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 regulations regarding price aim to insure that the customer has complete price information before a contract is created.¹ The business of healthcare, however, has certain characteristics that distinguish it from most other businesses and that in some cases should limit the ability of health care businesses to freely set prices.

One important characteristic of health care 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.² 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” and/or “Statement of Financial Responsibility” or other 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.³

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¹ See e.g., New Jersey’s Consumer Fraud Act at N.J.S.A. 56:8-151.1(3) and N.J.A.C. 13:45A-16.2 (a) 12ii and iii which require a general contractor in New Jersey to provide full disclosure in advance of labor and material costs.

² See infra notes 7-20 and accompanying text.

³ See e.g., Cape Regional Medical Center v. Karen Sanchez an unpublished decision of the Superior Court of New Jersey, on file with the author (hereinafter Sanchez) at 2. (This case involved a patient who received Emergency Room services at Cape Regional following a car accident. The patient was not covered by her auto insurer for medical care but was covered by her Medicaid carrier, however by the time Cape Regional submitted their claim to the Medicaid carrier it was too late and thus denied. Cape Regional sued Sanchez for the total billed charges $1,495 even though it would have accepted $494.85 from Medicaid as full payment. The court notes that Cape Regional based its claim against Sanchez on the “authorization for treatment signed by the Defendant and the authorization
In reality however, this type of agreement amounts to a blank check given by the patient to the hospital with the amount to be filled in unilaterally by the hospital at a later date.\(^4\) This situation would, perhaps, be tolerable if hospitals or other providers of healthcare used their discretion in these cases to charge (fill in) a fair and reasonable price for the medical goods and services provided.\(^5\) 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. But, in the case of healthcare, for reasons discussed \textit{infra}, the amount ultimately charged by the hospital or other provider, when based on the provider’s list or chargemaster prices is not reasonable but is exorbitant and grossly unfair.\(^6\)

A chargemaster is an extensive price list created and maintained by hospitals and other providers.\(^7\) 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).\(^8\) Hospitals update, that is increase these list prices frequently.\(^9\) From 1984 to 2004 for example, chargemaster prices increased 10.7\% per year, and this was much faster than Medicare allowable costs (6.3\%) or hospital net-

\(^4\) \textit{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.”) \textit{Id.}

\(^5\) 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. \textit{See generally}, George A. Nation III, \textit{Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured}, 94 Kentucky Law Journal 101 (2005-2006).

\(^6\) \textit{See infra} notes 21-42 and accompanying text.

\(^7\) \textit{See e.g.}, Uwe E. Reinhardt, \textit{The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy} 25.1 Health Affairs 57 at 58 (Jan/Feb 2006). (“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.”).

\(^8\) \textit{Id.} (noting that a sample chargemaster posted on the website of California’s state government contains close to 20,000 items).

\(^9\) \textit{Id.}
revenues (6.6%). Thus, as discussed infra 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. In addition, there are other reasons for a hospital to set continually higher list prices and no reason for them not to constantly increase list prices. Hospitals in general do not provide prospective patients with a copy of the chargemaster. 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. 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. 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 or how much operating room time, or how much suture material etc. is needed to perform this procedure. Moreover, in some cases such as emergency services a patient may not even know in a general way what treatment he is seeking. In other words, while a hospital’s chargemaster is

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10 See Gerard F. Anderson, MARKETWATCH: From ‘Soak the Rich’ to “Soak the Poor’: Recent Trends in Hospital Pricing, 26.3 Health Affairs 780 (May/June 2007) at 781.
11 See e.g., C.P. Tompkins, S.H. Altman and E. Eilat, The Precarious Pricing System for Hospital Services, 25(1) Health Affairs 45 (2006) (individual items in the chargemaster are subject to smaller- or larger-than average increases based on the advice of an “array of consultants and computer software to determine optimal increases in charges for various services (where optimal means “the largest increase in net revenues for a given increase in charges”)). Id. at 49. See also infra notes 206-233 and accompanying text.
12 See infra notes 233-240 and accompanying text.
13 There is no downside to high list or chargemaster prices (chargemasters are very rarely made public so no customers are frightened away) only potential reward.
14 See Reinhardt 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.”)
15 See Anderson supra note 10, at 784 noting the reasons that chargemaster information will not allow self-pay patients to negotiate lower prices (patients don’t 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). Id.
16 Id.
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.17

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 a la carte pricing based on 
chargemasters, consumers will not be able to effectively negotiate price.18 But, neither 
government insurers nor most private insurers accept a la carte pricing, rather they demand 
procedure based pricing based either on DRGs (diagnostic related groups) for inpatient care or 
on APCs (ambulatory payment classification) for outpatient services.19 It should be noted, 
however, that even in the case of Medicare reimbursement, higher chargemaster rates result 
indirectly in higher net revenues for hospitals.20 If hospitals published procedure based prices, 
and applied them to individual consumers, then consumers could effectively compare prices 
among providers.

Another important characteristic of health care is that chargemaster or list prices are not 
fair or reasonable. They are grossly inflated because they are not set to be paid but set to be 
discounted.21 Hospitals, in general, do not expect to recover these inflated prices, but for reasons 
discussed infra they are very reluctant to reduce them for self-pay patients.22 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

17 Id.
18 Id.
19 See Reinhardt supra note 7 at 59-60 discussing various billing/price setting methods for various payers.
20 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.)
21 Id. at 57 (chargemasters rates are much higher than the prices U.S. hospitals are actually paid; in 2004 U.S. 
hospitals were actually paid only about 38% of their charges by patients or their insurers).
22 See infra notes 206-233 and accompanying text.
uninsured, receives a detailed itemized bill reflecting chargemaster prices.\textsuperscript{23} As a result, hospitals sometimes claim that all patients are billed at chargemaster rates.\textsuperscript{24} However, while all patients are billed chargemaster rates all patients are \textit{not} expected to pay the billed charges.\textsuperscript{25} As discussed \textit{infra}, for insured patients the billed (chargemaster based) amount is dramatically (at least 50\%) discounted!\textsuperscript{26} 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. Self-pay patients, who represent a small portion of a hospitals patients, are the only patients expected to actually pay the full hospital bill based on chargemaster rates.\textsuperscript{27} Self-pay patients include: the uninsured, (it is important to note that even with the Patient Protection and Affordable Care Act (aka “ObamaCare”) hereinafter the ACA there will still be a significant number of Americans without health insurance, for example it is estimated that ten years after the ACA becomes fully operational there will be 30 million Americans uninsured)\textsuperscript{28} 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).\textsuperscript{29} In addition, the term self-pay patient in this article also includes patients covered by automobile insurance for

\textsuperscript{23} \textit{See} Reinhardt, \textit{supra} note 7 at 58 (“Typically, a hospital will submit for all of its patients, detailed bills based on its chargemaster, even to patients covered by Medicare.”) (It might be argued that because hospitals initially bill all of their patients at their chargemaster prices they do not engage in “price discrimination” … but the author finds such argument unpersuasive) \textit{Id.} at 60.
\textsuperscript{24} \textit{Id.}
\textsuperscript{25} \textit{Id.} At 57 (in 2004 hospitals were actually paid only about 38\% of their charges), and 58-60 (discussing the specifics of discounting chargemaster charges for government and private insurers).
\textsuperscript{26} \textit{See infra} notes 206-233 and accompanying text.
\textsuperscript{27} \textit{See} Anderson \textit{supra} note 10 at 780 (hospitals often present self-pay patients with bills that reflect the hospitals full charge), Tompkins et al., \textit{supra} note 11 at 49 (self-payers usually forced to accept the full charges set by the hospital).
\textsuperscript{29} \textit{See} Anderson \textit{supra} note 10 at 780 (listing the various groups of self-pay patients who were required to pay for care at chargemaster rates).
health care, and patients covered by workers compensation because in these cases hospitals also expect full payment of the billed charges or an amount very close to the billed charges.\textsuperscript{30}

