sup> Tompkins et al., *supra* note 11, at 48 (“The gap between charges and actual payments (net patient revenues) now averages about 255 percent and is growing rapidly.”).

<sup>42</sup> See *id.* at 46–48 (describing how prices are set for various payers); Reinhardt, *U.S. Hospital Services*, *supra* note 7, at 59–63 (similar).

<sup>43</sup> See *infra* Part II.

<sup>44</sup> See *infra* Part II.B.

<sup>45</sup> See *infra* Part II.A.

<sup>46</sup> See *infra* Part II.C.



## II. BACKGROUND: SITUATIONS IN WHICH IT IS NECESSARY TO DETERMINE THE FAIR AND REASONABLE VALUE OF MEDICAL SERVICES

### A. *The Uninsured*

It is important to note that the uninsured are often divided into two groups (the poor or indigent uninsured and the non-poor/non-indigent uninsured) for purposes of discussing healthcare policy.<sup>47</sup> Unfortunately, there is no generally accepted definition of poor or indigent when it comes to those without health insurance.<sup>48</sup> In this article when the term “uninsured” is used, it includes both the poor and non-poor unless otherwise stated.

As noted in the Introduction, the usual premise in a free market is that a seller may set his price at any level he chooses, but buyers may refuse to buy. This premise is applicable to hospitals and other healthcare providers

<sup>47</sup> See, e.g., *Nassau Anesthesia Assocs. PC v. Chin*, 924 N.Y.S.2d 252, 255 (N.Y. Dist. Ct. 2011) (where the court would *not* reduce chargemaster charges for uninsured patients who had the financial ability to pay); Nation, *supra* note 5, at 121 (discussing Medicare rules that allow write-offs for the uninsured only if based on financial indigency); Rebecca Levenson, Comment, *Allocating the Costs of Harm To Whom They Are Due: Modifying the Collateral Source Rule After Health Care Reform*, 160 U. PA. L. REV. 921, 935–36 (2012) (discussing “willfully” uninsured individuals—that is the non-poor uninsured who could buy health insurance but choose not to—and suggesting harsher treatment for the willfully, non-poor, uninsured); Anderson, *supra* note 10, at 786 (“On 29 April 2006 the AHA [American Hospital Association] board of trustees approved a set of policies to lower the rates for poor, uninsured people.”); *id.* at 786–87 (The AHA guidelines are *not* binding on hospitals, but do at least define “poor.” The guidelines provide that “uninsured patients with incomes below 100 percent of the federal poverty level should receive care at ‘no charge.’ Patients with incomes of 100–200 percent of poverty should be asked to pay no more than the price paid to the hospital under contract by a public or private insurer, or 125 percent of the Medicare rate for applicable services.”).

<sup>48</sup> For example, § 9007(a) of the Patient Protection and Affordable Care Act of 2010 [hereinafter ACA], Pub. L. No. 111-148, 124 Stat. 855 (to be codified as amended in scattered sections of 21, 25, 26, 29, and 42 U.S.C.), amended 26 U.S.C. by enacting section 501(r) of the Internal Revenue Code (I.R.C.), which adds certain requirements for hospitals that seek to comply with the federal income tax exemptions provided by section 501(c)(3). One of these requirements limits the amount a hospital may charge poor (that is patients eligible for financial assistance under the hospital’s financial assistance policy of FAP) uninsured patients for emergency or other medically necessary care. *Id.* § 90007(a) (to be codified as I.R.C. § 501(r)(5)(A)). However, under the proposed regulations it is left to each hospital to define poor, that is FAP eligible, patients. See *Additional Requirements for Charitable Hospitals*, 77 Fed. Reg. 38,148–49 (proposed June 26, 2012) (to be codified at 26 C.F.R. pt. 1) (“Neither the statute nor these proposed regulations establish specific eligibility criteria that a FAP must contain.”).

when they set prices with private insurers and HMOs.<sup>49</sup> However, I argue here that the special characteristics of healthcare render this premise inapplicable when a hospital or other provider is contracting directly with self-pay patients or when calculating the fair and reasonable value of necessary medical care as a component of damages for personal injury.<sup>50</sup> For example, when an uninsured patient receives treatment at a hospital, she usually receives a bill that is priced at the hospital's chargemaster rate(s).<sup>51</sup> Since the patient is not insured, the huge discounts the hospital has negotiated with insurers (and factored into its inflated chargemaster rates) do not apply, and the uninsured patient is faced with a bill that is 250 to 500% (or more) of the amount the hospital would accept as full payment from insurers.<sup>52</sup> The hospital bases its claim for this exorbitant amount on the contract entered into with the patient—for example, the “Statement of Financial Responsibility” usually signed by the patient upon admission to the hospital, pursuant to which the patient allegedly agreed to pay “chargemaster” or “list” prices for all care received.<sup>53</sup> In addition, the hospital claims that its list prices are “reasonable and customary” because all patients are *billed* at these rates before discounts are applied.<sup>54</sup>

Agreements such as the “Statement of Financial Responsibility” should not be used as justification to hold uninsured patients liable for unconscionably high chargemaster prices.<sup>55</sup> If patients were told the truth, no patient would ever freely agree to pay the hospital's list or chargemaster prices. For example, if a hypothetical patient entering the hospital for gall bladder surgery were told the truth, the patient would be told that according to the chargemaster his bill would likely be about \$14,000, but that the hospital has agreed to do the same exact procedure (with anesthesia and everything) for HMOs at a price of \$5600, for Blue Cross/Blue Shield at a

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<sup>49</sup> See *supra* notes 32–43.

<sup>50</sup> See *infra* Parts IV.A–C.

<sup>51</sup> See Reinhardt, *U.S. Hospital Services*, *supra* note 7, at 62.

<sup>52</sup> See *supra* notes 34–42.

<sup>53</sup> See, e.g., *Cape Reg'l Med. Ctr. v. Sanchez*, No. CPM DC 109-11, at \*2 (N.J. Super. Ct. Law Div. Mar. 26, 2012) (on file with the Baylor Law Review). The court noted that Cape Regional based its claim against Sanchez on the “authorization for treatment signed by the Defendant and the authorization for financial responsibility also signed by Defendant.” *Id.* at \*2. The court also noted that these documents routinely form the basis of a hospital's collection effort. *Id.*

<sup>54</sup> See *supra* note 24.

<sup>55</sup> See Nation, *supra* note 5, at 126–27.

price of \$4700, for Aetna at a price of \$5000, for Medicare at a price of \$2590 and for Medicaid at a price of \$1260.<sup>56</sup> With this real and meaningful information, no patient with capacity would freely agree to pay \$14,000 for the gall bladder surgery. If the patient offered \$6000 the hospital would likely agree and the patient would save more than fifty percent. Of course, if the patient is in pain and needs the procedure he may agree to anything, or if he is stuck with the same “deal” at any other nearby hospital, he may agree, but in neither case is his agreement freely given as required under contract law.<sup>57</sup> Assuming no emergency, and no contract of adhesion, the real reason that patients “agree” to pay \$14,000 for gall bladder surgery is that they are deceived by the “chargemaster,” or “list price,” language in their Financial Responsibility Agreement and they are ignorant regarding the odd characteristics of hospital pricing.<sup>58</sup>

I have argued elsewhere, in detail, that contracts calling for payment of hospitals’ chargemaster or list prices by the uninsured are unenforceable under the doctrine of unconscionability, and I will not repeat those arguments here.<sup>59</sup> More recently, the ACA includes provisions designed to limit the amount that federally tax-exempt hospital organizations may charge poor uninsured patients.<sup>60</sup> In addition, courts and even some hospitals have begun to recognize the unfairness of forcing the uninsured (some recognize this unfairness only for the poor uninsured) to pay the exorbitant chargemaster prices.<sup>61</sup> As a result, some hospitals have begun to voluntarily discount the bills of the uninsured to bring them closer to their contractually discounted reimbursement rates.<sup>62</sup> The relevant point for this

<sup>56</sup>This example is hypothetical, but the percentage differences in the prices expected to be paid by the various insurers are estimates based on actual discounts. *See, e.g.,* Nassau Anesthesia Assoc. PC v. Chin, 924 N.Y.S.2d 252, 254 (N.Y. Dist. Ct. 2011).

<sup>57</sup>*See* Nation, *supra* note 5, at 127

<sup>58</sup>*See, e.g.,* Sanchez, at \*1–4, \*9 (on file with the Baylor Law Review) (“The patient or one of his or her loved ones signs the authorization form for payment which is in reality a blank check with the numbers to be filled in by the hospital billing department.”).

<sup>59</sup>*See* Nation, *supra* note 5, at 137–38.

<sup>60</sup>*See* I.R.C. § 501(r)(5) (West 2010). The ACA provisions are discussed in more detail later. *See infra* Part IV.G.

<sup>61</sup>*See* Anderson, *supra* note 10, at 786–87 (discussing the non-binding recommendation of the AHA).

<sup>62</sup>*See* Tim Darragh, *Hospitals Discount Care for the Uninsured*, THE MORNING CALL (October 4, 2012), [http://articles.mcall.com/2012-10-04/health/mc-hospitals-discount-to-uninsured-20120929\\_1\\_uninsured-patients-uninsured-people-nonprofit-hospitals](http://articles.mcall.com/2012-10-04/health/mc-hospitals-discount-to-uninsured-20120929_1_uninsured-patients-uninsured-people-nonprofit-hospitals) (discussing hospitals that voluntarily reduce full charges for self-pay patients). For instance at Lehigh Valley

article is, if the amount billed by the hospital based on its chargemaster is so unreasonably high as to be unenforceable, how much should an uninsured patient pay for the medical care they receive? In words at least, the answer is easy; an uninsured patient (rich or poor) should have to pay no more than the fair and reasonable value of the medical care received. But given the huge difference between the price billed and the average price actually paid by insurers, and the significant difference in the prices paid by individual insurers, how should fair value be determined?<sup>63</sup>

For example, a New York district court recently addressed the issue of fair and reasonable value of medical expenses in the context of an uninsured patient in *Nassau Anesthesia Associates P.C. v. Chin*.<sup>64</sup> In that case, a medical provider Nassau Anesthesia Associates sued Larry Chin for anesthesia services rendered as part of open-heart surgery.<sup>65</sup> Nassau sought \$8675, the chargemaster list price for the services rendered.<sup>66</sup> The court noted that Nassau was entitled to the fair and reasonable value of its services.<sup>67</sup> The court also noted that Nassau would have accepted, as full payment, much less than \$8675 from private or government insurers.<sup>68</sup> Specifically, the court notes that the provider would have been paid between \$5208.01 (Blue Cross Blue Shield) and \$6970 (United Healthcare) if covered by private insurance, \$1605.29 if covered by Medicare, and \$797.50 if covered by Medicaid.<sup>69</sup> However, Mr. Chin was uninsured, so Nassau sought the entire billed amount as payment.<sup>70</sup> Nassau received a default judgment as to liability when Mr. Chin failed to appear.<sup>71</sup> However, Nassau was still required to prove its damages.<sup>72</sup> Nassau could not establish

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Health Network the discounts are greater for poor self-pay patients but “even a well-heeled patient who is uninsured and completes the reduced price application will be billed no more than 33 percent of the full charge.” *Id.* At nearby St. Luke’s University Health Network uninsured patients are asked to pay no more than 20% of charges. *Id.* However, at another area hospital, Sacred Heart, only those uninsured patients making no more than 150% of the federal poverty level qualify for discounted care. *Id.*

<sup>63</sup> See *infra* Part IV.D.

<sup>64</sup> 924 N.Y.S.2d 252 (N.Y. Dist. Ct. 2011).

<sup>65</sup> See *id.* at 253.

<sup>66</sup> *Id.*

<sup>67</sup> *Id.*

<sup>68</sup> See *id.* at 254.

<sup>69</sup> *Id.*

<sup>70</sup> *Id.* at 253.

