Hospital Chargemaster Insanity: Heeling The Healers

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I. Introduction

A chargemaster is a list of all of the goods and services provided by a hospital and the hospital’s list price, or charge, for each item. Each hospital maintains its own unique chargemaster, which it updates annually or more frequently as it sees fit, and extreme variation in list prices among hospitals, even those in the same geographic area, is common. The list prices contained in the chargemaster are truly arbitrary and capricious from the point of view of pricing except in one respect, the higher the list price the higher the hospital’s revenue. While increases in chargemaster prices

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3 See, e.g., Elizabeth Rosenthal, As Hospital Prices Soar, A Stitch Tops $500, N.Y. Times, Dec. 2, 2013 quoting Glen Melnick, a professor of health economics at the University of Southern California “How do hospitals set prices? They set prices to maximize revenue, and they raise prices as much as they can – all research supports this.” Id. at 2. “Chargemaster prices are basically arbitrary, not connected to underlying costs or market prices ... hospitals can set them at any level they want.” Id. at 3. There are no restraints.” Id.; Temple Univ. Hosp. v. Healthcare Mgmt. Alts., 832 A.2d 501, 510 (Pa. Super. Ct. 2003)(noting that chargemaster prices “bear no relationship to the amount typically paid for those services”); “See Christopher P. Tompkins et al, The Precarious Pricing System for Hospital Services, 25 HEALTH AFF. 45, 50-52 (2006) (individual items in the chargemaster are subject to smaller or larger
do not produce a dollar for dollar increase in revenue, and there is not a consistent amount of increase in revenue tied to increases in list prices either on a per product/service basis or on an overall basis, the relation between chargemaster prices and revenues is, in the aggregate, positive. Beyond that however there is no rhyme or reason to the setting of chargemaster prices.

Today chargemaster prices are insanely high, often running 10 times the amount that hospitals routinely accept as full payment from insurers. Moreover, the relative level of a particular hospital’s chargemaster prices bears no relationship to either the quality of the services the hospital provides or, to the cost of the services provided. The purpose of these fictitious list prices is to serve as a starting

than average increases based on the advice of an ”arsenal of consultants and computer software ... used to determine optimal increases in charges for various services. Optimality implies a higher payoff for a given rate of increase ...”). (“Over time, a hospital’s chargemaster is bent, stretched, and distorted by numerous pressures and responses”); Reinhardt, U.S. Hospital Services, supra note 1 at 59 (noting that chargemaster rates “do not bear any systematic relationship to the amounts third-party payers actually pay them for the listed services”). Reinhardt also notes that “... chargemaster prices would yield truly enormous profits if these prices were actually enforced. See, Reinhardt, supra note 1 at 63; Lucette Lagnado, California Hospitals Open Books, Showing Huge Price Differences, Wall Street J., Dec. 27, 2004, (quoting William McGowan, chief financial officer of the UC Davis Health System: “There is no method to this madness. As we went through the years, we had these cockamamie formulas. We multiplied our costs to set our charges.”). 4 See George A. Nation III, Determining the Fair and Reasonable Value of Medical Services: The Affordable Care Act, Government Insurers, Private Insurers and Uninsured Patients, hereinafter “Fair and Reasonable”) 65 Baylor Law Rev. 425 (2013) at 454 (“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.”).


6 See, e.g., Steven Brill, Bitter Pill: How Outrageous Pricing and Egregious Profits are Destroying Our Health Care, Time, Mar. 4, 2013, at 22 (noting that Medicare would have reimbursed the hospital at less than one-tenth the price an uninsured patient was billed for some items).


8 See supra note 3.
point or anchoring point, for negotiations with third-party payers regarding the amount that they will actually pay the hospital for its goods and services.  

Ironically, there is widespread agreement, even on the part of many hospital administrators, that the prices reflected on chargemasters are ludicrously high and are set in an arbitrary and capricious manner. Hospital administrators often argue that this does not matter because no one really pays chargemaster prices. In this contention however hospital administrators are mistaken. These insanely high chargemaster prices cause myriad problems throughout the healthcare system. For example, often self-pay patients are in fact expected to pay these exorbitant charges because many hospitals refuse to reduce their charges for many self-pay patients. As a result, debt collectors often working on behalf of so-called charitable

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9 See Gerard F. Anderson, From 'Soak the Rich' to 'Soak the Poor': Recent Trends in Hospital Pricing (hereinafter "Soak the Rich"), 26 HEALTH AFF. 780, 783 (2007) (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 pays full charges, the higher the charges the greater the incentive to sign a contract with hospital; Nation, Fair & Reasonable, supra note 3 at 454-457 (discussing reasons for high chargemaster prices).