A third important characteristic of the sale of healthcare is that hospitals and other providers engage in extensive and significant price discrimination.\textsuperscript{31} As discussed \textit{infra} providers of medical services routinely and significantly discount their chargemaster prices pursuant to specific contracts with HMOs and private insurance companies.\textsuperscript{32} While all insurers pay discounted rates, the amount of the discount and thus the amount paid by insurers for the same health care varies widely with no two insurers necessarily paying the same price for the same care.\textsuperscript{33} 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.\textsuperscript{34} Discounts from chargemaster prices given to insurers overall average about 62\%,\textsuperscript{35} but in specific cases can be 80\% or even more.\textsuperscript{36} To put it another way, hospitals and other providers typically and routinely accept less than 50\% of the chargemaster rates (sometimes a lot less) from HMOs, private insurers and government insurers as full payment on behalf of insured patients.\textsuperscript{37} Overall in 2004, for every $257 that a hospital charged based on its chargemaster rates it actually collected $100.\textsuperscript{38} 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 2½ times the average amount

\textsuperscript{30} \textit{Id.}
\textsuperscript{31} \textit{See infra} notes 152-180 and accompanying text.
\textsuperscript{32} \textit{See infra} notes 206-233 and accompanying text.
\textsuperscript{33} \textit{See,} Reinhardt, \textit{supra} note 7, at 60 (“The reality is that hospitals accept different payments from different payers for identical services, and that can properly be called price discrimination.”) \textit{id.}
\textsuperscript{34} \textit{Id.} at 58-60 (outlining payments to various insurers).
\textsuperscript{35} \textit{See e.g.,} Reindart, \textit{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.”)
\textsuperscript{36} \textit{See infra} notes 62-84 and accompanying text discussing \textit{Nassau Anesthesia Association P.C. v. Chin} where the discounts among the various payers ranged from 20 percent to 91 percent.
\textsuperscript{37} \textit{See} Anderson \textit{supra} note 10 at 781 (“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.”)
\textsuperscript{38} \textit{Id.}
paid by health insurers for the same exact care. All of these discounts are well known in advance by the hospital and are planned for in budgeting. Thus, with regard to medical services, different patients (or more accurately different insurers) pay dramatically different prices for the same medical care. In health care 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. The most important factor in determining the amount the hospital or other provider will accept as payment in full for its medical care is the identity of the insurer.

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. For example, in personal injury cases, and in self-pay cases such as those involving uninsured patients or out-of-network patients subject to balance billing, 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’s 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.

39 Id.
40 See Tompkins et al., supra note 11 at 48 (“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, services mix, and expected payer contract specifications, and an initial cost model based on current input costs, expected service volume, and so forth.”) id.
41 Id. at 47 (“The gap between charges and actual payments (net patient revenue) now averages 255 percent and is growing rapidly.”)
42 Id. at 47-50 (describing how prices are set for various payers); Reinhardt supra note 7 at 58-61 (similar).
43 See infra notes 47-151 and accompanying text.
44 See infra notes 25-127 and accompanying text.
45 See infra notes 47-84 and accompanying text.
46 See infra notes 129-151 and accompanying text.
and price discrimination with particular focus on the likely reasons hospitals charge different prices to different payers, and whether in fact, it’s 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.

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 health care policy. Unfortunately, there is no generally accepted definition of poor or indigent when it comes to those without health insurance. In this article when the term “uninsured” is used it includes both the poor and non-poor unless otherwise stated.

47 See e.g., Nation supra note 5 at 121 (discussing Medicare rules that allowed 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, 106. 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). Id.; See infra notes 81-84 and accompanying text, noting that the court would not reduce chargemaster charges for uninsured patients who had the financial ability to pay); Anderson supra note 10 at 784 (“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.”) The AHA guidelines are not binding on hospitals, but do at least define “poor”. The guidelines provided 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 contract price paid to the hospital by a public or private insurers, or 125 percent of the Medicare rate for applicable services. Id.

48 For example, under §9007(a) the Patient Protection and Affordable Care Act of 2010 (hereinafter ACA), Pub.L.No.111-148, 124 Stat. 119 (2010) (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.)(2004) (hereinafter 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 (Section 501(r)(s)(A)). However, under the proposed regulations it is left to each hospital to define poor, that is FAP eligible patients. See, Department of the Treasury, Internal Revenue Service 26 CFR Part 1 [Reg-130266-11] RIN 1545-BK 57 Additional Requirements for Charitable Hospitals (hereinafter ACA Proposed Regulations) at pg. 9 (“Neither the Statute nor the proposed regulations establish specific eligibility criteria that a FAP must contain.”) Id.
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 when they set prices with private insurers and HMO’s. 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. 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). 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 percent (or more) of the amount the hospital would accept as full payment from insurers. 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 agrees to pay at “chargemaster” or “list” prices for all care received. 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.

Agreements such as the “Statement of Financial Responsibility” should not be used as justification to hold uninsured patients liable for unconscionably high chargemaster prices. If patients were told the truth, no patient would ever freely agree to pay the hospital’s list or

49 See infra notes 241-260 and accompanying text.
50 See supra note 23.
51 See supra notes 35 - 42 and accompanying text.
52 See e.g., supra note 3.
53 See supra note 23.
54 See generally, Naton supra note 5.
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 HMO’s at a price of $5,600, for Blue Cross/Blue Shield at a price of $4,700, for Aetna at a price of $5,000, for Medicare at a price of $2,590 and for Medicaid at a price of $1,260.55 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 $6,000 the hospital would likely agree and the patient would save more than 50%. 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 contact law.56 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” “list price” language in their Financial Responsibility Agreement and they are ignorant regarding the odd characteristics of hospital pricing.57

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.58 More recently, the ACA includes provisions designed to limit the amount that federally tax-exempt hospital organizations may charge poor uninsured patients.59 In addition, courts and even some hospitals have begun to recognize the unfairness of forcing the uninsured (some recognize this unfairness only for the

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55 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 infra notes 63-147 and accompanying text.
56 See generally, Nation supra note 5.
57 See e.g., Sanchez supra note 3 and quote at note 4.
58 See Nation supra note 5.
59 See supra note 48. The ACA provisions are discussed in more detail infra at notes 298-319 and accompanying text.
poor uninsured) to pay the exorbitant chargemaster prices. 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. The relevant point for this article is, if the amount billed by the hospital based on its chargemaster is so unreasonably high as to be unenforceable, then 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?

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 Association P.C. v. Chin.* In that case, a medical provider Nassau Anesthesia Assoc. sued Larry Chin for anesthesia services rendered as part of open-heart surgery. Nassau sought $8,675.00 the chargemaster list price for the services rendered. The court noted that Nassau was entitled to the fair and reasonable value of its services. The court also noted that Nassau would have accepted, as full payment, much less than $8,675 from private or government insurers. Specifically, the court notes that the provider would have been paid between $5,208.01 (Blue Cross Blue Shield) and $6,970.00 (United Healthcare) if covered by private insurance, $1,605.29.