<sup>71</sup> *Id.*

<sup>72</sup> *Id.*

that Mr. Chin had failed to pay an “agreed upon amount” (evidently there was no “Statement of Financial Responsibility” or similar agreement signed by Mr. Chin); thus, Nassau’s damages were dependent upon proof of “the fair and reasonable value” of its services.<sup>73</sup>

The court ruled that the determination of the reasonable value of a health provider’s services requires more than ministerial examination of the provider’s bills.<sup>74</sup> An important factor according to the court was the amount charged by other practitioners of similar standing for similar services.<sup>75</sup> The court also noted that “a patient’s strained financial condition” may be considered in determining whether billed amounts are reasonable.<sup>76</sup> However, the court stated that the mere fact that a provider accepts lesser amounts for the same service from commercial or government insurers does not necessarily mean that the providers charge is unreasonable.<sup>77</sup> The court recognized that providers may give substantial discounts to private insurers for various reasons such as volume of payments, promptness of payment, and assurance of payment.<sup>78</sup>

The court concluded that the fair and reasonable value of Nassau’s services was “the average amount that it would have accepted as full payment from third-party payors such as private insurers and federal healthcare programs.”<sup>79</sup> That amount, as calculated by Nassau’s billing manger, was \$4252.11.<sup>80</sup> The court, citing *Temple University Hospital, Inc. v. Healthcare Management Alternatives, Inc.*, held that the amounts actually received by medical providers from insurers are a far better indicator of the reasonable value of a provider’s services than the list prices unilaterally set by the provider.<sup>81</sup> The court also cited *Temple* for the assertion that, since the price the hospital unilaterally sets for the uninsured bears no relationship to the amount typically paid for these services, acceptance of

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<sup>73</sup> *Id.*

<sup>74</sup> *Id.*

<sup>75</sup> *Id.*

<sup>76</sup> *Id.* at 254.

<sup>77</sup> *Id.*

<sup>78</sup> *Id.*

<sup>79</sup> *Id.* at 255.

<sup>80</sup> *Id.*

<sup>81</sup> *See id.* at 254; *Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alts., Inc.*, 832 A.2d 501, 508–09 (Pa. Super. Ct. 2003) (“[B]ased on the Hospital’s data, the full published charges in 1994 were approximately 172% of its actual costs, while in 1995 and 1996, the published rates were approximately 300% of its actual costs.”).

providers published rates is untenable.<sup>82</sup> A more realistic standard is what insurers actually pay and providers accept.<sup>83</sup> The court did, however, limit its holding to cases where the provider fails to prove either that the defendant agreed to pay the providers “uninsured patient fee” (chargemaster/list charges), or that the patients had the financial ability to pay list charges.<sup>84</sup> In other words, the courts holding was limited to the poor uninsured who had not signed a “statement of Financial Responsibility” or similar agreement.<sup>85</sup> I argue here that these limitations are not appropriate.<sup>86</sup>

### B. *Personal Injury Litigation*

Pursuant to the law of torts, a plaintiff may recover the value of her reasonable and necessary medical expenses as a part of her damages from the tortfeasor/defendant.<sup>87</sup> Traditionally, the dollar value of medical expenses was the undiscounted amount billed by the hospital (that is, calculated using its chargemaster).<sup>88</sup> Usually the plaintiff submits an affidavit from the billing administrator of the hospital, which states that all of the charges reflected on the hospital’s bill/invoice were necessary, reasonable, and customary, along with a copy of the hospital’s bill to establish this amount.<sup>89</sup> Remember every patient, insured and uninsured, is billed at chargemaster rates before the application of negotiated discounts.<sup>90</sup> Thus, the tortfeasor is required to reimburse the victim/plaintiff for medical

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<sup>82</sup> *Nassau*, 924 N.Y.S.2d at 255.

<sup>83</sup> *Id.*

<sup>84</sup> *Id.*

<sup>85</sup> *See id.*

<sup>86</sup> *See infra* Part IV.E.1.

<sup>87</sup> *See* 22 AM. JUR. 2D *Damages* § 396 (2003) (noting that a plaintiff may recover both economic and non-economic damages).

<sup>88</sup> *See, e.g.,* *Lopez v. Safeway Stores, Inc.*, 129 P.3d 487, 491, 495–96 (Ariz. Ct. App. 2006) (holding, in a slip and fall case in which the plaintiff’s medical bills totaled \$59,700, that although the healthcare providers were contractually bound to accept \$16,837 as full payment from plaintiff’s health insurers, the court, in applying the common law collateral source rule, allowed the plaintiff to recover \$59,700 as economic damages); Lori A. Roberts, *Rhetoric, Reality, and the Wrongful Abrogation of the Collateral Source Rule in Personal Injury Cases*, 31 REV. LITIG. 99, 99–101 (2012) (discussing the *Lopez* case in the context of arguing that unwarranted rhetoric is wrongly being used to abrogate the collateral source rule).

<sup>89</sup> *See, e.g.,* *Cape Reg’l Med. Ctr. v. Sanchez*, No. CPM DC 109-11, at \*1–4 (N.J. Super. Ct. Law Div. Mar. 26, 2012) (on file with the Baylor Law Review).

<sup>90</sup> *See Reinhardt, U.S. Hospital Services*, *supra* note 7, at 63; *see also* notes 23–31 and accompanying text.

care at the billed or chargemaster rate.<sup>91</sup> Usually in these cases the hospital never received the chargemaster price; rather, the victim/plaintiff's insurance carrier paid the hospital a much lower discounted amount based on the insurer's contract with the hospital.<sup>92</sup> The insurer may have recovered this amount from the plaintiff via subrogation, though many insurers do not pursue subrogation in this context.<sup>93</sup>

As courts and lawmakers have come to understand the details of hospital pricing and billing practices, specifically that chargemaster/list prices are set to be discounted not paid, they have begun to adopt policies to limit the recovery of medical expenses to “the amount actually paid or incurred on behalf of the patient.”<sup>94</sup> For example, assume that a tort occurred, and as a result, the victim/plaintiff sought medical treatment. Further assume that the hospital sent a detailed bill to the victim/plaintiff listing every good and service provided to the patient and charging the patient the chargemaster price for each one. Remember that hospitals always and routinely send such bills even to insured patients even though insured patients and their insurers are only required to pay the discounted balance.<sup>95</sup> Further assume the hospital's bill totals \$1495, but the hospital accepted \$494.85 as payment in full from the patient's insurer. At common law the collateral source rule prevents the defendant/tortfeasor from arguing that the plaintiff's out-of-pocket medical expenses are \$0 (the insurance company paid, not the plaintiff/patient).<sup>96</sup> Under the collateral source rule, the defendant is prevented from offering any evidence concerning any

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<sup>91</sup> See, e.g., *Lopez*, 129 P.3d at 496.

<sup>92</sup> See *id.* at 491.

<sup>93</sup> Subrogation refers to the right of the insurance company that paid for the plaintiff's medical expenses to recover the amount paid from the tortfeasor (defendant), which reduces the amount recovered by the plaintiff. See ROBERT E. KEETON & ALAN I. WIDISS, *INSURANCE LAW: A GUIDE TO FUNDAMENTAL PRINCIPLES, LEGAL DOCTRINES, AND COMMERCIAL PRACTICES* § 3.10(a)(1) (abr. ed. 1988); Levenson, *supra* note 47, at 928–34.

<sup>94</sup> See, e.g., *Haygood v. Garza De Escabedo*, 356 S.W.3d 390, 391, 393 (Tex. 2011) (applying a Texas statute that states “recovery of medical or health care expenses incurred is limited to the amount actually paid or incurred by or on behalf of the claimant” and discussing the two-tiered system and hospital billing (quoting TEX. CIV. PRAC. & REM. CODE ANN. § 42.0105 (West 2008))).

<sup>95</sup> See Reinhardt, *U.S. Hospital Services*, *supra* note 7, at 63.

<sup>96</sup> See RESTATEMENT (SECOND) OF TORTS § 920A(2) (1979) (“Payments made to or benefits conferred on the injured party from other sources are not credited against the tortfeasor's liability, although they cover all or a part of the harm for which the tortfeasor is liable.”).

reimbursement made to or on behalf of the plaintiff by a collateral source.<sup>97</sup> Insurance companies are considered collateral sources, and thus a jury cannot be told that the patient/plaintiff's medical expenses were paid for by insurance.<sup>98</sup> The collateral source rule promotes fairness because, if a victim of a tort had the prudence to acquire medical insurance, the tortfeasor should not benefit from the insurance.<sup>99</sup> If this were allowed the tortfeasor would receive a windfall.<sup>100</sup> To prevent this, the collateral source rule prevents the defendant from presenting evidence of any collateral source benefits received by the plaintiff.<sup>101</sup>

For this article, the relevant issue is whether the collateral source rule, or the principal of fairness on which it is based, requires that the jury also not be told that the patient's bill was discounted by \$1000.15 or 67%. In terms of the collateral source rule, it seems clear that the \$494.85 payment by the insurer is a collateral source benefit that should be kept from the jury.<sup>102</sup> But what about the \$1000.15 discount the insurance company negotiated with the hospital? Is that also a collateral source benefit to the patient or simply a benefit to the insurer?<sup>103</sup> If it is simply a benefit to the insurer, the rule would not prevent telling the jury that the hospital discounted its bill to \$494.85.<sup>104</sup> Many states have modified the common law collateral source rule to allow juries to be told of the \$1000.15 discount, often as part of tort reform, and often noting that a hospital's chargemaster rates are illusionary or phantom charges.<sup>105</sup> For our purposes the question is: what is the reasonable value of the medical services received by the patient/plaintiff—\$494.85, \$1495, or some amount between the two? As

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<sup>97</sup> See *Propeller Monticello v. Mollison*, 58 U.S. (17 How.) 152, 155 (1854) (introducing the collateral source rule to the United States by stating "[t]he wrongdoer . . . is bound to make satisfaction for the injury he has done.").

<sup>98</sup> *Haygood*, 356 S.W.3d at 395.

<sup>99</sup> See *Helfend v. S. Cal. Rapid Transit Dist.*, 465 P.2d 61, 66 (Cal. 1970) (finding that a person who has invested years of premiums to acquire insurance should benefit from his prudence thrift, not the tortfeasor).

<sup>100</sup> See *Haygood*, 356 S.W.3d at 395.

<sup>101</sup> See *id.* at 391.

<sup>102</sup> *Id.*

<sup>103</sup> See *id.* at 395 ("An adjustment in the amount of [the hospitals full charges] to arrive at the amount owed is a benefit to the insurer, one it obtains from the provider for itself, not for the insured.").

<sup>104</sup> See *id.* at 391, 395.

<sup>105</sup> See Roberts, *supra* note 88, at 124–32 (discussing rhetorical themes of illusory medical bills and windfalls in states modifying or abolishing the collateral source rule).



discussed in Parts III.E., IV.F., and IV.G., the plaintiff via the collateral source rule or legislation should be able to recover the fair and reasonable value of his medical expenses from the defendant, regardless of the amount paid by his insurer or the amount billed by the hospital.

For example, in the case *Haygood v. Escabedo*, the Texas Supreme Court ruled that the common-law collateral source rule was modified by a Texas statute so that it does not allow recovery as damages of medical expenses a healthcare provider was not entitled to be paid.<sup>106</sup> In other words, reasonable expenses for receiving medical care are, in Texas, equal to the amount healthcare providers have a right to be paid for the care (the contract adjusted amount), not the amount the healthcare provider billed for the care (chargemaster/list prices).<sup>107</sup> This case involved damages for injuries resulting from an automobile collision. Haygood was billed a total of \$110,069.12 for the medical care he received.<sup>108</sup> Haygood was covered by Medicare Part B, which, the court noted, “pays no more for . . . medical and other health services than the “reasonable charge” for such service.”<sup>109</sup> The court also noted that federal law prohibits healthcare providers who agree to treat Medicare patients from charging more than Medicare has determined to be reasonable.<sup>110</sup> Thus, Haygood’s healthcare providers adjusted their bills with credits of \$82,329.69, or 75%, leaving a total of \$27,739.43 due.<sup>111</sup>

At trial, Escabedo moved to exclude evidence of medical expenses other than those owed or paid (i.e. \$27,739.43).<sup>112</sup> Haygood asserted the collateral source rule and moved to exclude evidence of any amounts other than those billed (i.e. \$110,069.12).<sup>113</sup> The trial court denied Escabedo’s motion and granted Haygood’s.<sup>114</sup> At trial, Haygood offered evidence from the various healthcare providers that the charges billed were reasonable and the services were necessary.<sup>115</sup> The jury found Escabedo at fault and awarded Haygood

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<sup>106</sup> *Haygood*, 356 S.W.3d at 396.