10 See, supra notes 3 and 5.

11 See e.g., Brill, supra note 6 at 7 (reporting the statement of a Stanford Hospital administrator regarding chargemaster rates as follows: “Those are not our real rates, ... It’s a list we use internally in certain cases, but most people never pay those prices. I doubt that Brian [Grissler] [CEO] has even seen the list in years. So I’m not sure why you care.” The Administrator went on to say: “I’ve told you I don’t think a bill like this is relevant, [V]ery few people actually pay those rates.”

12 See infra notes 100-137 and accompanying text.

13 See infra notes 94-185 and accompanying text.

14 See e.g., George A. Nation III, Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured, (hereinafter ‘Obscene Contracts’) 94 Kentucky Law J. 101, 101-105 (2005-2006) (citing examples of hospitals demanding their chargemaster rates from uninsured patients); Brill supra note 6 (Brill recounts various examples of self-pay patients being billed full charges by hospitals). The Affordable Care Act does provide some protection from chargemaster prices for patients of tax-exempt hospitals who qualify for the treating hospital’s financial assistance plan. See Nation, Fair & Reasonable supra note 3 at 467-72 (arguing that the ACA’s approach is inadequate and actually exacerbates the problem of chargemaster pricing).
hospitals hound many self-pay patients mercilessly, to the point of bankruptcy, in a usually futile attempt to collect these outrageous charges.

In addition, chargemaster prices increase constantly and create upward pressure on pricing throughout the healthcare marketplace resulting in overall higher prices. This is born out by the fact that over the last 10 years increases in the price for hospital care, along with price increases for drugs and medical devices, not intensity of service or demographic change produced most of the increase in healthcare's share of GDP. High chargemaster prices is one of the reasons that healthcare in the United States is more expensive than any other developed country. Also, the chargemaster pricing system contributes significantly to a lack of price competition in healthcare, which exacerbates the problem. That is, the chargemaster system makes meaningful comparison-shopping by patients on the basis of price impossible because it all but eliminates price transparency,

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15 See, e.g., 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, (hereinafter "Wolves") 42 Rutgers Law Journal 4, at 174-180 (2010) (discussing harsh collection tactics used by many charitable hospitals); Melissa B. Jacoby and Elizabeth Warren, Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress, 100 Nw. U.L. Rev. 535, 548 (2006) (between 46% and 56% of bankruptcy filers have identified a medical reason for bankruptcy); Christopher Taner Robertson et al., Get Sick, Get Out: The Medical Causes of Home Mortgage Foreclosures, 18 Health Matrix 65, 66-68 (2008) (49% of home foreclosures were partially caused by a health problem, and 23% by medical bills).

16 See, A Review of Hospital Billing and Collection Practices Before the Subcomm. On Oversight and Investigations of the H. Comm. On Energy and Commerce, 108 Cong. 21 (2004) [hereinafter Anderson Testimony] (statement of Gerard F. Anderson, Director, Johns Hopkins Center for Center for Hospital Finance and Management) (noting that less than 1 in 10 uninsured people pay even a portion of their charges, ... but the toll on the uninsured was substantial, noting that nearly one half of personal bankruptcies are related to medical bills).

17 See, infra notes 138-159 and accompanying text.


19 See, Anderson, It's The Prices Stupid, supra note 5 at 102-103 (arguing that the monopoly power on the supply side of the market allows hospitals to set exorbitant prices that drive up the overall cost of healthcare).