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60 See e.g., supra note 48 discussing the non-binding recommendation of the AHA.
61 See e.g., Tim Darragh, *Hospitals Discount Care for Uninsured,* THE MORNING CALL, October 4, 2012 at News 4 (discussing hospitals who voluntarily reduce full charges for self-pay patients – at Lehigh Valley 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 full charges.” At nearby St. Luke’s University Health Network uninsured patients are asked to pay no more than 20 percent of charges. However, at another area hospital, Sacred Heart, only those uninsured patients making no more than 150 percent of the federal poverty level qualify for discounted care).
62 See infra notes 261-290 and accompanying text.
64 See *Nassau* 924 N.Y.S. 2d 252.
65 Id.
66 Id.
if covered by Medicare, and $797.50 if covered by Medicaid. However, Mr. Chin was uninsured so Nassau sought the entire billed amount as payment. Nassau received a default judgment as to liability when Mr. Chin failed to appear. However, Nassau was still required to prove its damages. Nassau failed to establish 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.

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. An important factor according to the court is the amount charged by other practitioners of similar standing for similar services. The court also noted that “a patient’s strained financial condition” maybe considered in determining whether billed amounts are reasonable. 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. 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.

The court concluded that the fair and reasonable value of Nassau’s services was “the average amount it would have accepted as full payment from third-party payors such as private

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67 Id. at 254.  
68 Id. at 253.  
69 Id.  
70 Id.  
71 Id.  
72 Id.  
73 Id. at 254.  
74 Id.  
75 Id.
insurers and federal healthcare programs.” That amount, as calculated by Nassau’s billing manager was $4,252.11. The court, citing *Temple Univ. Hosp. v. Healthcare Mgt. Alternatives*, 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. 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 providers published rates is untenable. A more realistic standard is what insurers actually pay and providers accept. The court did, however, limit its holding to cases where the provider failed to prove either that the defendant agreed to pay the providers “uninsured patient fee” or chargemaster/list charges or prove the patients financial ability to pay list charges. In other words, the courts holding was limited to the poor uninsured who had not signed a statement of Financial Responsibility of similar agreement. I argue here that these limitations are not appropriate.

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. Traditionally, the dollar value of medical expenses was the undiscounted amount billed by the

76 *Id.*
77 *Id.* at 255.
79 See Nassau 924 N.Y.S. 2d 253 at 255.
80 *Id.*
81 *Id.*
82 *Id.*
83 *Id.*
84 See infra notes 291-297 and accompanying text.
hospital (that is, calculated using its chargemaster). Usually the plaintiff submits an affidavit from the billing administrator of the hospital which stated 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. Remember every patient, insured and uninsured, is billed at chargemaster rates before the application of negotiated discounts. Thus, the tortfeasor was required to reimburse the victim/plaintiff for medical care at the billed or chargemaster rate. 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. The insurer may have recovered this amount from the plaintiff via subrogation, though many insurers do not pursue subrogation in this context.

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 amounts actually paid or incurred on behalf of the patient.” For example, assume that a tort occurred and as a result the victim/plaintiff sought medical treatment. Further assume that the hospital sent a

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86 See e.g., Lopez v. Safeway Stores, Inc., 129 P.3d 487 (Ariz. Ct. App. 2006) (a slip and fall case in which the plaintiffs medical bills totaled $59,700, the healthcare providers were contractually bound to accept $16,837 as full payment from plaintiffs health insurers, but the court, applying the common law collateral source rule, allowed the plaintiff to recover $59,700 as economic damages). See also, Lori A. Roberts, Rhetoric, Reality, and the Wrongful Abrogation of the Collateral Source Rule in Personal Injury Cases, 31 Rev. Litig. 99 (2012) (in which the author discusses the Lopez case in the context of arguing that unwarranted rhetoric is wrongly being used to abrogate the collateral source rule).

87 See e.g., Sanchez supra note 3 at 2-3.
88 See supra notes 21-30 and accompanying text.
89 See e.g., Lopez supra note 86.
90 Id.
91 Id. 2-11.
92 See e.g., Haygood v. De Escalado, 54 Tex.Sup.J.1377, 2011 Tex LEXIS 514 (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; charges and amounts actually paid). Id. 2-11.
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. Further assume the hospital’s bill totals $1,495, 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). Under the Collateral Source Rule, the defendant is prevented from offering any evidence concerning any reimbursement made to or on behalf of the plaintiff by a collateral source. 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. 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. If this were allowed the tortfeasor would receive a windfall. To prevent this, the collateral source rule prevents the defendant from presenting evidence of any collateral source benefits received by the plaintiff.

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 $1,000.15 or 67%. In terms of the collateral source rule, it seems clear that the

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93 See Restatement (Second) Torts §920A(2)(1979) (“Payments made to or benefits conferred of 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.”).
94 See, The Propeller Monticello v. Molllison, 58 U.S. (17 How.) 152 (1854) introducing the collateral source rule to the United States (“The wrongdoer … is bound to make satisfaction for the injury he has done.”).
95 Id.
96 See e.g., Helferd v. S. Cal. Rapid Transit Dist. 465 P.2d 61,66 (cal. 1970)(a person who has invested years of premiums to acquire insurance should benefit from his prudence thrift not the tortfeasor).
97 Id.
98 See supra note 93.
$494.85 payment by the insurer is a collateral source benefit that should be kept from the jury.\textsuperscript{99} But what about the $1,000.15 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?\textsuperscript{100} 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.\textsuperscript{101} Many states have modified the common law collateral source rule to allow juries to be told of the $1,000.15 discount, often as part of tort reform, and often noting that a hospitals chargemaster rates are illusionary or phantom charges.\textsuperscript{102} For our purposes the question is, what is the reasonable value of the medical services received by the patient/plaintiff; $494.85, $1,495, or some amount between the two? As discussed \textit{infra} 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.\textsuperscript{103}

For example, in the case \textit{Haygood v. Escabedo}\textsuperscript{104} 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 health care provider was not entitled to be paid.\textsuperscript{105} In other words, reasonable expenses for receiving medical care are, in Texas, equal to the amount health care providers have a right to be paid for the care (the contract adjusted amount) not the amount the health care provider billed for the care (chargemaster/list prices).\textsuperscript{106} This case

\textsuperscript{99} \textit{Id.}
\textsuperscript{100} \textit{See e.g.}, \textit{Haygood supra} note 92 at 12-13 (“An adjustment in the amount of those charges [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.”)
\textsuperscript{101} \textit{Id.}
\textsuperscript{102} \textit{See} \textit{Roberts supra} note 86 at 124-132 (discussing rhetorical themes of illusory medical bills and windfalls in states modifying or abolishing the collateral source rule.).
\textsuperscript{103} \textit{See infra} notes296-297 and accompanying text.
\textsuperscript{104} \textit{See} \textit{Haygood supra} note 92 (2011 Tex. LEXIS 514).
\textsuperscript{105} \textit{Id.} at 2.
\textsuperscript{106} \textit{Id.}
involved damages for injuries resulting from an automobile collision. Haygood was billed a total of $110,069.12 for the medical care he received.\(^{107}\) 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.”\(^{108}\) The court also noted that federal law prohibits health care providers who agree to treat Medicare patients from charging more than Medicare has determined to be reasonable.\(^{109}\) Thus, Haygood’s health care providers adjusted their bills with credits of $82,329.69 or 75% leaving a total of $27,739.43 due.\(^{110}\)