<sup>107</sup> *Id.* at 397.

<sup>108</sup> *Id.* at 392.

<sup>109</sup> *Id.* (quoting 42 C.F.R. § 405.501(a) (2012)).

<sup>110</sup> *Id.*

<sup>111</sup> *Id.*

<sup>112</sup> *Id.*

<sup>113</sup> *Id.*

<sup>114</sup> *Id.*

<sup>115</sup> *Id.*

\$110,069.12 for past medical expenses.<sup>116</sup> Escabedo objected to the award of past medical expenses in excess of the amounts actually paid and owed to the healthcare providers, but was overruled by the trial court.<sup>117</sup>

The court of appeals reversed by applying a Texas statute that states: “recovery of medical or healthcare expenses incurred is limited to the amount actually paid or incurred by or on behalf of the claimant.”<sup>118</sup> The court of appeals stated that the statute precluded evidence or recovery of expenses that “neither the claimant nor anyone acting on his behalf will ultimately be liable for paying.”<sup>119</sup> The Texas Supreme Court upheld the court of appeals noting the great disparity that exists between amounts billed and payments accepted by healthcare providers.<sup>120</sup> The court also noted, that healthcare providers rarely expect chargemaster or list prices to be paid, and in fact they are very rarely if ever actually paid.<sup>121</sup> But healthcare providers routinely bill all patients, including insured patients, at list or chargemaster rates with reductions to reimbursement rates shown separately as adjustments or credits.<sup>122</sup>

The court quoted the Restatement (Second) of Torts, which states the collateral source rule reflects “the position of the law that a benefit that is directed to the injured party should not be shifted so as to become a windfall for the tortfeasor.”<sup>123</sup> The court ruled that the contract adjustments to the billed charges were not benefits directed to the injured party—rather they were benefits of the insurer.<sup>124</sup> Thus, the collateral source rule did not prevent the introduction of evidence of these discounts.<sup>125</sup> The court noted that “[t]o impose liability for medical expenses that a healthcare provider is not entitled to charge does not prevent a windfall to a tortfeasor; it creates one for [the] claimant.”<sup>126</sup> Thus, under Texas law, the collateral source rule does not prevent the introduction of evidence of discounts applied to billed

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<sup>116</sup> *Id.*

<sup>117</sup> *Id.*

<sup>118</sup> *Id.* at 396 (quoting TEX. CIV. PRAC. & REM. CODE ANN. § 41.0105 (West 2008)).

<sup>119</sup> *Id.* at 392 (quotations omitted).

<sup>120</sup> *Id.* at 391.

<sup>121</sup> *See id.* at 393.

<sup>122</sup> *Id.* at 394.

<sup>123</sup> *Id.* at 395 (quoting RESTATEMENT (SECOND) OF TORTS § 920A cmt. b (1979)).

<sup>124</sup> *Id.*

<sup>125</sup> *See id.* at 396.

<sup>126</sup> *Id.* at 395.

charges.<sup>127</sup> In Texas, the reasonable value of medical care is the amount actually paid and accepted by the provider for the care provided.<sup>128</sup>

### C. Balance Billing

The phrase “balance billing” usually refers to a situation where an insured patient has received medical services from a provider that is either not part of the patients’ insurer’s “network” or while part of the network is not in the top tier of providers.<sup>129</sup> The term “network” refers to those providers with whom an insurance company has entered into a reimbursement contract, pursuant to which the insurer has agreed to direct its insured to the providers for necessary treatment, and the providers have agreed to discount their chargemaster prices for the insurance company.<sup>130</sup>

When a patient receives care out-of-network the patient is responsible to pay the provider the difference between the provider’s chargemaster rate and the amount the insurer paid, which is usually the amount it would have paid for the same treatment within the network (discounted pursuant to reimbursement contracts with in-network providers).<sup>131</sup> If the patient receives care in-network, but from a lower tier, then, usually, the patient is responsible for the difference between the amount the insurer has negotiated with the top tier providers and amount the insurer has negotiated with the lower tier provider.<sup>132</sup> In both cases the insurer pays only its lowest discounted amount; but, since the provider is either not in the insurance companies network or is not in the top tier, the provider has not agreed to

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<sup>127</sup> *Id.* at 399–400.

<sup>128</sup> *Id.* at 396–97.

<sup>129</sup> See Uwe E. 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, 2131 (2011) [hereinafter *The Many Different Prices*] (The “potentially high prices for health care procured from providers not in the insurer’s network of providers” is relevant for determining family budgets.); Anna Wilde Mathews, *Medical Care Time Warp*, WALL ST. J., Aug. 2, 2012, at B2 (noting that insurers are reducing the size of their networks of healthcare providers and adopting tiered designs with patients facing bigger out-of-pocket charges if they go to providers that aren’t in the top category and even bigger charges if patients go completely out of network).

<sup>130</sup> See Survey, America’s Health Insurance Plans, *The Value of Provider Networks and the Role of Out-of-Network Charges in Rising Health Care Costs: A Survey of Charges Billed by Out-of-Network Physicians*, at \*1 (Aug. 2009), <http://www.ahip.org/Value-of-Provider-Networks-Report>.

<sup>131</sup> See Reinhardt, *The Many Different Prices*, *supra* note 129, at 2126–29; Survey, *supra* note 130, at \*1.

<sup>132</sup> Survey, *supra* note 130, at \*1.

accept that amount as full payment. Thus providers argue that the patient is responsible for the balance.<sup>133</sup>

Essentially, an out-of-network patient subject to balance billing is in the same position as an uninsured patient or a patient who self-insures with a health savings account; and, it is similarly unfair to demand payment of a balance based on the provider's unreasonably high chargemaster rates.<sup>134</sup> The patient should be responsible for the balance based on the fair and reasonable value of the medical services received (not the chargemaster rate) less the amount paid by the patient's insurance company.<sup>135</sup> The same is true in the case of patients who receive care from a lower tier; they should be responsible for no more than the difference between the amount the insurer paid and the fair and reasonable value of the care received.<sup>136</sup> For example, in the case of *Daughters of Charity Health Services of Waco v. Linnstaedter*, Donald Linnstaedter and Kenneth Bolen were injured in an auto collision while riding together in the course of their employment.<sup>137</sup> Both were treated at a hospital owned by Daughters of Charity Health Services of Waco.<sup>138</sup> The hospital charges billed (chargemaster rates) were \$22,704.25.<sup>139</sup> Both victims were covered by workers compensation insurance, and the workers compensation carrier paid a discounted amount of \$9737.54, which was the amount set by the Texas Labor Code.<sup>140</sup> The Texas Labor Code also provides that hospitals "may not pursue a private claim against a workers' compensation claimant" for all or part of the costs of treatment.<sup>141</sup> Nevertheless, within a week of the accident, the hospital filed a lien seeking the balance of its full charges with the county clerk.<sup>142</sup> The lien attached to the employees' causes of action, and under the Texas Property Code, a tortfeasor cannot obtain a release by judgment or settlement unless the hospitals charges are paid in full.<sup>143</sup>

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<sup>133</sup> See Reinhardt, *The Many Different Prices*, *supra* note 129, at 2125–26; Mathews, *supra* note 129, at B2.

<sup>134</sup> See *supra* Part II.A.

<sup>135</sup> See *infra* Part IV.D.

<sup>136</sup> See *infra* Part IV.D.

<sup>137</sup> 226 S.W.3d 409, 410 (Tex. 2007).

<sup>138</sup> *Id.*

<sup>139</sup> *Id.*

<sup>140</sup> *Id.*

<sup>141</sup> *Id.* at 411 (quoting TEX. LAB. CODE ANN. § 413.042(a) (West 2006)).

<sup>142</sup> *Id.* at 410.

<sup>143</sup> *Id.* at 411 (citing TEX. PROP. CODE ANN. § 55.007 (West 2007)).

The employees filed suit against the other driver, John Paul Jones, and their claims were eventually settled for \$175,000; but, Jones' insurer paid \$12,966.71 of that amount to the hospital to discharge its lien.<sup>144</sup> The employees brought suit against the hospital to recover the \$12,966.71 paid pursuant to the hospital's lien.<sup>145</sup> The employees claimed that the lien was invalid under the Labor Code.<sup>146</sup> The court ruled in favor of the employees noting that a hospital that treats workers' compensation patients is bound by the Labor Code's provisions.<sup>147</sup> Among those provisions are caps on reimbursement that prevent a provider from seeking additional money from patients or their workers' compensation carriers.<sup>148</sup> In addition, workers' compensation fee guidelines are intended to provide both fair and reasonable reimbursement for healthcare providers.<sup>149</sup>

The hospital argued that because the employees had sought the amount billed (\$22,704.25) from Jones rather than the amount their workers' compensation carrier paid (\$9737.54), the hospital should be able to recover the *balance* of its billed charges.<sup>150</sup> The court agreed in part with hospital, noting that "[w]e agree that a recovery of medical expenses in that amount [\$22,704.25] would be a windfall; as the hospital had no claim for these amounts against the patients, they in turn had no claim for them against Jones."<sup>151</sup> The Texas Supreme Court, however, in upholding the lower court allowed the employees/patients to keep this amount, noting that "[w]hile the settlement here exceeded the full medical bill, there is no evidence it was intended to pay those expenses [billed hospital charges] rather than lost earnings, pain and mental anguish, or physical impairment."<sup>152</sup> In the course of its holding, the court clearly established that fair and reasonable medical expenses are measured by the amount actually paid to the provider, not by the amount billed by the provider.<sup>153</sup> Moreover, in the case of balance billing, since the hospital has a claim only for the fair and reasonable value of the medical care it provided, this limits the balance due to the difference

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<sup>144</sup> *Id.* at 410.

<sup>145</sup> *Id.*

<sup>146</sup> *Id.*

<sup>147</sup> *Id.* at 411.

<sup>148</sup> *Id.* at 411–12.

<sup>149</sup> *Id.* at 412.

<sup>150</sup> *Id.*

<sup>151</sup> *Id.*

<sup>152</sup> *Id.* at 412.

<sup>153</sup> *Id.*

between the amount the hospital was paid by the insurer and the fair and reasonable value of the care provided rather than the unreasonable amount billed.<sup>154</sup>

### III. THE WACKY WORLD OF HOSPITAL PRICING: PRICE DISCRIMINATION AND DISCOUNTS

#### A. Price Discrimination

The way in which hospitals price their goods and services may seem wacky, but there is actually a logic to the process, at least from the hospital's perspective.<sup>155</sup> As discussed in Part III.E., higher list prices mean higher net revenues,<sup>156</sup> though one must always remember that a hospital's chargemaster prices are set to be discounted not paid.<sup>157</sup> Thus, it should not be surprising that very few patients and no insurance companies pay these list prices to the hospital.<sup>158</sup> Insurers, who are the most common payers, pay a much smaller amount arrived at either by applying a negotiated discount factor to the hospital's chargemaster prices or based on a negotiated procedure or per diem reimbursement system.<sup>159</sup> Hospitals negotiate different discounts with different private insurers, and, as noted, government insurers set their own rates.<sup>160</sup> As a result, the amount the hospital has agreed to accept for the same services and goods varies dramatically depending on who is paying the hospital.<sup>161</sup> Government insurers pay the least; private insurers pay about 14% more on average than Medicare, and uninsured or other self-pay patients owe the most.<sup>162</sup> All

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<sup>154</sup> *Id.*; see also *infra* Parts III.E., IV.G.

<sup>155</sup> See Tompkins et al., *supra* note 11, at 51, 53–54 (“From the viewpoint of the individual hospital, the process and outcomes (charges) of the price-setting process are logical; the charges fulfill their purpose by supplying revenues, albeit from a shrinking base of charge-related payers and services.”). Generally, the chargemaster is an accounting tool used to generate adequate revenue, and that charge levels greatly affect revenues from many sources, so increased chargemaster levels results in more revenue overall for the hospital. *Id.*

<sup>156</sup> See *infra* Part III.E.

<sup>157</sup> See *infra* Part III.E.