20 See infra notes 94-159 and accompanying text.
encourages complex and meaningless (to the patient) à la carte pricing, and contributes to rampant price discrimination.\textsuperscript{21}

Creating a more competitive healthcare market is necessary in order for the United States to continue to provide the highest quality healthcare in the world.\textsuperscript{22} The chargemaster pricing system has been a significant factor in the destruction of the competitive market for healthcare. I argue here that the government needs to step in, not to take over responsibility for providing health care, but just the opposite, to eliminate the chargemaster pricing system and allow a more competitive market in healthcare to flourish, which will allow each individual to take greater responsibility for their own acquisition of health care goods and services. An individual’s behavior is the single most important factor in determining individual health; only 10 to 15% of an individual’s health is due to access to healthcare services, the rest is determined by behavior, genetics and social conditions. Individual behavior is also a critical factor in driving efficiency in healthcare delivery.\textsuperscript{23} The purpose of the solution I argue for here is to empower individuals to force hospitals to compete on the basis of price and quality. I begin in Part II with an overview of the chargemaster system, Part III discusses the problems

\textsuperscript{21} See infra notes 94-185 and accompanying text.
\textsuperscript{22} See Nation, Wolves, supra note 15 at nt. 33 and 198-201 (refuting the argument that U.S. healthcare is no better than in other developed countries – it just costs more, by analyzing the what exactly is meant by “better” and “quality”). William H. Frist, Connected Health and the Rise of the Patient Consumer, 33 Health Aff. 191, 192 (2014) (citing Steven A. Schroeder, We Can Do Better – Improving the Health of the American People, 357, N. Engl. J. Med. 1221 (2007).
\textsuperscript{23} Steven A. Schroeder, We Can Do Better – Improving the Health of the American People, 357 New Engl. J. Med. 1221, at 1226 (Although inadequate health care accounts for only 10% of premature deaths, among the five determinants of health [genetic predisposition (30%), behavioral pattern (40%), social circumstances (15%), environmental exposure (5%)] health care receives by far the greatest share of resources and attention.) Schroeder notes that behavioral causes (sexual behavior (2%), alcohol (8.5%), motor vehicle (4.3%), guns (2.9%), drug induced (1.7%), obesity and inactivity (36.8%), smoking (43.8%) [including 200,000 people who had a problem with substance abuse or mental illness]) account for nearly 40% of deaths in the United States.
associated with the chargemaster system, and part IV recommends a solution. Part V concludes.

II. The Evolution of Chargemaster Insanity

I, and others, have written at length regarding the craziness of the chargemaster pricing system and I do not want to repeat that work here.24 As noted in the introduction, even many hospital administrators agree that the prices reflected on their chargemasters are exorbitant and are set in an arbitrary and capricious manner.25 This Part provides an overview of how the current chargemaster system developed. The chargemaster system today is indefensible in terms of overall logic or pricing, it is unfair in practice, and even cruel when applied to individual self-pay patients. However, it did not result from some evil conspiracy or overall desire to do harm. Rather, it accreted over many years as a result of many decisions made by hospital administrators, each of which at the time made sense, in response to a variety of outside forces.

Hospitals began as refuges where the sick poor could die in peace.26 No payment was requested or expected; at this time hospitals were pure charities existing exclusively on donations of money and labor, and the affluent received their medical care at home.27 Overtime, as medical science developed, hospitals became places that provided treatment to alleviate suffering and even cure illness in

25 See *supra* notes 3 and 5.
27 *Id.*
exchange for payment. As a result, hospitals began to attract more affluent customers/patients. Payment by patients eventually became the norm, although the amount charged was typically assessed on a sliding scale based on the ability of the patient to pay. Overtime, medical science continued to improve and the services provided by hospitals became even more valued. The economic depression of the late 20s and early 30s resulted in the failure of many hospitals because patients were unable to pay for medical care. As a result, the first health payment plans were developed directly between hospitals and patients. Patients contributed a small amount monthly to a central fund that was distributed to local hospitals. Patients had a source of funds available to pay for medical care if needed, and as a result of the fund hospitals had assurance of payment for medical bills, which allowed them to remain solvent. However, by 1940 less than 10% of the U.S. population was covered by health insurance.