At trial, Escabeldo moved to exclude evidence of medical expenses other than those owed or paid (i.e. $27,739.43).\(^{111}\) Haygood asserted the collateral source rule and moved to exclude evidence of any amounts other than those billed (i.e. $110,069.12).\(^{112}\) The trial court denied Escabeldo’s motion and granted Haygood’s.\(^{113}\) At trial Haygood offered evidence from the various health care providers that the charges billed were reasonable and the services necessary.\(^{114}\) The jury found Escabeldo at fault and awarded Haygood $110,069.12 for past medical expenses.\(^{115}\) Escabeldo objected to the award of past medical expenses in excess of the amounts actually paid and owed to the health care providers, but was overruled by the trial court.\(^{116}\)

The court of appeals reversed 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

\(^{107}\) Id.
\(^{108}\) Id.
\(^{109}\) Id.
\(^{110}\) Id.
\(^{111}\) Id. at 3.
\(^{112}\) Id.
\(^{113}\) Id.
\(^{114}\) Id. at 8-10.
\(^{115}\) Id. at 3-4.
\(^{116}\) Id.
behalf of the claimant.” 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.” The Texas Supreme Court upheld the court of appeals noting the great disparity that exists between amounts billed and payments accepted by health care providers.

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. But health care providers routinely bill all patients, including insured patients, at list or chargemaster rates with reductions to reimbursement rates shown separately as adjustments or credits.

The court cites the Restatement (Second) of Torts noting that 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.” The court ruled that the contract adjustments to the billed charges are not benefits directed to the injured party – rather they are benefits of the insurer. Thus, the collateral source rule does not prevent the introduction of evidence of these discounts. The court notes that “to impose liability for medical expenses that a health care provider is not entitled to charge does not prevent a windfall to a tortfeasor; it creates one for the claimant.” Thus, under Texas law the collateral source rule does not prevent the introduction or evidence of discounts applied to billed charges. In Texas, the

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117 Id.
118 Id. at 4.
119 Id. at 5-7.
120 Id.
121 Id. at 8-10.
122 Id. at 13.
123 Id.
124 Id.
125 Id.
126 Id. at 25-26.
reasonable value of medical care is the amount actually paid and accepted by the provider for the care provided.\textsuperscript{127}

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.\textsuperscript{128} 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 insureds to the provider for necessary treatment, and the providers have agreed to discount their chargemaster prices for the insurance company.\textsuperscript{129}

When a patient receives care out-of-network the patient is responsible to pay the provider the difference between the providers 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.).\textsuperscript{130} 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.\textsuperscript{131} 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

\textsuperscript{127} Id.

\textsuperscript{128} 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 Affairs 2125 at 2133, 11 (Nov. 2011) (referring to the “potentially high prices for health care procured form providers not in the insurer’s network of providers.”); Anna Wilde Mathews, *Medical Care Time Wrap*, THE WALL STREET JOURNAL Aug. 2, 2012 at B(1). The author notes 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.


\textsuperscript{130} See supra notes 128-129 and accompanying text.

\textsuperscript{131} See supra notes 128-129 and accompanying text.
not in the top tier, the provider has not agreed to accept that amount as full payment, thus providers argue that the patient is responsible for the balance.\textsuperscript{132}

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 providers unreasonably high chargemaster rates.\textsuperscript{133} 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. 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. For example, in the case of\textit{Daughters of Charity Health Services of Waco v. Linnstaedter},\textsuperscript{134} Donald Linnstaedter and Kenneth Bolen were injured in an auto collision while riding together in the course of their employment.\textsuperscript{135} Both were treated at a hospital owned by Daughters of Charity Health Services of Waco.\textsuperscript{136} The hospital charges billed (chargemaster rates) were $22,704.25.\textsuperscript{137} Both victims were covered by workers compensation insurance and the workers compensation carrier paid a discounted amount of $9,737.54 which was the amount set by the Texas Labor Code. The Texas Labor Code\textsuperscript{138} also provides that hospitals “may not pursue a private claim against a workers’ compensation claimant” for all or part of the costs of treatment.\textsuperscript{139} Nevertheless, within a week of the accident, the hospital filed a lien seeking the balance of its

\textsuperscript{132} See supra notes 128-129 and accompanying text.

\textsuperscript{133} See supra notes 47-84 and accompanying text.

\textsuperscript{134} 226 S.W. 3d 409 (2007) (Tex.Sup.Ct.).

\textsuperscript{135} Id. at 410.

\textsuperscript{136} Id.

\textsuperscript{137} Id.

\textsuperscript{138} Id.

\textsuperscript{139} Id. at 411.
full charges with the county clerk.\textsuperscript{140} 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.\textsuperscript{141}

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.\textsuperscript{142} The employees brought suit against the hospital to recover the $12,966.71 paid pursuant to the hospital’s lien.\textsuperscript{143} The employees claimed that the lien was invalid under the Labor Code.\textsuperscript{144} 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.\textsuperscript{145} Among those provisions are caps on reimbursement that prevent a provider from seeking additional money from patients or their worker compensation carriers.\textsuperscript{146} In addition, workers’ compensation fee guidelines are intended to provide both fair and reasonable reimbursement for health care providers.\textsuperscript{147}

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 ($9,737.54) the hospital should be able to recover the \textit{balance} of its billed charges.\textsuperscript{148} The court agreed, in part with hospital noting that: “We 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

\begin{footnotesize}
\textsuperscript{140} Id. at 410. \\
\textsuperscript{141} Id. \\
\textsuperscript{142} Id. \\
\textsuperscript{143} Id. \\
\textsuperscript{144} Id. \\
\textsuperscript{145} Id. at 412. \\
\textsuperscript{146} Id. at 411-412. \\
\textsuperscript{147} Id. at 412. \\
\textsuperscript{148} Id. 
\end{footnotesize}
the patients, they in turn had no claim for them against Jones.”¹⁴⁹ The Texas Supreme Court, however in upholding the lower courts allowed the employees/patients to keep this amount noting that: “While 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.”¹⁵⁰ In the course of its holding the court clearly establishes that fair and reasonable medical expenses are measured by the amount actually paid to the provider not by the amount billed by the provider. 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 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.¹⁵¹

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.¹⁵² As discussed infra, higher list prices mean higher net revenues,¹⁵³ though one must always remember that a hospital’s chargemaster prices are set to be discounted not paid.¹⁵⁴ Thus, it should not be surprising that very few patients and no insurance companies pay these list prices to the

¹⁴⁹ Id.
¹⁵⁰ Id.
¹⁵¹ Id. See also, infra notes 295-296 and accompanying text.
¹⁵² See e.g., Tompkins et al., supra note 11 at 48-50 (noting that “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.” Also noting that 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).
¹⁵³ See infra notes 206-240 and accompanying text.
¹⁵⁴ See supra note 154.
Insurers, who are the most common payers, pay a much smaller amount arrived at either by applying a negotiated discount factor to the hospitals chargemaster prices or based on a negotiated procedure or per diem reimbursement system. Hospitals negotiate different discounts with different private insurers, and, as noted, government insurers set their own rates. 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. Government insurers pay least; private insurers pay about 14% more on average than Medicare, and uninsured or other self-pay patients owe the most. All patients get billed at chargemaster rates, but most are not expected to pay them. This pricing system results in hospitals engaging in apparent price discrimination, that is charging a different price to different buyers for the same goods or services. This practice is sometimes referred to as dynamic pricing.