<sup>158</sup> See Reinhardt, *U.S. Hospital Services*, *supra* note 7, at 57–63.

<sup>159</sup> See *id.*

<sup>160</sup> *Id.* at 59–61.

<sup>161</sup> See *id.* at 63.

<sup>162</sup> See *A Review of Hospital Billing and Collection Practices Before the Subcomm. on Oversight and Investigations of the H. Comm. on Energy and Commerce*, 108th Cong. 21 (2004)

patients are billed at chargemaster rates,<sup>163</sup> but most are not expected to pay them.<sup>164</sup> This pricing system results in hospitals engaging in apparent price discrimination.<sup>165</sup> Price discrimination is the practice of charging a different price to different buyers for the same goods or services.<sup>166</sup> This practice is sometimes referred to as dynamic pricing.<sup>167</sup>

In general, price discrimination, or dynamic pricing, may be practiced either because it allows the seller to pursue a social objective, or because it allows the seller to maximize profits.<sup>168</sup> Traditionally, doctors had a sliding fee schedule that varied with the economic status of the patient.<sup>169</sup> The traditional rationale for this price discrimination was to achieve a social and charitable goal of providing health care to the poor.<sup>170</sup> In essence, the doctor's price discrimination creates a transfer payment from rich to poor for the purpose of providing health care to the poor.<sup>171</sup> Today, many argue that Medicaid's reimbursement rates are a modern version of this traditional practice because Medicaid's reimbursement rates are usually below marginal cost (Medicare rates are also said to be below marginal cost).<sup>172</sup> This then forces hospitals to maximize revenue from other patients, perhaps

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[hereinafter *Anderson Testimony*] (statement of Gerard F. Anderson, Director, Johns Hopkins Center for Center for Hospital Finance and Management) ("First, private pay insurers pay an average of 14 percent more than Medicare for a similar patient.").

<sup>163</sup> See Reinhardt, *U.S. Hospital Services*, *supra* note 7, at 59 ("Typically, a hospital will submit, for all of its patients, detailed bills based on its chargemaster, even to patients covered by Medicare.").

<sup>164</sup> *Id.* at 58–61 (explaining how the amount due from various payers is calculated).

<sup>165</sup> *Id.* at 60–61.

<sup>166</sup> *Id.* at 58 (discussing price discrimination by hospitals).

<sup>167</sup> *Id.* at 60–61; see also Julia Angwin & Dana Mattioli, *Don't Like This Price? Wait a Minute*, WALL ST. J., Sept. 5, 2012, at A1 (discussing dynamic pricing of consumer goods); Chelsea Phipps, *More Law Schools Haggle on Scholarships*, WALL ST. J., July 30, 2012, at B4 (noting that high tuition levels are a sign of prestige, so instead of dropping tuition (this is the list price similar to a hospital's chargemaster price) to attract students, many schools use scholarships—every member of Illinois College of Law's class of 2014 received some amount of scholarship).

<sup>168</sup> See Reinhardt, *U.S. Hospital Services*, *supra* note 7, at 63–64.

<sup>169</sup> See *id.*

<sup>170</sup> See *id.*

<sup>171</sup> See *id.*

<sup>172</sup> See, e.g., Allen Dobson et al., *The Cost-Shift Payment 'Hydraulic': Foundation, History, and Implications*, 25 HEALTH AFF. 22, 25–26 (2006) (discussing Medicare underpayment and hospital responses).

via price discrimination or dynamic pricing, in order to cover the Medicare and Medicaid shortfall.<sup>173</sup>

This brings us to the other reason to engage in price discrimination, and that is to maximize profits.<sup>174</sup> As long as a seller never agrees to a price below marginal cost, unless doing so has other positive effects on goodwill or reputation, or unless required by law to do so, a seller will increase profits by charging more to those customers willing to pay more.<sup>175</sup> In order to implement price discrimination, several requirements must be met: high fixed cost, the ability to divide customers into separate groups based on the price they are willing to pay, and an inability for customers to resell goods/services.<sup>176</sup> Thus, price discrimination is commonly practiced in such businesses as airlines and universities.<sup>177</sup> For example, it is common on a given airline flight to have many passengers who each paid a different price for a ticket of the same class on the same flight.<sup>178</sup> In universities or professional schools, it is common for different students to receive different levels of scholarships and thus pay a different net cost for attending the same school.<sup>179</sup>

In the case of hospitals, it seems unlikely that charging the uninsured and other self-pay patients much higher prices furthers any ethical or charitable goal; quite the opposite, it seems unethical and uncharitable.<sup>180</sup> Nor does this practice likely result in increased profit, as most uninsured patients do not in fact pay the billed charges, even though they are liable for them and often driven into bankruptcy because of these exorbitant charges.<sup>181</sup> The high rates charged to self-pay patients, especially the

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<sup>173</sup> *Id.* at 25–27.

<sup>174</sup> See Reinhardt, *U.S. Hospital Services*, *supra* note 7, at 63 (“By charging some groups more than others, profit-seeking sellers can extract from the buy side more revenue and profits for a given sales volume than they could with a single price.”).

<sup>175</sup> See *id.* at 63–64.

<sup>176</sup> See *id.*

<sup>177</sup> See *supra* note 167 (citing references regarding dynamic pricing for consumer goods and graduate schools).

<sup>178</sup> See *supra* note 167.

<sup>179</sup> See *supra* note 167.

<sup>180</sup> See Reinhardt, *U.S. Hospital Services*, *supra* note 7, at 62; Tompkins et al., *supra* note 11, at 52 (suggesting that this result is shocking or even seems punitive to the uninsured but is probably inadvertent).

<sup>181</sup> See *Anderson Testimony*, *supra* note 162, at 12, 21 (noting that less than 1 in 10 uninsured people pay even a portion of their charges, in most hospitals only 3 percent of total revenues come



uninsured, are most likely an unintended result of the evolution of hospital pricing, rather than the result of a plan to either maximize profits or achieve a charitable purpose.<sup>182</sup> As for charging private insurers more than government insurers, it seems likely that hospitals do so to maximize profits by deriving higher payments from insurers willing to pay more to have access to the hospital for their insureds.<sup>183</sup>

### B. Hospitals Use Discounts to Purchase Value

Price discrimination, charging a different price for the same good or service to different buyers,<sup>184</sup> assumes that the only value received by the seller from the buyer is the price paid. However, when a seller agrees to sell for less to a buyer who, for example, buys a large quantity of goods, the seller has not engaged in true price discrimination.<sup>185</sup> Rather, the lower price reflects the lower costs to the seller when selling a large quantity to a single buyer.<sup>186</sup> Essentially, in this type of case, the seller is purchasing additional value from the buyer with the discount, and this is not true price discrimination.<sup>187</sup> For example, a university may allow the child of a very famous person to attend free of charge, or a restaurant may allow a movie or sports star to eat for free because of the public relations value that results from the association with the famous person. This concept, purchasing value with discounts, likely explains some of the varying discounts hospitals offer to private insurers, and it is part of the reason lower prices are accepted from government insurers.<sup>188</sup> That is, the fair and reasonable

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from the uninsured, but that the toll on the uninsured was substantial, noting that nearly half of all personal bankruptcies are related to medical bills).

<sup>182</sup> See Tompkins et al., *supra* note 11, at 52 (characterizing the impact on the uninsured as inadvertent).

<sup>183</sup> See *id.* at 50 (noting that setting chargemaster prices is crafty and high-tech, involving an arsenal of consultants and computer software to determine optimal increases in charges for various services where “optimal” means a higher payoff (increase in net revenues) for a given rate of increase).

<sup>184</sup> See Reinhardt, *U.S. Hospital Services*, *supra* note 7, at 58.

<sup>185</sup> See, e.g., Mark Armstrong, *Price Discrimination*, HANDBOOK OF ANTITRUST ECONOMICS 433, 435 (Paolo Buccirossi ed., 2008) (“Pure quantity discounts are generally not challenged by competition authorities if they merely reflect cost efficiencies stemming from the larger volume of product sold (and are therefore not discriminatory).”).

<sup>186</sup> *Id.*

<sup>187</sup> See *id.* at 436.

<sup>188</sup> See Tompkins et al., *supra* note 11, 53 (noting that having to collect revenues directly from patients is a costly and unwanted activity for hospitals and is not necessary when a patient is

value of medical care for individuals is likely to be somewhat higher than the amounts paid by insurers.<sup>189</sup>

In the case of hospitals, insurers sell valuable benefits to the hospital in return for discounted prices.<sup>190</sup> These benefits include an increased volume of business, access to patients who have been essentially prescreened by the insurer for credit worthiness—that is, the hospital is assured of payment for insured patients from the insurance company or government.<sup>191</sup> In addition, the hospital gets easy and quick (compared to collecting from individual patients) access to its discounted fees from the insurance company or government.<sup>192</sup> Finally, hospitals may receive some marketing and advertising benefits from a private insurance company's listing the hospital as a "network" hospital—that is, one where the full benefit of the company's insurance will be available.<sup>193</sup> These benefits are valuable to the hospital and likely account for the difference in the rates paid by private insurers.<sup>194</sup> As discussed in notes 258 through 265, these benefits do not account for the huge discounts from chargemaster prices given to

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covered by insurance, and that part of the justification for discounts given to insurers is the guarantee of patient volume); *Flushing Hosp. & Med. Ctr. v. Woytisek*, 364 N.E.2d 1120, 1122 (N.Y. 1977) (private insurers may be able to obtain very substantial discounts from medical providers for a variety of reasons, i.e., "volume of payments, promptness in paying, assurance of payment"); *see also* *Nassau Anesthesia Assocs. PC v. Chin*, 924 N.Y.S.2d 252, 254 (N.Y. Dist. Ct. 2011) (citing *Woytisek*, 364 N.E. 2d at 1122).

<sup>189</sup> *See, e.g., Anderson Testimony*, *supra* note 162, at 21 ("The rate that self pay individuals should pay should be greater than what insurers and managed care plans are currently paying hospitals.").

<sup>190</sup> *See supra* note 188.

<sup>191</sup> *See supra* note 188.

<sup>192</sup> *See supra* note 188.

<sup>193</sup> *See Reinhardt, The Many Different Prices*, *supra* note 129, at 2131 (patients are encouraged by lower out-of-pocket costs to go to hospitals and other providers that are in network and top tier).

<sup>194</sup> *See Reinhardt, U.S. Hospital Services*, *supra* note 7, at 61–62 (noting that the dollar level of payments to private insurers is negotiated annually between each insurer and each hospital, and that the actual dollar payments have traditionally been kept as strict, proprietary trade secrets by both hospitals and the insurers); *Reinhardt, The Many Different Prices*, *supra* note 129, at 2129 (noting that today the price discrimination in health care is charitably motivated only at the fringes, for very poor, uninsured Americans, but for the most part, price discrimination reflects the relative bargaining power in local markets of those who pay for health care and those who provide it).

insurers.<sup>195</sup> These huge discounts are caused primarily by the fact that chargemaster rates are set unreasonably high so they can be discounted.<sup>196</sup>

### C. The Problem with All-Payer Systems

In response to the perceived price discrimination practiced by the hospitals, especially that involving the uninsured or other self-pay patients, some have recommended an “all-payer system.”<sup>197</sup> These systems may use various methods to arrive at a price for a particular good or service.<sup>198</sup> For example, the price may either be set by the government or each hospital may be permitted to set its own price.<sup>199</sup> Regardless of how the price is set, once set, that price must be posted for public view and applied to all patients without discrimination.<sup>200</sup> For those who see unfairness in price discrimination, all-payer systems seem a good answer. For example, rather than forcing the uninsured to pay much higher prices, or allowing government insurers to force providers to accept reimbursements that are below cost, all payers must pay the same price.<sup>201</sup> However, if at least part of what appears to be price discrimination is really market-driven discounting designed to purchase new value from the buyer,<sup>202</sup> then any all-payer system will be disruptive to the market and create inefficiency.<sup>203</sup> For the reasons stated in the preceding section, I do not think all-payer systems are appropriate for hospitals or other health care providers. I do, however, argue that some less pervasive restrictions on setting prices for self-pay patients are necessary.<sup>204</sup>

<sup>195</sup> See *infra* notes 258–265 and accompanying text.