Health insurance became more prevalent during World War II in part due to the government enacting the Stabilization Act, which limited wage increases, but did not prohibit the offering of employee benefits such as medical insurance. As a result, health insurance was offered as an alternative to raising wages. Even more important however was the tax treatment afforded to employer-sponsored health

28 Id. at 156.
29 Id.
30 Id.
31 See, Laura A. Scofea, The Development and Growth of Employer-Provided Health Insurance, Monthly Labor Review, March 1994 at 5. (More than 100 hospitals nationwide had failed in the first year of the Depression and those that remained in business had only a 50 percent occupancy rate.”) Id.
32 Id.
33 Id.
34 Id.
35 Id.
36 Id.
insurance. Employers were not required to pay payroll tax on amounts contributed to employee health insurance plans, and employees generally were not taxed on this benefit. This favorable tax treatment paved the way for employer-sponsored health insurance in the United States. Also significant, were favorable rulings from both the National Labor Relations Board and the Supreme Court that treated health insurance benefits as wages for purposes of collective bargaining. Finally, commercial insurers, who were initially reluctant to enter the market for health insurance because of concerns of adverse selection associated with individual policies, found that by offering group coverage through employers they could profitably sell health insurance. By 1958 almost 75% of the U.S. population was covered by some form of health insurance.

Health insurance became even more common due to the enactment of Medicare and Medicaid in 1965. Due to Medicare, virtually all U.S. citizens age 65 and older received free hospital insurance. In addition, Medicaid, through federal and state cooperation, insured many indigent patients. By the end of the 1960s health insurance became the norm for most patients and resulted in the third-party payer system. The majority of patients no longer paid directly for their own hospital care, Medicare, Medicaid and private commercial or non-profit insurance

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37 See, Melissa Thomasson, Health Insurance in the United States, E.H. Net Encyclopedia, edited by Robert Whaples, April 17, 2003 [http://eh.net/encyclopedia/health-insurance-in-the-united-states/](http://eh.net/encyclopedia/health-insurance-in-the-united-states/) (“Perhaps the most influential aspect of government intervention that shaped the employer-based system of health insurance was the tax treatment of employer provided contributions....”) Id. at 9.
38 See Scofea, supra note 31 at 6; Inland Steel Co. v. NLRB, 170 F.2d 247 (7th Cir. 1948).
39 Thomasson, supra note 37 at 6-7 (“The Success of Blue Cross and Blue Shield showed just how easily adverse selection problems could be overcome by focusing on providing health insurance only to groups of employed workers.”) Id.
40 Id. at 9 (“In 1958 nearly 75 percent of Americans had some form of private insurance coverage.”).
41 Id. at 10.
42 Id.
43 Id.
companies paid the bills. At this time hospital fees were usually the same for all patients, cost +10%, and the sliding scale was no longer used because the relative wealth of the patients was not a direct factor in payment for most hospital patients.\(^{44}\)

In the 1930s when medical insurance began to develop, insurance companies like Blue Cross, which became the dominant provider of hospital insurance, generally reimbursed hospitals based on their per diem costs plus a small supplement.\(^{45}\) The chargemaster, also known as a charge description master, developed at this time as an accounting tool designed to keep track of the cost of the goods and services provided by the hospital.\(^{46}\) Starting in the 1950s, commercial insurers began to offer a new type of health insurance, which indemnified individual patients for the costs that they incurred.\(^{47}\) This insurance often involved co-payments as well as deductibles that patients were required to pay directly to the hospital.\(^{48}\) As a result of the increased administrative work involved with respect to these patients, hospital’s charged these patients cost plus 10%, or what became known as “billed charges”.\(^{49}\) This formula, cost plus 10%, was commonly used by hospitals to determine billed charges for the next 30 years.\(^{50}\)

With the passage of Medicare and Medicaid in 1965 things began to change.\(^{51}\) Both of the government insurers initially reimbursed hospitals based on the Blue

\(^{44}\) See, Anderson Testimony, supra note 16 at 18.
\(^{45}\) See Tompkins et al., supra note 3 at 45.
\(^{46}\) See, Anderson Testimony, supra note 16 at 18.
\(^{47}\) Tompkins et al., supra note 3 at 46.
\(^{48}\) Id.
\(^{49}\) Id.
\(^{50}\) Id.
\(^{51}\) Id.
Cross per diem cost plus a supplement model.\textsuperscript{52} Government insurers continued to use a cost-based reimbursement system until 1983.\textsuperscript{53} At this time a prospective payment system based on diagnosis, or DRGs (diagnostic related groups) was adopted.\textsuperscript{54} The DRG system is not based directly on hospital costs. In the non-government insurance market much of the growth between the 1960s in the mid-1980s occurred with regard to indemnity based insurance products and as a result more patients were billed based on the hospital’s “billed charges”.\textsuperscript{55} Billed charges are calculated at charge master rates. Moreover, during this time most hospitals began to require Blue Cross to reimburse based on a discount off of “billed charges”.\textsuperscript{56} By the mid-1980s there were two forms of hospital payment systems; non-government (private) insurers who usually reimbursed based on a negotiated discount from billed charges, and government insurers who reimbursed based on rates they set, which were based to some extent on the charges billed by individual hospitals.\textsuperscript{57} Until this time, hospitals charged most of their patients the same amount, billed charges, and the prices reflected on most chargemasters were calculated at cost +10%. When government insurers began setting their own rates the practice of hospitals’ accepting different prices from different third party payers began.