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. Traditionally, doctors had a sliding fee schedule that varied with the economic status

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155 See Reinhardt, supra note 7 at 57-61.
156 Id.
157 Id.
158 Id.
159 Id.
161 See Reinhardt supra note 7 at 58 (“Typically, a hospital will submit, for all of its patients, detailed bills based on its chargemaster, even to patients covered by Medicare.”)
162 Id. at 58-61 (explaining how the amount due from various payers is calculated).
163 Id. at 60-61 (discussing price discrimination by hospitals).
164 Id. See also, Julia Angwin and Dana Mattioli, Don’t Like This Price? Wait a Minute, THE WALL STREET JOURNAL September 5, 2012, B1 (discussing dynamic pricing of consumer goods); Chelsea Phipps, More Law Schools Haggle on Scholarships, THE WALL STREET JOURNAL, July 30, 2012 B4 (noting that high tuition levels are a sign of prestige so instead of dropping tuition [this is the list price similar to a hospitals chargemaster price] to attract students, many schools use scholarships – every member of Illinois College of Law class of 2014 received a scholarship – no one paid the list price).
165 See Reinhardt supra note 7 at 58-61.
of the patient. The traditional rationale for this price discrimination was to achieve a social/charitable goal of providing health care to the poor. 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. 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.) This then forces hospitals to maximize revenue from other patients, perhaps via price discrimination or dynamic pricing, in order to cover the Medicare/Medicaid shortfall.

This brings us to the other reason to engage in price discrimination and that is to maximize profits. 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. 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 resell goods/services. Thus, price discrimination is commonly practiced in such businesses as airlines and universities. 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

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166 Id.
167 Id.
168 Id.
170 Id. at 22-25.
171 See Reinhardt supra note 7 at 60-61 (“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). Id. at 61.
172 See Reinhardt supra note 7 at 60-61.
173 Id.
174 See supra note 164 (citing references regarding dynamic pricing for consumer goods and graduate schools).
flight. 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.

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. 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 are often driven into bankruptcy because of these exorbitant charges. The high rates charged to self-pay patients, especially the 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. 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.

B. Hospitals Use Discounts to Purchase Value

Price discrimination, charging a different price for the same good or service to different buyers, 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, any buyer, who purchases a large quantity of goods for example, the seller has not engaged in true price discrimination. Rather,
the lower price reflects the lower costs to the seller when selling a large quantity to a single buyer.\(^\text{182}\) 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. 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 is part of the reason lower prices are accepted from government insurers.\(^\text{183}\) That is, the fair and reasonable value of medical care is likely to be somewhat higher than the amounts paid by insurers.\(^\text{184}\)

In the case of hospitals, insurers sell valuable benefits to the hospital in return for discounted prices; 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.\(^\text{185}\) 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.\(^\text{186}\) Finally, hospitals may receive some marketing/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

\(^\text{182}\) Id. at 4.

\(^\text{183}\) See e.g., Tompkins et al., supra note 11 at 49-50 (noting that having to collect revenues directly from patients is a costly and unwanted activity for hospitals, something that is not necessary when a patient is covered by insurance and that part of the justification for discounts given to insurers is the guarantee of patient volume); Flushing Hosp. v. Waytisek, 364 N.E. 2d 1120 (NY 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 of payment, assurance of payment”) Id. at 1121. (This case is cited in Nassau supra note 63).

\(^\text{184}\) See e.g., Anderson Testimony supra note 60 at 7 (“The rate that self-pay individuals should pay should be greater than what insurers and managed care plans are currently paying hospitals”).

\(^\text{185}\) See supra note 183.

\(^\text{186}\) See supra note 183.
will be available.\textsuperscript{187} These benefits are valuable to the hospital and likely account for the difference in the rates paid by private insurers.\textsuperscript{188} As discussed \textit{infra}, however, these benefits do not account for the huge discounts from chargemaster prices given to insurers.\textsuperscript{189} These huge discounts are caused primarily by the fact that chargemaster rates are set unreasonably high so they can be discounted.\textsuperscript{190}

C. The Problem with All-Payer Systems

In response to the perceived price discrimination practiced by the hospitals (especially that involving the uninsured of other self-pay patients) some have recommended an “all payer system.”\textsuperscript{191} These systems may use various methods to arrive at a price for a particular good or service. For example, the price may either be set by the government or each hospital may be permitted to set its own price,\textsuperscript{192} but regardless of how the price is set, once set, that price must be posted for public view and applied to all patients without discrimination.\textsuperscript{193} 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.\textsuperscript{194} However, if at least part of what appears to be price discrimination is really market driven

\textsuperscript{187} Patients are encouraged by lower out-of-pocket costs to go to hospitals and other providers that are in network and top tier.

\textsuperscript{188} See Reinhardt \textit{supra} note 7 at 60 (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, \textit{supra} note 128 at 2128 (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).

\textsuperscript{189} See \textit{infra} notes 245-251 and accompanying text.

\textsuperscript{190} See \textit{e.g.}, Reinhardt \textit{supra} note 7 at 60 (“Invoices at chargemaster prices, however, are insincere, in the sense that they would yield truly enormous profits if these prices were actually paid”).

\textsuperscript{191} See \textit{e.g.}, Reinhardt \textit{supra} note 7 at 74 (discussing such a system).

\textsuperscript{192} Id.

\textsuperscript{193} See Reinhardt \textit{supra} note 128 at 2128 (recommending such a system).

\textsuperscript{194} See \textit{supra} notes 152-178 and accompanying text.
discounting designed to purchase new value from the buyer, then any all-payer-system will be disruptive to the market and create inefficiency. 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.

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 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. 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.

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. First, self-pay patients account for a relatively small percentage of health care buyers. Second, the price I suggest for these self-pay patients is based on a price freely set by

195 See supra notes 181 - 190 and accompanying text.
196 That is, some buyers will pay more than they would in a competitive market and some will pay less.
197 See infra notes 261-290 and accompanying text.
198 See Reinhardt supra note 7 at 58 (noting that Medicare and Medicaid set their own prices).
199 See e.g., Dobson et al., supra note 169 at 22-33.
200 See e.g., M.E. Paster and E.O. Teisberg, Redefining Competition in Health Care, Harvard Business Review (June 2004) at 1-14.
201 See infra notes 261-290 and accompanying text.
202 See supra note 178.
the market. 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. Neither the government nor the hospital, nor any single private insurer has control over the base. In addition, it would be possible 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.

E. Why are Chargemaster Prices so Unreasonably High?

The answer to this question is complex. Part of the answer lies in the history of hospital billing and the various government and private insurer reimbursement systems that have been used in the past. 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. 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. 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. As a result of this practice by

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203 See infra notes 261-267 and accompanying text.
204 See infra notes 268-276 and accompanying text.
205 In certain cases the value of benefits received by the hospital may exceed 10-15 percent.
206 See Anderson Testimony supra note 160 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, supra note 7 at 57-66 (similar).
207 See Tompkins et al., supra note 11 at 46.
208 Id. at 51 (“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 781 (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]).
209 See Anderson supra note 10 at 782 (noting that some hospitals had increased their charges to obtain higher outlier payments in Medicare payments based on the hospital’s own charges).
some hospitals, CMS has changed its outlier policies. Also, until 2004 Medicare rules were interpreted by providers as prohibiting discounting chargemaster prices for the uninsured. While CMS clarified the situation in 2004 allowing hospitals to offer discounts at least to the indigent uninsured, hospitals were still reluctant to discount their charges for the uninsured because of the common negotiation strategy, used by private insurers, of insisting on being charged the same as the lowest paying patient. Today, under the ACA as discussed infra hospitals are required to discount charges to the poor uninsured though hospitals have complete discretion in defining who qualifies as poor. 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 (this is also why hospitals and other providers continue to have an incentive to set ever higher change master prices), and in part for other reasons.