<sup>196</sup> See Reinhardt, *U.S. Hospital Services*, *supra* note 7, at 63 (“Invoices at chargemaster prices, however, are insincere, in the sense that they would yield truly enormous profits if those prices were actually paid.”).

<sup>197</sup> See, e.g., *id.* (discussing such a system).

<sup>198</sup> See *id.*

<sup>199</sup> *Id.*

<sup>200</sup> See Reinhardt, *The Many Different Prices*, *supra* note 129, at 2129–30 (recommending such a system).

<sup>201</sup> See *supra* Part III.A.

<sup>202</sup> See *supra* Part III.B.

<sup>203</sup> That is, some buyers will pay more than they would in a competitive market and some will pay less.

<sup>204</sup> See *infra* notes 275–306 and accompanying text.

*D. All-Payer Systems and Price Fixing*

It seems odd to suggest that more price fixing can solve the hospital pricing problem when price fixing is very likely a major cause of the problem. Government insurers such as Medicare and Medicaid are essentially price fixers,<sup>205</sup> and many blame their unreasonable low prices/reimbursement rates for causing hospitals and other providers to shift their unreimbursed costs to private insurers and self-pay patients.<sup>206</sup> An all-payer system, especially one where the price is set by the government, will only create more problems. Encouraging a freer and more transparent market for the sale of health care is the only approach that will result in appropriate pricing.<sup>207</sup>

The solution that I suggest for self-pay patients can be described as a form of price fixing, but it has some important differences when compared to a government controlled all-payer system.<sup>208</sup> First, self-pay patients account for a relatively small percentage of health care buyers.<sup>209</sup> Second, the price I suggest for these self-pay patients is based on a price freely set by the market.<sup>210</sup> That is, my solution uses, as a base, the average reimbursement rate paid by private insurers and then adjusts this base to arrive at an estimate of the fair and reasonable value of the health care purchased.<sup>211</sup> Neither the government nor the hospital, nor any single private insurer, has control over the base. In addition, it would be possible, in appropriate cases, to allow hospitals or other providers and patients to present evidence to the court to refute the suggested amount by which the base will be adjusted.<sup>212</sup>

*E. Why Are Chargemaster Prices so Unreasonably High?*

The answer to this question is complex. Part of the answer originates in the history of hospital billing and the various government and private

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<sup>205</sup> See Reinhardt, *U.S. Hospital Services*, *supra* note 7, at 60–61 (noting that Medicare and Medicaid set their own prices).

<sup>206</sup> See generally Dobson et al., *supra* note 172.

<sup>207</sup> See Michael E. Porter & Elizabeth Olmsted Teisberg, *Redefining Competition in Health Care*, HARV. BUS. REV., June 2004, at 65–76.

<sup>208</sup> See *infra* Part IV.D.

<sup>209</sup> See *supra* note 181.

<sup>210</sup> See *infra* Part IV.D.1.

<sup>211</sup> See *infra* Part IV.D.2.

<sup>212</sup> In certain cases the value of benefits received by the hospital may exceed 10–15%.

insurer reimbursement systems that have been used in the past.<sup>213</sup> Historically, hospitals were required by CMS (Centers for Medicare and Medicaid Services) to have a uniform set of prices that were charged to all patients, and at that time higher chargemaster rates resulted directly in higher payments to hospitals.<sup>214</sup> While today, neither government insurers nor most private insurers usually use chargemaster rates to directly determine reimbursements, higher chargemaster rates are still associated, albeit indirectly, with higher net hospital revenues.<sup>215</sup> For example, until quite recently, a hospital could significantly increase its Medicare reimbursement for outliers (patients who cost significantly more to treat than other patients) by hiking up their chargemaster prices.<sup>216</sup> As a result of this practice by some hospitals, CMS has changed its outlier policies.<sup>217</sup> Also, until 2004, Medicare rules were interpreted by providers as prohibiting discounting chargemaster prices for the uninsured.<sup>218</sup> While CMS clarified the situation in 2004, by allowing hospitals to offer discounts at least to the indigent uninsured,<sup>219</sup> hospitals were still reluctant to discount their charges for the uninsured because of private insurers' common negotiation strategy of insisting on being charged the same as the lowest paying patient.<sup>220</sup> Today, under the ACA as discussed Part IV.G., hospitals

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<sup>213</sup> See *Anderson Testimony*, *supra* note 162, at 1–6 (discussing the history of hospital billing and its impact on high chargemaster prices); *Tompkins et al.*, *supra* note 11, at 45–55 (similar); *Reinhardt, U.S. Hospital Services*, *supra* note 7, at 57–66 (similar).

<sup>214</sup> See *Tompkins et al.*, *supra* note 11, at 53.

<sup>215</sup> See *id.* at 54 (“The strategies and methods used to determine charge levels, which greatly affect revenues from many sources, have resulted in rapidly growing charges and wide variations among hospitals.”); *Anderson*, *supra* note 10, at 784 (noting that hospitals receive a very small proportion of the increase in charges above the rate of increase in costs and that the exact relationship depends on the functional form and model used [what is important here is that the relationship is positive]).

<sup>216</sup> See *Anderson*, *supra* note 10, at 785 (noting that some hospitals had increased their charges to obtain higher outlier payments in Medicare payments based on the hospital’s own charges).

<sup>217</sup> See *Tompkins et al.*, *supra* note 11, at 53 (noting that the CMS administrator blamed a small number of hospitals for “gaming the current rules” by rapidly inflating charges).

<sup>218</sup> See *Anderson*, *supra* note 10, at 786 (noting that until recently many lawyers advised their hospital clients that the hospital could not discount charges to self-pay patients because giving such discounts would violate Medicare rules).

<sup>219</sup> See *Tompkins et al.*, *supra* note 11, at 52–53 (noting that adverse publicity caused a clarification of Medicare rules so that they did permit hospitals to give discounts to low-income patients).

<sup>220</sup> *Id.* at 53.

are required to discount charges to the poor uninsured though hospitals have complete discretion in defining who qualifies as poor.<sup>221</sup> Thus, extremely high chargemaster prices are a legacy of the past that lives on in part because high chargemaster prices still result in higher net revenues for hospitals and other providers<sup>222</sup> (this is also why hospitals and other providers continue to have an incentive to set ever higher chargemaster prices), and in part for other reasons.<sup>223</sup>

Today, the main reason that chargemaster prices are so incredibly high is that the higher they are the more money a hospital or other provider is likely to make.<sup>224</sup> This fact applies to government and private insurers alike; while chargemaster rates are rarely used today to directly determine reimbursement amounts, they do have an indirect impact.<sup>225</sup> In one form or another, a hospital's billed (chargemaster) charges are used indirectly to determine the ultimate dollar level of reimbursement payments.<sup>226</sup> To put it another way, the higher the chargemaster prices the greater the reimbursement amount the hospital will receive from third party payers.<sup>227</sup> For example, Medicare reimbursement formulas are usually tied to procedures performed via the DRG (diagnosis-related group) system for inpatient care and the APC (ambulatory payment classification) system for outpatient services.<sup>228</sup> Medicare usually pays a fixed fee per case based on the DRG or APC classification; thus, higher chargemaster rates would not seem to affect Medicare reimbursement rates, and they don't do so directly.<sup>229</sup> However, the process followed under Medicare to arrive at the actual dollar amount of reimbursement is complex and governed by statute, but part of the process involves the periodic recalibration of the DRG weights and this is based in part on average standardized billed

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<sup>221</sup> See *infra* Part IV.G.

<sup>222</sup> See Tompkins et al., *supra* note 11, at 53.

<sup>223</sup> See *Anderson Testimony*, *supra* note 162, at 16 (noting that many hospitals calculate bad debt and charity care based on chargemaster prices in order to inflate these numbers).

<sup>224</sup> See Tompkins et al., *supra* note 11, at 53.

<sup>225</sup> See Reinhardt, *U.S. Hospital Services*, *supra* note 7, at 58–61 (discussing how different payers calculate payments); Tompkins et al., *supra* note 11, at 50–51 (noting that even though most private insurers are not reimbursed as a direct percentage of charges, they do maintain a default payment rate for example, 40% of billed charges, for services not governed by fee schedules or other fixed payment amounts and that these can affect about 20–30% of all services).

<sup>226</sup> See Reinhardt, *U.S. Hospital Services*, *supra* note 7, at 58–61.

<sup>227</sup> See Tompkins et al., *supra* note 11, at 53.

<sup>228</sup> See Reinhardt, *U.S. Hospital Services*, *supra* note 7, at 58–62.

<sup>229</sup> *Id.* at 59–61.

(chargemaster rates) charges for all cases falling into each DRG in the most recent period.<sup>230</sup> In addition, Medicare calculates the yearly base payment amount in dollars, which is then multiplied by the DRG weight to arrive at a dollar amount of reimbursement.<sup>231</sup> As a result of this process, the higher a hospital sets its chargemaster rates the higher its likely reimbursement will be from Medicare.<sup>232</sup> Moreover, many states calculate their Medicaid reimbursement rates as a percentage of either the Medicare DRG reimbursement or as a percentage of the APC reimbursement.<sup>233</sup> As noted above, Medicaid reimbursement rates are widely believed to be below fully allocated costs.<sup>234</sup> This fact puts significant pressure on hospitals to increase revenue from all sources and thus continues to push chargemaster rates ever upward.<sup>235</sup>

With regard to private insurers, reimbursement rates for inpatient services are negotiated each year either as a negotiated per diem rate, or a fixed charge per procedure based on the DRG system, or APC system, or in a few cases as a direct discount from chargemaster prices.<sup>236</sup> However, high chargemaster rates are more relevant to reimbursements from private insurers than first appears.<sup>237</sup> One commentator notes:

About 20 percent of services [were] charge-related in the short term—that is, [they were] paid [or reimbursed] based on full or discounted charges per se—although a much higher percentage of services are paid nominally on the basis of charges through contract language that uses charge levels as reference points for discounts and to derive fixed payment amounts.<sup>238</sup>

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<sup>230</sup> *Id.* at 60–62.

<sup>231</sup> *Id.*

<sup>232</sup> *Id.*

<sup>233</sup> *Id.* at 61.

<sup>234</sup> See Reinhardt, *The Many Different Prices*, *supra* note 129, at 2127–29 (noting that the low [below cost] Medicare and Medicaid reimbursements have been cited as the major cause of hospitals shifting costs to private payers, though Reinhardt questions this conclusion).

<sup>235</sup> See *id.*

<sup>236</sup> See Reinhardt, *U.S. Hospital Services*, *supra* note 7, at 60–61.

<sup>237</sup> See Tompkins et al., *supra* note 11, at 50.

<sup>238</sup> *Id.*

The fact that many contracts refer to list prices even nominally encourages hospitals to keep chargemaster rates high.<sup>239</sup> In addition, each private payer has a default payment rate (for example, forty percent of billed charges) for services not covered by fee schedules or other fixed payment amounts.<sup>240</sup> Moreover, Medicare's payment for the facility component of outpatient services is directly based on charges.<sup>241</sup> One commentator notes that "[t]hese payments [facility component] average approximately 5 percent of the total medical services payments (10 percent of the outpatient department, which in turn is about half of the total medical services)."<sup>242</sup>

Thus, one commentator notes that "charge levels . . . greatly affect revenues from many sources,"<sup>243</sup> and states that even today, ever increasing chargemaster rates result in increasing revenue for providers and this is the main reason chargemaster rates are so high and continue to increase quickly.<sup>244</sup> But there are also other reasons. One reason is to encourage private insurers to negotiate a contract with the hospital.<sup>245</sup> Extremely high list prices help this process in two ways.<sup>246</sup> First, it shows insurers how much they or their insureds will have to pay if the companies' insureds receive treatment in the hospital and the insurance company has not negotiated a contract with the hospital.<sup>247</sup> Thus, the higher the chargemaster prices the greater the incentive for private insurers to sign a contract with the hospital.<sup>248</sup> Second, extremely high chargemaster prices allow the insurance company to demonstrate its value to its insureds because each

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<sup>239</sup> *See id.*

<sup>240</sup> *See* Reinhardt, *U.S. Hospital Services*, *supra* note 7, at 58–61.