\textsuperscript{52} Id.
\textsuperscript{53} Id.
\textsuperscript{54} Id.
\textsuperscript{55} Id.
\textsuperscript{56} Id.
\textsuperscript{57} Id.
Initially the reimbursements to hospitals from the government insurers were very generous providing a profit margin to the hospital of over 12%. When this became apparent, Medicare and Medicaid cut back their reimbursements dramatically. This loss of revenue created pressure on hospitals to seek additional funds from private insurers, and to try to “work” the Medicare and Medicaid reimbursement formulas to squeeze out additional revenue. Hospitals responded by quickly increasing the list prices in their chargemasters.

Eventually, both government and large private insurers demanded reimbursement models based on bundled or procedure based pricing rather than unbundled a la cart pricing. However, list prices contained in hospitals’ chargemasters still played an important role. For example most private insurers negotiated a provision in their contracts to cover expenses that were not part of procedure based pricing, and such provisions used a formula of some percentage, for example 40%, of list prices. Moreover, CMS provided for outlier reimbursements to hospitals, which for a time were tied directly to the hospital’s list prices. Finally, since fewer and fewer insurers or patients paid chargemaster

58 Id.
59 Id. at 47.
60 See Nation, Fair & Reasonable, supra note 4 at 453 discussing hospitals quickly increasing their chargemaster rates to increase their Medicare outlier payments.) Medicare has since revised its outlier payments formula.
61 Tompkins et al., supra note 3 at 47.
62 Id.
63 Id. at 50 (“About 20 percent of services are charge-related in the short term – that is, paid based on full or discounted charges per se – although a much higher percentage of services are paid nominally on the basis of contract language that uses charge levels as reference points for discounts and to drive fixed payment amounts (notes omitted).”) Id. (Each private payer has a default payment rate (for example, 40 percent of billed charges) for services not governed by fee schedules or other fixed payment amounts, which can affect something on the order of 20-30 percent of all services.”) Id. at 5.
64 Id. at 53.
prices directly, market forces that might have restrained their rise failed.\textsuperscript{65} Government and private insurers controlled reimbursement amounts directly, in the former case via rate setting, and in the latter via contracts with providers.

The result was that chargemaster prices skyrocketed.\textsuperscript{66} They lost any direct connection to costs or with the amount the hospital actually expected to receive in exchange for its goods and services. Each hospital used a different method to arrive at its chargemaster prices and each payer had a different formula for determining the amount of its reimbursement.\textsuperscript{67} As a result, no two hospitals necessarily charge the same amount for the same services, and no two payers necessarily pay the same amount for the same goods and services provided by the same hospital. The only constant is that the higher a hospital sets its chargemaster prices the higher its reimbursements from both government and private insurers.\textsuperscript{68} Hospital revenues do not, however, increase dollar for dollar with increases in chargemaster prices, but there was, and still is, a positive relationship between chargemaster prices and hospital revenues.\textsuperscript{69} Moreover, hospitals have no incentive to reduce either the

\begin{itemize}
\item \textsuperscript{65} Id. at 47 (noting that as a result, billed charges define directly prices for a shrinking proportion of patients). Id.
\item \textsuperscript{66} Id. at 48 ("The gap between charges and actual payments (net patient revenues) now averages about 255 percent and is growing rapidly.").
\item \textsuperscript{67} Id. at 54; See Nation, \textit{Fair & Reasonable}, supra note 3 at 454: 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 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 form third party payers (notes omitted).
\item \textsuperscript{69} Id.
\end{itemize}
absolute level or the rate of increase of charge master prices; in fact, they have every incentive to continue to quickly increase prices.70