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. 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. In one form or another, a

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210 See Tompkins et al., supra note 11 at 51 (noting that the CMS administrator blamed a small number of hospitals for “gaming the current rules” by rapidly inflating charges).
211 See Anderson supra note 10 at 785 (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).
212 See Tompkins et al., supra note 11 at 51 (noting that adverse publicity caused a clarification of Medicare rules so that they did permit hospitals to give discounts to low-income patients).
213 Id.
214 See infra notes 298-319 and accompanying text.
215 See supra note 208.
216 See Anderson Testimony supra note 160 at 5 (noting that many hospitals calculate bad debt and charity care based on charge master prices in order to inflate these numbers).
217 See supra note 208.
218 See Reinhardt supra note 7 at 58-61 (discussing how different payers calculate payments); Tompkins et al., supra note 11 at 47-49 (noting that even though most private insurers are not reimbursed as a direct percentage of charges,
hospital’s billed (chargemaster) charges are used indirectly to determine the ultimate dollar level of reimbursement payments. To put it another way, the higher the chargemaster prices the greater the reimbursement amount the hospital will receive from third party payers. 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. Medicare usually pays a fixed fee per case based on the DRG or APC classification; thus higher chargemaster rates would not seem to effect Medicare reimbursement rates, and they don’t do so directly. 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 (chargemaster rates) charges for all cases falling into each DRG in the most recent period. 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. As a result of this process, the higher a hospital sets its’ chargemaster rates the higher its likely reimbursement will be from Medicare. 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. As noted above, Medicaid reimbursement rates are widely believed to be below fully allocated costs. This fact puts

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219 See Reinhardt supra note 7 at 58-63.
220 Id.
221 Id.
222 Id.
223 Id.
224 Id.
225 See Reinhardt supra note 128 at 2127-2129 (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).
significant pressure on hospitals to increase revenue from all sources and thus continues to push chargemaster rates ever upward.

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. However, high chargemaster rates are more relevant to reimbursements from private insurers than first appears. One commentator notes: “About 20% 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 drive fixed payment amounts.” The fact that many contracts refer to list prices even nominally encourages hospitals to keep chargemaster rates high. In addition, each private payer has a default payment rate (for example 40% of billed charges) for services not covered by fee schedules or other fixed payment amounts. Moreover, Medicare’s payment for the facility component of outpatient services is directly based on charges. One commentator notes that “These 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.”

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226 See Reinhardt supra note 7 at 60-61.
227 See Tompkins et al., supra note 11 at 48.
228 Id.
229 See supra note 218.
230 See Tompkins et al., supra note 11 at 49 (noting that the facility component of outpatient services is directly based on charges).
231 Id.
Thus, one commentator notes that “…charge levels greatly affect revenues from many sources” 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. But there are also other reasons. One reason is to encourage private insurers to negotiate a contract with the hospital. Extremely high list prices help this process in two ways. First, it shows insurers how much they or their insured’s 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. Thus, the higher the chargemaster prices the greater the incentive for private insurers to sign a contract with the hospital. Second, extremely high chargemaster prices allow the insurance company to demonstrate its value to its insureds because each hospital bill a patient/insured receives shows the chargemaster based charge and the huge savings the insured has reaped because he has insurance.

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. For example, if the hospital treats an indigent patient free of charge and the care provided would be billed at $3,000 but reimbursed at only $1,000 by insurers, some hospitals may claim $3,000 worth of charity care by measuring such care based on its chargemaster rates. The same is true for bad debt expense. Inflating these measures can pay big public relations and political dividends for

\[\text{\footnotesize\textsuperscript{232}}\text{ Id. at 48.}\]
\[\text{\footnotesize\textsuperscript{233}}\text{ Id. at 50 (“The strategies and methods used to determine charge levels, which greatly affect revenues from many sources, have resulted in rapidly growing changes and wide variation among hospitals).}\]
\[\text{\footnotesize\textsuperscript{234}}\text{ See Anderson supra note 10 at 782 (noting that hospitals set high charges as a negotiating strategy with managed care plans; if a plan does not have a contract with the hospital then it must pay full charges, the higher the charges the greater the incentive to sign a contract with the hospital).}\]
\[\text{\footnotesize\textsuperscript{235}}\text{ Id.}\]
\[\text{\footnotesize\textsuperscript{236}}\text{ Id.}\]
\[\text{\footnotesize\textsuperscript{237}}\text{ Id.}\]
\[\text{\footnotesize\textsuperscript{238}}\text{ See Anderson Testimony supra note 160 at 5 (noting that hospitals routinely use charge rates to quantify the amount of bad debt and charity care they provide to help with fundraising and to meet charitable obligations – but using chargemaster prices vastly overstates these amounts).}\]
hospitals.\textsuperscript{239} For example, a hospital's tax exempt status may depend on providing a certain dollar amount of charity care or community benefit.\textsuperscript{240}

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 hospital/provider accepts as full payment from government or private insurers.\textsuperscript{241} That is, the lowest contract adjusted/discounted rate. 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.\textsuperscript{242} As discussed supra, private insurers bring large groups of profitable patients to the hospital/provider, and provide assured, easy and rapid payment of discounted charges.\textsuperscript{243} Insurers in essence pre-approve patients in terms of creditworthiness and may also offer some marketing/advertising benefits by making a

\textsuperscript{239} See e.g., Stephanie Strom, Congress Questions The I.R.S. about Delays In Its Oversight of Nonprofit Hospitals, THE NEW YORK TIMES, Oct. 31, 2011 (THE NEW YORK TIMES Reprints at http://www.nytimes.com/2011/11/01/business/congress-asks-irs...) (visited 11/10/12) (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 at 141-180 and notes (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) id. at 144-146 esp. nts. 20 and 21.

\textsuperscript{240} See e.g., Suzanne Sataline, Illinois High Court Rules Nonprofit Hospital Can Be Taxed, WALL ST. J., March 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).

\textsuperscript{241} See e.g., Temple University Hospital v. Healthcare Management Alternatives, 832 A.2d 501 at 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 supra note 63 at 285 (same).

\textsuperscript{242} See infra notes 268-276 and accompanying text.

\textsuperscript{243} See supra notes 181 - 190 and accompanying text.
hospital provider known to its insureds. A relevant question for this article, discussed infra, is; what is the value of these benefits?²⁴⁴

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 can’t begin to account for the huge discounts from chargemaster prices given to insurers.²⁴⁵ Rather, as discussed supra 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.²⁴⁶ That is, chargemaster prices are set to be discounted, not paid. If these prices were actually paid they would yield truly enormous profits.²⁴⁷ As discussed infra the proposed regulations under the ACA seem to be continuing the tradition of odd reimbursement schemes by relying on these exorbitant chargemaster prices to implement its price limitations.²⁴⁸

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.²⁴⁹ 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

²⁴⁴ See infra notes 268-290 and accompanying text.
²⁴⁵ See supra note 190 quoting Reinhardt supra note 7 at 60 saying that chargemaster prices would yield truly enormous profits if these prices were actually enforced.
²⁴⁶ See supra notes 152 - 90 and accompanying text.
²⁴⁷ See Reinhardt supra note 7 at 60.
²⁴⁸ See infra notes 298-319 and accompanying text.
²⁴⁹ See Temple supra note 78 at 510 (noting that chargemaster prices “bear no relationship to the amount typically paid for those services”); Tompkins et al., supra note 11 at 60 (noting that: “Over time, a hospital’s chargemaster is bent, stretched, and distorted by numerous pressures and responses.”); Reinhardt supra note 7 at 58 (noting that chargemaster rates “do not bear any systemic relationship to the amounts third-party payers actually pay for the listed services.”)
the fair and reasonable value of medical services. To do so creates a windfall to the hospital or other recipient of the reimbursement for medical expenses.