<sup>241</sup> *See* Tompkins et al., *supra* note 11, at 53 (noting that the facility component of outpatient services is directly based on charges).

<sup>242</sup> *See id.*

<sup>243</sup> *Id.* at 54.

<sup>244</sup> *Id.* ("The strategies and methods used to determine charge levels, which greatly affect revenues from many sources, have resulted in rapidly growing changes and wide variations among hospitals.").

<sup>245</sup> *See* Anderson, *supra* note 10, at 785 (noting that hospitals set high charges as a negotiating strategy with managed care plans; if a plan does not have a contract with the hospital then it must pay full charges, the higher the charges the greater the incentive to sign a contract with the hospital).

<sup>246</sup> *See id.*

<sup>247</sup> *See id.*

<sup>248</sup> *Id.*



hospital bill a patient/insured receives shows the chargemaster based charge and the huge savings the insured has reaped because he has insurance.<sup>249</sup>

Another reason to keep chargemaster rates extremely high is because it allows the hospital to inflate the dollar value of its charitable care and bad debt.<sup>250</sup> For example, if the hospital treats an indigent patient free of charge and the care provided would be billed at \$3000 but reimbursed at only \$1000 by insurers, some hospitals may claim \$3000 worth of charity care by measuring such care based on its chargemaster rates.<sup>251</sup> The same is true for bad debt expense.<sup>252</sup> Inflating these measures can pay big public relations and political dividends for hospitals.<sup>253</sup> For example, a hospital's tax exempt status may depend on providing a certain dollar amount of charity care or community benefit.<sup>254</sup>

#### IV. ANALYSIS: DETERMINING THE FAIR AND REASONABLE VALUE OF MEDICAL SERVICES

##### A. *Contract Adjusted Rates Are Too Low to Be Applied to Self-Pay Patients*

It has been argued that the fair and reasonable value of medical services for self-pay patients should be determined by the lowest amount the

<sup>249</sup> See *id.*

<sup>250</sup> See *Anderson Testimony*, *supra* note 162, at 16 (noting that hospitals routinely use charge rates to quantify the amount of bad debt and charity care they provide to help with fundraising and to meet charitable obligations, but using chargemaster prices vastly overstates these amounts).

<sup>251</sup> See *id.*

<sup>252</sup> See *id.*

<sup>253</sup> See, e.g., Stephanie Strom, *Congress Questions the I.R.S. About Delays in Its Oversight of Nonprofit Hospitals*, N.Y. TIMES, Nov. 1, 2011, at B9 (noting that the Illinois Department of Revenue sought to revoke the property tax exemptions of three nonprofit hospitals after a court ruling held that a fourth hospital in the state did not provide enough charity care to justify the tax benefit); George A. Nation III, *Non-Profit Charitable Tax-Exempt Hospitals— Wolves In Sheep's Clothing: To Increase Fairness and Enhance Competition In Health Care All Hospitals Should Be For-Profit and Taxable*, 42 RUTGERS L.J. 141, 144–47 & nn.20–21 (2010) (noting that under the traditional definition of charity, helping the poor and needy, most charitable hospitals fail miserably in accomplishing a charitable mission and prompting calls from commentators, politicians and courts to require charitable hospitals to earn their tax benefits).

<sup>254</sup> See, e.g., Suzanne Sataline, *Illinois High Court: Nonprofit Hospital Can Be Taxed*, WALL ST. J., Mar. 19, 2010, at B4 (noting that the Illinois Supreme Court held that the state Department of Revenue was correct when it decided that the charity care provided by Provena Covenant Medical Center was too small to qualify for tax exemption).

hospital/provider accepts as full payment from government or private insurers.<sup>255</sup> That is, the lowest contract adjusted/discounted rate.<sup>256</sup> I argue here that this amount is too low because it does not recognize the value that private insurers provide to hospitals in exchange for discounted prices.<sup>257</sup> As discussed in Part III.B., private insurers bring large groups of profitable patients to the hospital/provider, and provide assured, easy and rapid payment of discounted charges.<sup>258</sup> Insurers in essence pre-approve patients in terms of creditworthiness and may also offer some marketing/advertising benefits by making a hospital provider known to its insureds.<sup>259</sup> A relevant question for this article, discussed in Part IV.D.2., is: what is the value of these benefits?<sup>260</sup>

### *B. Chargemaster or List Prices Are Too High*

While private insurers are clearly bringing valuable benefits to hospitals, it is also clear that the value of these benefits cannot begin to account for the huge discounts from chargemaster prices given to insurers.<sup>261</sup> Rather, as discussed in Part III.A. and B., it seems likely that the exorbitant prices reflected on chargemasters are the result of gamesmanship related to the odd reimbursement schemes that have been applied to hospitals by both government and private insurers.<sup>262</sup> That is, chargemaster prices are set to be discounted, not paid. If these prices were actually paid, they would yield truly enormous profits.<sup>263</sup> As discussed in Part IV.G., the proposed regulations under the ACA seem to be continuing the tradition of odd

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<sup>255</sup> See, e.g., *Temple Univ. Hosp. v. Healthcare Mgmt. Alts., Inc.*, 832 A.2d 501, 510 (Pa. Super. Ct. 2003) (concluding that the hospital should receive the average charge for the services at issue contained in contracts with government agencies and insurance companies); *Nassau Anesthesia Assocs. PC v. Chin*, 924 N.Y.S.2d 252, 254–55 (N.Y. Dist. Ct. 2011).

<sup>256</sup> See, e.g., *Temple Univ. Hosp.*, 832 A.2d at 510; see also *Nassau Anesthesia Assocs. PC*, 924 N.Y.S.2d at 254–55.

<sup>257</sup> See *infra* notes 284–293 and accompanying text.

<sup>258</sup> See *supra* Part III.B.

<sup>259</sup> See *supra* Part III.B.

<sup>260</sup> See *infra* Part IV.D.2.

<sup>261</sup> See Reinhardt, *U.S. Hospital Services*, *supra* note 7, at 63 (saying that chargemaster prices would yield truly enormous profits if these prices were actually enforced).

<sup>262</sup> See *supra* Part III.A–B.

<sup>263</sup> See Reinhardt, *U.S. Hospital Services*, *supra* note 7, at 63.

reimbursement schemes by relying on these exorbitant chargemaster prices to implement its price limitations.<sup>264</sup>

In our quest for the fair and reasonable value of medical services, it is clear that chargemaster prices are *not* an appropriate basis from which to calculate fair and reasonable value.<sup>265</sup> A hospital invoice of itemized billed charges at chargemaster rates is, when it comes to measuring fair value, a complete fiction and should not be used by courts or others to establish the fair and reasonable value of medical services.<sup>266</sup> To do so creates a windfall to the hospital or other recipient of the reimbursement for medical expenses.<sup>267</sup>

### C. Government Insurers Set Reimbursement Rates That Are Too Low

There is a significant body of research suggesting that the reimbursements rates paid by government insurers such as Medicare and Medicaid are actually below fully allocated cost for most hospitals.<sup>268</sup> As noted in Part III.D., these government insurers are essentially price fixers and hospitals must either accept their reimbursement rates or refuse to accept patients with government insurance.<sup>269</sup> Why more hospitals don't simply refuse to accept government insured patients is an important and complex question.<sup>270</sup> A detailed answer to this question is beyond the scope of this article. It is sufficient to present purposes to note that such a refusal carries the risk of important negative consequences. For example, to refuse

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<sup>264</sup> See *infra* Part IV.G.

<sup>265</sup> See *Temple Univ. Hosp. v. Healthcare Mgmt. Alts.*, 832 A.2d 501, 510 (Pa. Super. Ct. 2003) (noting that chargemaster prices “bear no relationship to the amount typically paid for those services”); *Tompkins et al.*, *supra* note 11, at 51–52 (“Over time, a hospital’s chargemaster is bent, stretched, and distorted by numerous pressures and responses.”); *Reinhardt, U.S. Hospital Services*, *supra* note 7, at 59 (noting that chargemaster rates “do not bear any systematic relationship to the amounts third-party payers actually pay them for the listed services”).

<sup>266</sup> See *supra* note 265.

<sup>267</sup> See *Daughters of Charity Health Servs. of Waco v. Linnstaedter*, 226 S.W.3d 409, 412 (Tex. 2007) (noting that recovery of medical expenses at chargemaster rates would be a windfall).

<sup>268</sup> See generally *Dobson et al.*, *supra* note 172 (on average in the U.S. Medicaid’s payments to hospitals fall well short of fully allocated costs, even after the separate disproportionate-share hospital (DSH) subsidies paid by the federal government and the states to hospitals with disproportionately large loads of uninsured or Medicaid patients are accounted for).

<sup>269</sup> See *Reinhardt, U.S. Hospital Services*, *supra* note 7, at 60 (noting that Medicare has been referred to as a “dumb price fixer” by a former Medicare administrator).

<sup>270</sup> See generally *Nation*, *supra* note 253 (discussing the importance and value of tax-exempt status to hospitals and the leverage this gives the government).

to accept government insured patients in certain contexts is simply illegal (as is the refusal to accept and treat any patient in an emergency room).<sup>271</sup> In addition, very serious political consequences, which could include the loss of tax exempt status, could result if charitable hospitals attempted to stand up to government intimidation.<sup>272</sup> Also, especially in the case of Medicare, not all reimbursable rates are unprofitable for hospitals.<sup>273</sup> That is, for certain procedures or facilities the reimbursement rates may be reasonable.<sup>274</sup> Moreover, even for procedures where government reimbursement rates are below fully allocated cost, these reimbursements may cover a significant portion of fixed costs.<sup>275</sup> If this portion of these fixed costs weren't covered, the hospital would not, in some cases, be able to profit from certain services, which with the addition of private reimbursements are, overall, profitable.<sup>276</sup>

#### *D. A Method for Calculating the Fair and Reasonable Value of Medical Services*

##### *1. The Base or Starting Amount*

It is clear that neither extreme (chargemaster prices nor the lowest price actually paid by insurers), should be used unadjusted as the measure of the fair and reasonable value of medical services. The prices actually paid by private insurers though are a good place to start in calculating the value of medical services because these contracts reflect most strongly an effectively operating free market.<sup>277</sup> This basis can be further strengthened by taking the average of the various reimbursement rates for private insurers.<sup>278</sup> This average is a true reflection of market forces because this amount is

<sup>271</sup> See, e.g., 42 U.S.C.A. § 1395dd (West 2012) (requiring hospitals to provide care for emergency medical conditions to any patient).

<sup>272</sup> For example, regulations proposed under the ACA provide that if a hospital has any procedure that discourages individuals from seeking emergency medical care it may lose its tax-exempt status under I.R.C. 501(c)(3). See *supra* note 48.

<sup>273</sup> See Tompkins et al., *supra* note 11, at 48–53 (discussing “loopholes” found in the Medicare payment system involving billed charges and facility reimbursement).

<sup>274</sup> *Id.*

<sup>275</sup> *Id.*

<sup>276</sup> *Id.*

<sup>277</sup> See Reinhardt, *U.S. Hospital Services*, *supra* note 7, at 61–62 (noting that each private insurer negotiates the dollar level of payments with each hospital every year).

<sup>278</sup> See *id.*

negotiated each year between the hospital and its insurers.<sup>279</sup> Eliminating government insurers like Medicare and Medicaid makes sense because, as noted in Part III.D., these entities essentially dictate rates often below cost based on their reimbursement formula.<sup>280</sup>

With regard to private insurers, we could choose the lowest negotiated rate, the highest or the average. The lowest rate is likely too low because it represents substantial extra value, most likely related to an increase in volume of business for the hospital or other provider that only the largest insurer can provide, and this benefit is difficult to quantify.<sup>281</sup> That is, all insurers offer assured, quick and easy payment—the difference between them likely relates to the number of additional patients a particular insurance company can bring to the hospital.<sup>282</sup>

Some good arguments may be made for using the highest negotiated reimbursement rate because this is closest to the proper individual rate. That is, individuals don't bring the extra benefits that insurance companies do to the hospital, so individuals should pay more than the highest negotiated rate. The potential problem with using the highest negotiated rate is that it could be easily manipulated by hospitals by entering into an agreement with a very small insurer at a very high rate. Thus, I think the best starting point is the average of the negotiated private insurer reimbursement amounts. But, while this is a good starting point it is not a good ending. As noted, self-pay patients should pay more than this amount because these patients don't provide to hospitals the same benefits as private insurers.<sup>283</sup> The question is, how much more should individual self-pay patients pay? Tortfeasors should also pay more than the average private insurance amount, because it's unfair, as discussed in Part I.B., to allow tortfeasors to benefit from the victims acquisition of medical insurance.