Another, perhaps equally perplexing question is why hospitals were not, and still in many cases are not, willing to reduce their ridiculously high chargemaster prices for self-pay patients.71 One obvious reason that should not be overlooked is a revenue motive; every dollar a hospital recovers from self-pay patients adds to the bottom line.72 But there are other reasons. First, many private insurers negotiate contracts with hospitals that contain a provision insisting that the insurance company be offered the lowest price offered to any other customer.73 Thus, any

70 Id. As noted, the ACA prohibits tax exempt hospitals from charging patients who qualify for a specific hospital’s financial assistant policy chargemaster rates, but this does not provide any incentive for hospitals to lower or even slow the increase of their chargemaster prices. Id. at 467-70.
71 See supra note 24 for examples of hospitals unwilling to reduce chargemaster prices for self-pay patients. But see, Glen Melick and Katya Fonkych, Fair Pricing Law Prompts Most California Hospitals to Adopt Policies to Protect Uninsured Patients from High Charges, 32 HEALTH AFF. 1101 (2013) (discussing California’s Hospital Fair Pricing Act (AB774 (Chapter 755, statutes of 2006), and amended by AB 1503 (Chapter 445, statutes of 2010) which is similar to the provisions of the ACA in that qualifying patients may not be charged chargemaster rates, they must be charged no more than the highest amount of payment that the hospital would receive from any government sponsored program, including Medicare, Medi-Cal (California Medicaid) and Health Families (California’s Children’s Health Insurance Program. However, there are two key differences between the California plan and the ACA. First, the ACA allows each hospital to determine its own qualifications for financial assistance while the California law defines eligibility (generally at 350% of the federal poverty level). Second, the ACA allows eligible patients to be charged no more than amounts generally billed by the hospital (which may include amounts paid by private insurers) for emergency or other medically necessary care. In practice hospitals many charge more under the ACA than under California law. Studies suggest the California approach has been successful. See, California Hospital Fair Pricing Act Has Cut Prices for Uninsured, Jan 15, 2015 at www.californiahealthline.org/articles/2015/1/15/california-hospital-fair-pricing-act-has-cut-prices-for-uninsured.
72 See, e.g., Melnick and Fonkych supra note 71 at 1102 (noting that one study found that California hospitals, on average, collected more from uninsured patients than they collected from Medicare patients for the same services in 2006). Hospital administrators also like to tell the story of a hypothetical Arab Sheikh who comes to a U.S. hospital seeking health care. In that case, the Sheikh can easily pay the insanely high price and that’s good for the hospital. See, e.g., Rosenthal, supra note 3 at 6 (quoting Dr. Warren Browner as saying “you don’t really want to reduce your prices if you have a Saudi Sheikh come in with a suitcase full of cash who’s going to pay full charges”); Brill, supra note 6 at 10 (quoting John Gunn, COO of Sloan-Kettering as saying “we charge those rates so that when we get paid by a [wealthy] person from overseas it allows us to serve the poor”).
73 See Tompkins et al., supra note 3, at 53 (common negotiating practice of insisting on being charged the same as the lowest-paying customers).
reduction in charges offered to self-pay patients would have to be offered to any insurer with a contract with the hospital that contained such a clause. Although, in reality it would be very unusual that any discounted rate would be lower than the contracted rate the insurer already had. In addition, rules from CMS related to fraud, abuse and kickbacks, which have since been corrected, had been interpreted by many hospitals as requiring them to bill all patients at their chargemaster rates and preventing hospitals from discounting any bills, even for uninsured patients, without prior negotiation. The result, perhaps unintentional, but devastating nevertheless was that self-pay patients were expected to, and in many cases are still expected to, pay full billed charges; which is something no other payers would dream of doing, or be expected to do by the hospital.