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. As noted supra, these government insurers are essentially price fixers and hospitals must either accept their reimbursement rates or refuse to accept patients with government insurance. Why more hospitals don’t simply refuse to accept government insured patients is an important and complex question. 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 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). 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. Also, especially in the case of Medicare not all reimbursable rates are

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250 See supra note 249.
251 See Daughters of Charity supra note 134 at 412 (noting that recovery of medical expenses at chargemaster rates would be a windfall).
252 See e.g., Allen Dobson, Joan DaVonzo, and Namrata Sen, The Cost-Shift Payment “Hydraulic”: Foundation, History, and Implications; 25 Health Aff. 22 at 22-33 (2006) (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).
253 See e.g., Reinhardt supra note 7 at 60 (noting that Medicare has been referred to as a ‘Dumb price fixer’ by a former Medicare administrator).
254 See generally, Nation supra note 239 (discussing the importance and value of tax exempt status to hospitals and the leverage this gives the government).
255 See e.g., Emergency Medical Treatment and Labor Act (EMTALA) of the Social Security Act (42 U.S.C. 1395dd) §1867 requiring hospitals to provide care for emergency medical conditions to any patient).
256 For example, Regulations proposed under the ACA supra note 48 at 501(r)(B) provide that if a hospital has any procedure that discourages individuals from seeking emergency medical care it may lose its tax exempt status under IRC 501(c)(3).
unprofitable for hospitals.\textsuperscript{257} That is, for certain procedures or facilities the reimbursement rates may be reasonable.\textsuperscript{258} Moreover, even for procedures where government reimbursement rates are below fully allocated cost, these reimbursements may cover a significant portion of fixed costs.\textsuperscript{259} 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.\textsuperscript{260}

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.\textsuperscript{261} This basis can be further strengthened by taking the average of the various reimbursement rates for private insurers.\textsuperscript{262} This average is a true reflection of market forces because this amount is negotiated each year between the hospital and its insurers. Eliminating government insurers like Medicare and Medicaid makes sense because as noted supra these entities essentially dictate rates often below cost based on their reimbursement formula.\textsuperscript{263}

\textsuperscript{257} See e.g., Tompkins et al., supra note 11 at 49-63 (discussing “loopholes” found in the Medicare payment system involving billed charges and facility reimbursement).
\textsuperscript{258} Id.
\textsuperscript{259} Id.
\textsuperscript{260} Id.
\textsuperscript{261} See Reinhardt supra note 7 at 60 (noting that each private insurer negotiates the dollar level of payments with each hospital every year).
\textsuperscript{262} Id.
\textsuperscript{263} See supra notes 198-205 and accompanying text.
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. 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.

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. 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 supra 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 noted supra, given the oddities of hospital pricing we can’t assume the value of these benefits equals the huge discount from chargemaster prices.\footnote{See supra notes 152-240 and accompanying text.}

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.\footnote{See e.g., Maureen Farrell, Saving On Credit Card Processing Fees, Forbes.com magazine article; (http://www.forbes.com/2007/02/20/visa-americanexpress-globa...) (discussing various terms with issuers and processors); David Lazarus, Some Merchants Stop Taking Credit Cards Because of High Fees, Los Angeles Times, July 1, 2011 (Article Collection) (http://articles.latimes.com/print/2011/jul/01/business (similar).} 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.\footnote{See Lazarus supra 269 (referring to the benefits to merchants of accepting credit cards – convenience, increased sales).} Second, all of these potential customers have been prescreened by the card issuer in terms of credit worthiness.\footnote{Id. (discussing insurers need to borrow money to cover customer purchases so that merchants can get paid quickly).} Third, the card issuer processor assures easy and quick discounted payment to the retailer.\footnote{See Farrell supra note 269 (discussing “lag time” or how long the merchant must wait to get its money on credit card sales – suggesting a range of 1-5 days).} These are similar to the most important benefits that hospitals and other providers get from insurers.\footnote{See supra notes 181-190 and accompanying text.} 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.

While discounts vary from one card processor to another, just as hospital reimbursement rates vary from one private insurer to another, overall card processor’s receive a discount that is
usually less than 10% (sometimes as low as 2.0% sometimes as high as 8.0% or more) of the value of the transaction.\textsuperscript{274} 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 10-15% range.

Another commentator, Dr. Gerard Anderson, has suggested using a similar method for arriving at the amount self-pay patients should pay.\textsuperscript{275} Dr. Anderson calls his plan “DRG + 25%.”\textsuperscript{276} In Dr. Anderson’s formula DRG is equal to Medicare reimbursement rate, and to this base is added 25%.\textsuperscript{277} The 25% is arrived at as follows: 14 percent is added because it is the average difference between the Medicare rate and the average private insurance reimbursement rate, an additional 1 percent is added to this to account for the benefit of prompt payment that insurance companies provide, finally 10% is added to account for the fact that the 14% added first was based on the average private insurance rate and many private insurers pay more.\textsuperscript{278} Thus Dr. Anderson has DRG + 14% + 1% + 10% or DRG + 25%.\textsuperscript{279}

While there are differences, discussed \textit{infra}, between Dr. Anderson’s DRG + 25% formula and the formula I present in this article, the average negotiated private insurance reimbursement rate plus 10-15%, the two formulas are more similar than different.\textsuperscript{280} First Dr. Anderson and I agree that self-pay patients should pay more than private insurers because private

\textsuperscript{274} See Farrell \textit{supra} note 269 (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 12-8 percent).
\textsuperscript{275} See Anderson Testimony \textit{supra} note 160 at 7-9 (discussing the DRG + 25 percent plan and the maximum per diem rate).
\textsuperscript{276} \textit{Id.}
\textsuperscript{277} \textit{Id.}
\textsuperscript{278} \textit{Id.}
\textsuperscript{279} \textit{Id.}
\textsuperscript{280} See \textit{infra} notes 287-290 and accompanying text.
insurers provide benefits that self-pay patients do not provide.\footnote{See Anderson Testimony supra note 160 at 7-9.} Second, we arrive at similar rates. That is Dr. Anderson’s rate, DRG + 25\%, is essentially equal to my Average Negotiated Private Insurance Rate + 10-15\%. For example, my base rate is equal to Dr. Anderson’s DRG base plus 14\%.\footnote{Id.} To this Dr. Anderson adds 11\% while I add between 10-15\%.\footnote{Id.} Thus, my rate is essentially DRG + 24-29\%.\footnote{See supra notes 261-274 and accompanying text.} We also agree on the desirability of a market based rate. Dr. Anderson acknowledges that is this regard his formula is weak because his base is not set by the market.\footnote{See Anderson Testimony supra note 160 at 7.} He feels this weakness is outweighed by the easy ability to verify and monitor the Medicare reimbursement amount.\footnote{See supra notes 261-274 and accompanying text.}