## 2. Adjustments to the Base

The adjustment (increase) to be made to the average negotiated private insurer reimbursement rate should equal the value of the benefits (increased volume of business; assured, quick and easy payment; and marketing/advertising benefits) that private insurers provide to hospitals. As

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<sup>279</sup> See *id.*

<sup>280</sup> See *supra* Part III.D.

<sup>281</sup> See *supra* Part III.B.

<sup>282</sup> See *supra* Part III.B.

<sup>283</sup> See *supra* Part III.C.

noted in Part III., given the oddities of hospital pricing we can't assume the value of these benefits equals the huge discount from chargemaster prices.<sup>284</sup>

An indirect way to measure the value of these benefits is to look for the value of these benefits in other contexts. One useful comparison is with credit card companies and processors. That is, a retailer, like a hospital, may agree to accept a particular credit card (Master Card, Visa, etc.) and after negotiating a discount rate or fee with a processor the retailer gets certain benefits in exchange for effectively giving the card issuer and processor a discount.<sup>285</sup> First, the retailer gains access to all of the card issuer's members because they may now use their cards to make purchases from the retailer.<sup>286</sup> Second, all of these potential customers have been prescreened by the card issuer in terms of credit worthiness.<sup>287</sup> Third, the card issuer processor assures easy and quick discounted payment to the retailer.<sup>288</sup> These are similar to the most important benefits that hospitals and other providers get from insurers.<sup>289</sup> In addition, many card issuers offer extra benefits to card-holders to encourage them to use their cards (airline mileage programs, free gifts, or cash back etc.) and these programs make retailers who accept the cards more attractive to cardholders.<sup>290</sup>

While discounts vary from one card processor to another, just as hospital reimbursement rates vary from one private insurer to another, overall card processors receive a discount that is usually less than ten percent (sometimes as low as two percent sometimes as high as eight

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<sup>284</sup> See *supra* Part III.

<sup>285</sup> See, e.g., Maureen Farrell, *Saving On Credit Card Processing Fees*, FORBES.COM, (Feb. 20, 2007, 1:30PM), [http://www.forbes.com/2007/02/20/visa-americanexpress-globalpayment-ent-fin-cx\\_mf\\_0220creditcard.html](http://www.forbes.com/2007/02/20/visa-americanexpress-globalpayment-ent-fin-cx_mf_0220creditcard.html) (discussing various terms with issuers and processors); David Lazarus, *Some Merchants Stop Taking Credit Cards Because of High Fees*, L.A. TIMES, July 1, 2011, <http://articles.latimes.com/2011/jul/01/business/la-fi-lazarus-20110701> (similar).

<sup>286</sup> *Credit Cards: Statistics and Facts*, CANADIAN BANKERS ASSOCIATION, <http://www.cba.ca/en/media-room/50-backgrounders-on-banking-issues/123-credit-cards> (last updated May 7, 2013).

<sup>287</sup> See *Monitoring Your Credit Score and Credit Report*, WALL ST. J., Dec. 17, 2008, <http://guides.wsj.com/personal-finance/credit/how-to-monitor-your-credit-score-and-credit-report/>.

<sup>288</sup> *Credit Cards: Statistics and Facts*, *supra* note 286.

<sup>289</sup> See *supra* Part III.B.

<sup>290</sup> *Credit Cards: Statistics and Facts*, *supra* note 286.

percent or more) of the value of the transaction.<sup>291</sup> Of course, credit card issuers are not exactly like private health insurance companies, but the similarities suggest that the amount to be added to the average negotiated private insurance reimbursement base is relatively small, certainly within the ten to fifteen percent range.

Another commentator, Dr. Gerard Anderson, has suggested using a similar method for arriving at the amount self-pay patients should pay.<sup>292</sup> Anderson calls his plan “DRG + 25%.”<sup>293</sup> In Anderson’s formula, DRG is equal to Medicare reimbursement rate, and to this base is added twenty-five percent.<sup>294</sup> The twenty-five percent is arrived at as follows: fourteen percent is added because it is the average difference between the Medicare rate and the average private insurance reimbursement rate, an additional one percent is added to this to account for the benefit of prompt payment that insurance companies provide, finally ten percent is added to account for the fact that the fourteen percent added first was based on the *average* private insurance rate and many private insurers pay more.<sup>295</sup> Thus Anderson has DRG + 14% + 1% + 10% or DRG + 25%.<sup>296</sup>

While there are differences, discussed earlier, between Anderson’s DRG + 25% formula and the formula I present in this article, the Average Negotiated Private Insurance Reimbursement Rate + 10–15%, the two formulas are more similar than different.<sup>297</sup> First, Anderson and I agree that self-pay patients should pay more than private insurers because private insurers provide benefits that self-pay patients do not provide.<sup>298</sup> Second, we arrive at similar rates. That is Anderson’s rate, DRG + 25%, is essentially equal to my Average Negotiated Private Insurance Rate + 10–15%.<sup>299</sup> For example, my base rate is equal to Anderson’s DRG base plus

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<sup>291</sup> See generally Farrell, *supra* note 285 (discussing processor fees for qualified and nonqualified transactions (phone orders where the merchant copies down the card number from the customer) suggesting a range of five to eight percent).

<sup>292</sup> See Anderson Testimony, *supra* note 162, at 21 (discussing the DRG + 25% plan and the maximum per diem rate).

<sup>293</sup> *Id.* at 21–22.

<sup>294</sup> *Id.* at 19–21.

<sup>295</sup> *Id.* at 22.

<sup>296</sup> *Id.*

<sup>297</sup> See *infra* notes 305–309 and accompanying text.

<sup>298</sup> See Anderson Testimony, *supra* note 162, at 21.

<sup>299</sup> *Id.*

fourteen percent.<sup>300</sup> To this Anderson adds eleven percent while I add between ten and fifteen percent.<sup>301</sup> Thus, my rate is essentially DRG plus between twenty-four and twenty-nine percent.<sup>302</sup> We also agree on the desirability of a market-based rate. Anderson acknowledges that is this regard his formula is weak because his base is not set by the market.<sup>303</sup> He feels this weakness is outweighed by the easy ability to verify and monitor the Medicare reimbursement amount.<sup>304</sup>

We do however have some disagreements. First, I use a base set by the market. I do not think the average negotiated private insurance reimbursement rate is too difficult to verify or monitor.<sup>305</sup> Hospitals keep such information and since contracts with private insurers are renegotiated every year, this base will be constantly updated.<sup>306</sup> Also, by taking an average, there is no requirement to disclose any private insurer's specific negotiated rate, which would, as Anderson notes, be disruptive to the market.<sup>307</sup> Second, I believe that Dr. Anderson significantly undervalues the benefits provided by private insurers. Specifically, he assigns no value to assured payment, increased volume of business, and marketing all of which are benefits provided by private insurers, in addition to quick payment.<sup>308</sup> I would value these additional benefits at three and a half to eight percent of the base. However, I would make only a seven percent adjustment for the use of the average private insurer rate. As noted in Part IV.D.1., while credit card companies provide many of the same benefits to retailers that accept their cards, they also limit their risk by imposing individual credit limits on each customer.<sup>309</sup> Health insurers, while they may set certain lifetime limits,

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<sup>300</sup> *Id.*

<sup>301</sup> *Id.* at 21–22.

<sup>302</sup> See *supra* notes 277–291 and accompanying text.

<sup>303</sup> See *Anderson Testimony*, *supra* note 162, at 21–22 (suggesting an alternative plan, the “maximum [the hospital] charges any insurer or managed care plan on a per day basis” and noting that its advantage over DRG + 25% is that it is market determined).

<sup>304</sup> *Id.* at 22.

<sup>305</sup> See, e.g., *Nassau Anesthesia Assocs. P.C. v. Chin*, 924 N.Y.S.2d 252, 255 (N.Y. Dist. Ct. 2011) (referring to the average amount the hospital would have accepted as full payment from third-party payors such as private insurers and federal health programs and noting that the hospital's billing manager calculated this amount as \$4252.11); *Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alts., Inc.*, 832 A.2d 501, 513 (Pa. Super. Ct. 2003) (similar).

<sup>306</sup> See *Temple*, 832 A.2d at 513.

<sup>307</sup> See *Anderson Testimony*, *supra* note 162, at 19.

<sup>308</sup> *Id.* at 19–22.

<sup>309</sup> See *supra* Part IV.D.1.



usually must accept a broad range of potential medical expenses for each insured each year.<sup>310</sup> In addition, while credit card issuers expect to earn additional interest compensation from balances carried by many customers, health insurers receive fixed premiums for the year. Thus, I value the benefits provided by health insurers to hospitals and other providers at a somewhat higher amount than the benefits provided by credit card companies.

*E. Applying This Method to Uninsured Patients, Out-Of-Network Patients and Personal Injury Plaintiffs*

1. Uninsured Patients

As discussed in Part D.IV.1., uninsured patients (rich or poor) should not be obligated to pay for the medical services they receive at the treating hospital's chargemaster rates.<sup>311</sup> The argument made here is that non-indigent uninsured patients should be obligated to pay no more than 110 to 115 percent of the average reimbursement amount that the hospital would accept as full payment from private insurers. The uninsured should not be afforded a lower price for their care, with an exception for uninsured patients who are indigent,<sup>312</sup> because a lower price is unfair to the hospital.<sup>313</sup> As discussed, hospitals negotiate lower prices with insurers because the hospital receives certain benefits from the insurers.<sup>314</sup> In the case of non-indigent uninsured patients, the hospital does not receive these benefits and thus should not be required to reduce its rates to the same level that private insurers pay.<sup>315</sup> For indigent uninsured patients, non-profit charitable hospitals should work with these patients to either get them insurance under the ACA or discount the price they owe to a level they can afford.<sup>316</sup>

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<sup>310</sup> See Reinhardt, *U.S. Hospital Services*, *supra* note 7, at 60.

<sup>311</sup> See *supra* Part IV.D.1.

<sup>312</sup> See *infra* Part IV.G.

<sup>313</sup> See *supra* notes 185–196 and accompanying text.

<sup>314</sup> See *supra* notes 185–196 and accompanying text.

<sup>315</sup> See *infra* notes Part IV.G.

<sup>316</sup> See *infra* notes Part IV.G.

## 2. Patients Subject to Balance Billing

Insured patients who receive healthcare outside of their insurers' network should be required to pay no more than the difference between the amounts their insurer will pay and the fair and reasonable value of the medical services received. Specifically, these patients should pay no more than 110 to 115 percent the treating hospitals average private insurer reimbursement amount for the medical care provided less the amount paid by the patient's insurance company. The patient should be responsible for no more than this balance. If an insurance company has negotiated a rate with a hospital, but that rate is not low enough for the hospital to be included in the insurers top tier, then an insured who receives care at that hospital should pay either the difference between negotiated rate and the amount paid by the insurer or the differences between the fair and reasonable value of the medical services (calculated as suggested here) and the amount paid by the insurer, whichever is less.

## 3. Plaintiffs in Personal Injury Cases

A plaintiff in a personal injury case has a right to recover the fair and reasonable value of his/her medical expenses.<sup>317</sup> These plaintiffs should not be able to recover the full amount billed by the treating hospital, as this amount is calculated at chargemaster rates and bears virtually no connection to the value of the medical care received.<sup>318</sup> Nor should the plaintiff be limited to recovering only what their insurance company paid to the hospital. Rather a plaintiff should be able to recover 110 to 115 percent of the average amount that the treating hospital's private insurers would pay for such treatment.