Another reason that hospitals have historically benefited from high chargemaster rates is that they allowed hospitals to overstate their charity care, uncompensated care and community benefit. This was especially important for nonprofit charitable hospitals because it allowed them to justify their tax-exempt status. Historically, the reason that hospitals were tax-exempt was that they were charities; they were expected to provide free care to the extent they were financially able to do so, at least in an amount equal to the value of their tax exemptions. In 1969, based on a Revenue Ruling, the requirement was changed from providing

74 Id. (citing Medicare guidelines as a reason for refusing to reduce chargemaster rates for self-pay patients).
75 See Nation, “Fair & Reasonable,” supra note 3 at 456 (“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” (notes omitted)).
76 See Nation, Wolves, supra note 15 at 166-170 (discussing the evolution of tax law from Rev. Rule 56-185, which required hospitals to be “operated to the extent of its financial ability for those not able to pay ...” to Rev. Rule 69-545, which replaced the requirement of charity care with community benefit).
charitable care to providing a community benefit, based in part on the mistaken belief that Medicare and Medicaid would eliminate the need for charity care.\textsuperscript{77} Unfortunately, this belief proved to be mistaken, and to make matters worse community benefit is a broad, ill-defined concept that can include many different and questionable activities.\textsuperscript{78} In any event, it was and still is important to charitable hospitals to be able to demonstrate the value of their community benefit, charitable care and uncompensated care.\textsuperscript{79} Prior to 2008, by calculating those numbers based on chargemaster rates hospitals could greatly inflate the apparent value that they provided to the community.\textsuperscript{80} In 2008, the IRS redesigned Form 990 and started to require that Schedule H be filed by tax-exempt hospitals.\textsuperscript{81} Schedule H instructs hospitals to calculate their community benefit activities, including charitable care and uncompensated care, at cost.\textsuperscript{82} Thus, to the extent that this new requirement produces accurate information, that is, assuming the numbers cannot be gamed,\textsuperscript{83}

\textsuperscript{77} Id. at 169.
\textsuperscript{78} Id. at nt. 20 (sources criticizing the Community Benefit Standard).
\textsuperscript{79} See, e.g., Lucette Lagrado, \textit{Hospital Found “Not Charitable” Loses Its Status as Tax Exempt}, WALL ST. J., Feb. 19, 2004, at B1 (discussing the revocation of property tax exemption for Provena-Covenant Medical Center in Urbana, Illinois by the Illinois Department of Revenue); see also John D. Colombo, \textit{The Failure of Community Benefit}, 15 HEALTH MATRIX 29 at 37-40 (2005) (discussing other cases of hospitals losing their tax-exempt status); Suzanne Sataline, \textit{Illinois High Court Rules Nonprofit Hospital Can Be Taxed}, WALL ST. J., Mar. 19, 2010, at B4 (noting that the Illinois Supreme Court held that the state was correct when it decided in 2002 that the charity care provided by Provena Covenant Medical Center was too small to qualify for tax exemption).
\textsuperscript{80} See supra note 75.
\textsuperscript{83} An assumption I am not willing to make. See e.g., Bailey supra note 81 and the flexibility of calculating charity bad debt. See also, Tompkins et al., supra note 3 at 49: The cost of operating a hospital in part reflects strategic choices regarding mission (such as serving disadvantaged populations), jointly producing research and education, sponsoring social programs, and so forth. Thus, costs other than direct patient-related care can be combined in the accounting system and allocated across billable services, raising the total cost and introducing hospital-specific variation in
the amount of community benefit reported by hospitals is no longer inflated by increases in chargemaster rates. However, as noted above, hospitals have no incentive to reduce their chargemaster rates.

In fact, to this day every patient receives a bill reflecting unbundled billed charges, however insurers that have a contract with the hospital and their customers receive a huge negotiated discount from the billed charges. This allows hospitals to claim disingenuously that all patients are billed the same amount for the same services. In fact, as discussed supra, price discrimination in healthcare is rampant.

Some hospitals and economists have attempted to explain exorbitantly high chargemaster rates, and the unwillingness of many hospitals to reduce them for self-nominal "service costs." Even for a given mix of services, hospitals might differ greatly in relative efficiency, leading also to different revenue requirements. Id. Nation, Wolves, supra note 15 at 148: Moreover, a hospital’s ability to produce negative societal internalities such as excessive executive and doctor salaries or premium working conditions, or positive societal externalities, such as biomedical research, health education, free indigent care, or other “community benefits” is the direct result of secretly overcharging paying patients. These “contributions” form paying patients, which have been estimated to exceed thirty percent of the hospital charges paid by patients, are in no sense voluntary. Today, non-profit hospitals are more akin to mini-governments imposing a tax on all of their patients who pay for the services they receive. Moreover, paying patients have no right to “vote” for these mini-governments or even to have access to information regarding the amount of “tax” imposed or how the “taxes” are spent. In fact, this very lack of transparency or camouflage is one of the characteristics of the non-profit business model that attracts hospitals. Other attractive characteristics include; freedom from external financial discipline (due to the absence of investors/directors), increased public trust (though it is often misplaced), and increased profits form the tax exemption. (notes omitted). Putting these two passages together in the context of a hospital determining its “cost”, calls to mind the old adage: figures don’t lie, but liars can figure.