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.\footnote{See e.g., Nassau supra note 63 (the court refers 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 notes that the hospital’s billing manager calculated this amount as $4,252.11); Temple supra note 78 at 510 (similar).} Hospitals keep such information and since contracts with private insurers are renegotiated every year, this base will be constantly updated.\footnote{Id.} Also, by taking an average, there is no requirement to disclose any private insurer’s specific negotiated rate which would, as Dr. Anderson notes, be disruptive to the market.\footnote{Id.} 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. I would value these additional benefits at 3.5 to 8 percent of the base. However, I would make only a 7\% adjustment for the use of the average

\footnote{See Anderson Testimony supra note 160 at 7-9.}
\footnote{Id.}
\footnote{Id.}
\footnote{See supra notes 261-274 and accompanying text.}
\footnote{See Anderson Testimony supra note 160 at 7-9 – (he suggest an alternative plan, the “maximum they [the hospital] charges any insurer or managed care plan on a per day basis” – noting that its advantage over DRG + 25\% is that it is market determined).}
\footnote{Id.}
\footnote{Id.}
\footnote{See e.g., Nassau supra note 63 (the court refers 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 notes that the hospital’s billing manager calculated this amount as $4,252.11); Temple supra note 78 at 510 (similar).}
\footnote{Id.}
\footnote{See Anderson Testimony supra 160 at 7.}
private insurer rate. As noted supra 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.\textsuperscript{290} Health insurers, while they may set certain life time limits, usually must accept a broad range of potential medical expenses for each insured each year. In addition, while credit card issuers expect to earn additional interest compensation from balances carried by many customers, health issuers 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 supra, uninsured patients (rich or poor) should not be obligated to pay for the medical services they receive at the treating hospital’s chargemaster rates.\textsuperscript{291} The argument made here is that non-indigent uninsured patients should be obligated to pay no more than 110-115 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,\textsuperscript{292} because a lower price is unfair to the hospital.\textsuperscript{293} As discussed, hospitals negotiate lower prices with insurers because the hospital receives certain benefits from the insurers.\textsuperscript{294} 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

\textsuperscript{290} See supra notes 268-275 and accompanying text.
\textsuperscript{291} See supra notes 47-84 and accompanying text.
\textsuperscript{292} See infra notes 298-319 and accompanying text.
\textsuperscript{293} See supra notes 181-190 and accompanying text.
\textsuperscript{294} See supra notes 181-190 and accompanying text.
same level that private insurers pay. 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.295

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 amount 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. 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.296 Nor should the plaintiff be limited to recovering only what their insurance company paid to the hospital. Rather a plaintiff should be

295 See infra notes 298-319 and accompanying text.
296 See supra notes 206-240 and accompanying text.
able to recover 110-115 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 110-115 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 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. Allowing the tortfeasor to benefit from the plaintiff’s insurance would produce a windfall to the tortfeasor.

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 Patient Protection and Affordable Care Act of 2010 (ACA) the Internal Revenue Code (Code) was amended by the enactment of section 501(r) of the Code. This

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297 See supra notes 85-127 and accompanying text.
298 See ACA supra note 48 at § 9007(a).
section adds requirements for hospital organizations that are or wish to be recognized as tax
exempt under section 501(c)(3) of the Code.^[299] 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.” This amount is
known as “AGB”.^[300]

Under section 501(r)(4) of the Internal Revenue Code (Code) a non-profit hospital who
wishes to be tax exempt under 501(c)(3) must have a Financial Assistance Policy or “FAP.”^[301]
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.^[302] Neither the proposed
regulations nor the ACA mandate any particular eligibility criteria.^[303] Each hospital must
establish its own criteria regarding who qualifies for its FAP.^[304]

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.^[305] Moreover, the
proposed regulations provide that a non-profit hospital may not charge its full chargemaster or

^[299] Id.
^[300] See I.R.C. § 501(r)(5)(A) (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).
^[303] See ACA Proposed Regulations supra note 48 at 9 (“Neither the statute [ACA] nor these proposed regulations
establish specific eligibility criteria that a FAP [financial assistance policy] must contain”).
^[304] Id.
list prices to any FAP-eligible individual for any medical care;\textsuperscript{306} 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.\textsuperscript{307} 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.\textsuperscript{308} If within 240 days of the original bill the hospital determines that the patient is FAP-eligible, the billed charges must be reduced to AGB.\textsuperscript{309}

Under the proposed regulations, AGB may be calculated in one of two ways.\textsuperscript{310} 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.).\textsuperscript{311} This total is then divided by the sum of the associated gross or chargemaster (list) based charges for these claims.\textsuperscript{312} The result is an AGB percentage that is then applied to the gross or chargemaster based charges to determine the AGB amount.\textsuperscript{313} The AGB percentage must be calculated at least annually.\textsuperscript{314} The other method to

\textsuperscript{306} See ACA Proposed Regulations supra note 48 at 27 (The proposed regulations also require 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).
\textsuperscript{307} Id. at 34 (“The proposed regulations made 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”).
\textsuperscript{308} Id. at 34-35.
\textsuperscript{309} Id. at 8 (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).
\textsuperscript{310} Id. at 27-35.
\textsuperscript{311} Id. at 31-33.
\textsuperscript{312} Id.
\textsuperscript{313} Id.
calculate AGB is called the Prospective Medicare Method.\textsuperscript{315} 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.\textsuperscript{316}

It is interesting to note that under the ACA and the proposed regulations hospitals’ chargemasters with their exorbitant prices are now legally required to remain in place.\textsuperscript{317} 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.\textsuperscript{318} Moreover because of the unreasonably low reimbursement rates under Medicare, many hospitals will be forced to use their chargemaster rates to calculate AGB under the look-back method.\textsuperscript{319}

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 change master, but, these bills and the high prices reflected in them are rarely ever paid to hospitals. 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. To make sense of hospital billing one must understand that

\textsuperscript{314} Id.
\textsuperscript{315} Id. at 33-34.
\textsuperscript{316} Id.
\textsuperscript{317} See supra notes 305-316 and accompanying text.
\textsuperscript{318} See supra notes 306-307 and accompanying text.
\textsuperscript{319} See supra notes 223-225 and accompanying text.
chargemaster prices are set to be heavily discounted not paid. Moreover, the totals reflected on a hospitals itemized bill bear no 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 hospital deals with. Each hospital negotiates reimbursement rates annually with each private insurer and government insurers calculate their own reimbursement rates each year. Thus, for the same exact medical services different payers pay different amounts. The result of these odd billing practices is apparent rampant price discrimination. 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. 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 10-15 percent of the average private insurer reimbursement rate. The Patient Protection and Affordable Care Act (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. Moreover, after the Supreme Court’s decision upholding the ACA and its individual mandate to purchase health insurance, under the taxing power, even those who can afford insurance may decide instead to pay the tax and self-insure. Also, the Medicaid expansion called for in the ACA is now in question which

320 See Nation supra note 239 at nt. 8 (even after the ACA is fully operational in 2019 there will still be millions of Americans without health insurance).
322 Id. at 32 (the mandate is not a legal command to buy insurance … it makes going without insurance taxable).
could mean many more uninsured Americans. 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-eligibility is left to each hospital. In addition, the ACA does not prevent exorbitant chargemaster rates from being applied to all other self-pay patients. Moreover, the ACA essentially enshrines high chargemaster rates because of its references to them in the legislation. 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.

323 Id. at 52 (rejecting as coercive (“economic dragooning that leaves the States with no real option”) the Medicaid expansion).