In jurisdictions applying the common law collateral source rule, an amount equal to 110 to 115 percent of average reimbursement amount paid by private insurers should be considered a collateral source benefit, and juries should be told that this is the fair and reasonable value of medical services received by the plaintiff. The jury should not be told that the plaintiff was insured, nor how much the insurance company paid the hospital. If the insurer pursues subrogation against the patient, the patient will pay part of the award to the insurer but will retain the difference. This

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<sup>317</sup> 22 AM. JUR. 2D Damages § 396 (2003) (stating that a plaintiff may recover both economic and non-economic damages).

<sup>318</sup> See *supra* Part III.E.

is *not* a windfall to the plaintiff because this benefit results from the plaintiff's prudence in obtaining and in many cases paying for health insurance for his/her own benefit.<sup>319</sup> Allowing the tortfeasor to benefit from the plaintiff's insurance would produce a windfall to the tortfeasor.<sup>320</sup>

#### *F. Calculating Fair and Reasonable Reimbursement Rates for Government Insurers*

While it is beyond the scope of this paper to discuss the proper reimbursement rates for government insurers, such as Medicare and Medicaid, the arguments presented here suggest that those rates should be market based. For example, if Medicare were converted to a voucher-based program then each consumer would be free to negotiate the price of medical care with any provider. Another market-based solution would be to set Medicare reimbursement rates equal to the lowest private insurer rate. The point is, we should use the free market to set the price.

#### *G. Pricing Limitations Proposed Under the ACA*

Under the ACA the Internal Revenue Code (Code) was amended by the enactment of section 501(r) of the Code.<sup>321</sup> This section adds requirements for hospital organizations that are or wish to be recognized as tax exempt under section 501(c)(3) of the Code.<sup>322</sup> Thus, in order to remain a tax-exempt organization for federal tax purposes, a non-profit hospital must meet several new requirements, one of which is that the hospital may not charge certain (poor) uninsured patients more than the "amounts generally billed to individuals who have insurance covering such care."<sup>323</sup> This amount is known as "AGB".<sup>324</sup>

Under section 501(r)(4) of the Code, a non-profit hospital that wishes to be tax exempt under 501(c)(3) must have a Financial Assistance Policy or

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<sup>319</sup> See *supra* notes 94–101 and accompanying text.

<sup>320</sup> See *supra* Part II.B.

<sup>321</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9007(a), 124 Stat. 119, 855–56 (2010).

<sup>322</sup> *Id.*

<sup>323</sup> I.R.C. § 501(r)(5)(A) (West 2011).

<sup>324</sup> See *id.* (stating that hospital organization must limit amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the organizations financial assistance policy to not more than the amounts generally billed to individuals who have insurance covering such care).

“FAP.”<sup>325</sup> The proposed regulations require that the FAP include: (1) eligibility criteria for financial assistance, and whether such assistance includes free or discounted care; (2) the basis for calculating amounts charged to patients; (3) the method for applying for financial assistance; (4) in the case of an organization that does not have a separate billing and collections policy, the actions the organization may take in the event of nonpayment; and (5) measures to widely publicize the FAP within the community served by the hospital facility.<sup>326</sup> Neither the proposed regulations nor the ACA mandate any particular eligibility criteria.<sup>327</sup> Each hospital must establish its own criteria regarding who qualifies for its FAP.<sup>328</sup>

With regard to emergency or other medically necessary care a non-profit hospital may not charge a FAP-eligible uninsured patient more than the AGB amount.<sup>329</sup> Moreover, the proposed regulations provide that a non-profit hospital may not charge its full chargemaster or list prices to any FAP-eligible individual for *any* medical care;<sup>330</sup> the hospital must charge some amount less than its “gross” or chargemaster charges, but exactly how much less is not specified in the statute or in the proposed regulations.<sup>331</sup> The proposed regulations do include a safe harbor that permits hospitals to charge a FAP-eligible patient more than AGB if a FAP-eligible patient has not submitted a complete FAP application as of the time of the charge, as long as the hospital continues to make reasonable efforts to determine whether the patient is FAP eligible.<sup>332</sup> If within 240 days of the original bill

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<sup>325</sup> See *id.* § 501(r)(4)(A).

<sup>326</sup> Additional Requirements for Charitable Hospitals, 77 Fed. Reg. 38,148–55 (proposed June 26, 2012) (to be codified at 26 C.F.R. pt. 1).

<sup>327</sup> *Id.* at 38,149 (“Neither the [ACA] nor these proposed regulations establish specific eligibility criteria that a FAP [financial assistance policy] must contain.”).

<sup>328</sup> *Id.*

<sup>329</sup> See I.R.C. § 501(r)(5) (West 2011).

<sup>330</sup> Additional Requirements for Charitable Hospitals, 77 Fed. Reg. at 38,148–55 (requiring hospital facilities to limit the amount charged for *any* medical care it provides to a FAP-eligible individual to less than the gross charges [chargemaster rate] for that care).

<sup>331</sup> *Id.* at 38,155 (“The proposed regulations make clear that including the gross charges on hospital bills as the starting point to which various contractual allowances, discounts, or deductions are applied is permissible, as long as the gross charges are not the actual amount a FAP-eligible individual is expected to pay.”).

<sup>332</sup> *Id.* at 38,148–55.

the hospital determines that the patient is FAP eligible, the billed charges must be reduced to AGB.<sup>333</sup>

Under the proposed regulations, AGB may be calculated in one of two ways.<sup>334</sup> One method is called the “look-back” method and is based on actual past claims for any emergency or medically necessary care paid to the hospital by either Medicare fee-for-service only or Medicare fee-for-service together with all private health insurers paying claims to the hospital, including in each case any associated portions of these claims paid by Medicare beneficiaries or insured individuals (copay, deductibles etc.).<sup>335</sup> This total is then divided by the sum of the associated gross or chargemaster based charges for these claims.<sup>336</sup> The result is an AGB percentage that is then applied to the gross or chargemaster based charges to determine the AGB amount.<sup>337</sup> The AGB percentage must be calculated at least annually.<sup>338</sup> The other method to calculate AGB is called the Prospective Medicare Method.<sup>339</sup> That is, a hospital may determine AGB by using the billing and coding process the hospital would use if the FAP-eligible patient were a Medicare fee-for-service beneficiary and setting AGB at the amount Medicare and the Medicare beneficiary together would be expected to pay for the care.<sup>340</sup>

It is very unfortunate to note that, under the ACA and the proposed regulations, hospitals’ chargemasters, with their exorbitant prices, are now legally required to remain in place.<sup>341</sup> For example, if a hospital decided to completely revamp its chargemaster to reflect real prices, it would face the problem that it is required by the proposed regulations to charge *less than its gross charges* to FAP-eligible patients for any medical care.<sup>342</sup> Moreover because of the unreasonably low reimbursement rates under Medicare,

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<sup>333</sup> *Id.* (noting that if a patient has not made a FAP application within the 120-day notification period the hospital facility may take what the statute and regulations call “extraordinary collection actions,” the hospital facility must however accept and process FAP applications for 240 days from the date of the first billing statement).

<sup>334</sup> *Id.*

<sup>335</sup> *Id.*

<sup>336</sup> *Id.*

<sup>337</sup> *Id.*

<sup>338</sup> *Id.*

<sup>339</sup> *Id.*

<sup>340</sup> *Id.*

<sup>341</sup> See *supra* notes 329–340 and accompanying text.

<sup>342</sup> See *supra* notes 330–331 and accompanying text.

many hospitals will be forced to use their chargemaster rates to calculate AGB under the look-back method.<sup>343</sup> As a result of the ACA leaving in place current incentives, providers have to continue to increase their charge master rates.

Another problem caused by these extraordinarily high chargemaster rates is that they prevent individuals from self insuring for minor health events. This is true because the self-insured are expected to pay the very high charge master rates.<sup>344</sup> A detailed discussion of this topic is beyond the scope of this article. However, this is an important problem because if individuals could self-insure for minor events (annual physical, ear infection, sprained ankle, etc.) then individuals would have an incentive to seek out not just the best care, but the best care at the best price.<sup>345</sup> One of the most pernicious consequences of high chargemaster prices is that they lock in the current system of ensuring minor and catastrophic health events and this prevents normal market forces from creating efficiency in healthcare.

## V. CONCLUSION

Determining the fair and reasonable value of medical services is not easy. Hospital billing practices are odd to say the least, seeming to the uninitiated to be arbitrary and capricious. For example, hospitals send detailed itemized bills to every patient that reflect the exorbitant charges contained in a hospital's changemaster, but these bills and the high prices reflected in them are rarely ever paid to hospitals.<sup>344</sup> Rather, hospitals expect to receive, and are in fact quite happy to accept as full payment, less than half (often much less) of the totals reflected in these chargemaster based bills.<sup>345</sup> To make sense of hospital billing one must understand that chargemaster prices are set to be heavily discounted, not paid.<sup>346</sup> Moreover, the totals reflected on a hospitals itemized bill bear neither a specific relationship to the actual value of the goods and services received nor to the amounts actually paid on behalf of patients by the various insurers that the

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<sup>343</sup> See *supra* note 234 and accompanying text.

<sup>344</sup> See *supra* notes 155–183 and accompanying text.

<sup>345</sup> See *supra* notes 19–21 and accompanying text.

<sup>344</sup> See Reinhardt, *U.S. Hospital Services*, *supra* note 7, at 58.

<sup>345</sup> *Id.* at 60.

<sup>346</sup> See *supra* Part I.

hospital deals with.<sup>347</sup> Each hospital negotiates reimbursement rates annually with each private insurer, and government insurers calculate their own reimbursement rates each year.<sup>348</sup> Thus, for the same exact medical services different payers pay different amounts.<sup>349</sup> The result of these odd billing practices is apparent rampant price discrimination.<sup>350</sup> However, on closer inspection *some* of what appears to be price discrimination is in fact a purchase by hospitals of various benefits from private insurers.<sup>351</sup> Hospitals pay for these benefits by discounting their prices for private insurers.

This article argues that the best way to determine the fair and reasonable value of medical services is to start with the average amount the hospital would pay to private insurers and then add to this amount the value of the benefits private insurers provide to hospitals. By analogy to credit card processors, I suggest that the value of these benefits is no more than ten to fifteen percent of the average private insurer reimbursement rate. The ACA was designed to significantly reduce the number of Americans without health insurance. However, even under the most optimistic assumptions, when the ACA is fully effective, there will still be a large number of Americans without insurance.<sup>352</sup> Moreover, after the Supreme Court's decision upholding the ACA and its individual mandate to purchase health insurance under the taxing power,<sup>353</sup> even those who can afford insurance may decide instead to pay the tax and self-insure.<sup>354</sup> Also, the Medicaid expansion called for in the ACA is now in question, which could mean many more uninsured Americans.<sup>355</sup> While the ACA does impose a limit on the amount non-profit, tax-exempt hospitals may bill poor uninsured patients, it does not define who qualifies as poor. Defining "poor" or FAP-

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<sup>347</sup> See *supra* Part I.

<sup>348</sup> See Reinhardt, *U.S. Hospital Services*, *supra* note 7, at 60.

<sup>349</sup> See *supra* Part I.

<sup>350</sup> Reinhardt, *The Many Different Prices*, *supra* note 129, at 2128.

<sup>351</sup> See *supra* Part I.

<sup>352</sup> See Nation, *supra* note 253, at 142 n.8 (stating that even after the ACA is fully operational in 2019 there will still be millions of Americans without health insurance).

<sup>353</sup> See *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2608 (2012) (upholding the constitutionality of the ACA under the taxing power).

<sup>354</sup> *Id.* at 2594 ("the mandate is not a legal command to buy insurance . . . it makes going without insurance taxable").

<sup>355</sup> *Id.* at 2574 (rejecting as coercive ("economic dragooning that leaves the States with no real option") the Medicaid expansion).

eligibility is left to each hospital.<sup>356</sup> In addition, the ACA does not prevent exorbitant chargemaster rates from being applied to all other self-pay patients.<sup>357</sup> Moreover, the ACA essentially enshrines high chargemaster rates because of its references to them in the legislation.<sup>358</sup> Thus, exorbitant chargemaster rates are here to stay, but these should not be used to determine the fair and reasonable value of medical care. As I argue here, the fair value of medical care should be based on a market determined rate and adjusted as necessary.

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<sup>356</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9007(a), 124 Stat. 119 (2010).

<sup>357</sup> *Id.*

<sup>358</sup> *See id.*