See Nation, Fair & Reasonable, supra note 3 at 434 (noting that hospitals claim that their chargemaster rates are reasonable and customary because all patients are billed at these rates before discounts are applied [emphasis in original]); Reinhardt supra note 2 at 59 (hospitals submit for all patients detailed bills based on its chargemaster, even to patients covered by Medicare). Cf. Holland v. Trinity Health Care Corp., 791 N.W.2d 724, 728 (Mich. Ct. Ap. 2010)(finding chargemaster rates are usual and customary).

Medicare sets its own reimbursement rates, and private insurers negotiate their own rates. As a result, billed charges for most patients is not an accurate reflection of what they owe the hospital for the services and goods that they received.

See note 84.

See Nation, Fair & Reasonable, supra note 3 at 446-449 (discussing price discrimination by hospitals); Reinhardt supra 2 at 63 (concluding that hospitals engage in price discrimination).
pay patients, by using a theory of cost shifting.\textsuperscript{88} In essence, the cost shifting theory suggests that government insurers, Medicare and Medicaid reimburse hospitals below their cost and this forces hospitals to recover the amount of the loss from other patients.\textsuperscript{89} That is, hospitals shift their costs to privately insured and self-pay patients in order to make up for the short fall in government insurer reimbursement rates.

At best, the cost shifting theory explains a very small amount of the increase in chargemaster rates.\textsuperscript{90} In addition, it seems dubious to expect self-pay patients, the only ones expected to pay the chargemaster rates, to be able to make up the shortfall from government and/or private insurers. Self-pay patients include the uninsured and as a group self-pay patients do not have nearly the financial wherewithal of other market participants. Targeting this group for higher prices simply makes no sense.\textsuperscript{91}

The single most important reason that chargemaster rates remain so high is that competitive forces in the healthcare market have broken down, and as a result,

\textsuperscript{88} See supra note 72; William M. Sage, Putting Insurance Reform in the ACA’s Rearview Mirror, 52 Hous. L. Rev. 1081 at 1093-94 (discussing Cost-shifting); Allen Dobson et al., The Cost-Shift Payment “Hydraulic”; Foundation, History and Implications, 25 Health Aff. 22 (2006); Kathleen Stoll, Kim Bailey, Hidden Health Tax: Americans Pay a Premium, Families USA (2009) available at www.familiesusa.org. (concluding that hospitals shift the cost of care for the uninsured to the insured and dubs this cost-shift a “hidden health tax”). Id. at 1.
\textsuperscript{89} See supra note 88.
\textsuperscript{91} A lot of cost-shifting likely goes on in health care, especially by non-profit hospitals. See, supra note 83. However, it seems more likely to be shifting resources from the privately insured to hospital administrators for use as they see fit.
many hospitals may raise their chargemaster rates with impunity.\(^92\) Moreover, such rate increases are associated with increases, albeit much smaller ones, in revenues.\(^93\) Finally, hospitals currently have absolutely no reason to reduce their chargemaster rates. That is, they suffer no competitive disadvantage by setting their rates ever higher.

### III. Problems Associated With Chargemaster Insanity

The problems associated with insanely high chargemaster prices have been persistent and pernicious. These include placing a devastating burden on self-pay patients for no logical, fair or justifiable reason. In addition, exorbitant chargemaster prices produce upward pressure on the overall cost of healthcare.\(^94\) As noted above, many hospital administrators take the position that chargemaster prices do not matter because no one actually pays them.\(^95\) At best, these administrators are ignorant and at worst they are lying. A new refrain from hospital administrators seems to be that even if high chargemaster prices created problems in the past, the Affordable Care Act (ACA) will change that because there will no longer be a significant number of uninsured patients.\(^96\) This is also incorrect; based on

\(^{92}\text{See supra} \text{ notes 100-159 and accompanying text. (the determinant of the highest chargemaster rates is market share).}\)
\(^{93}\text{See supra} \text{ notes 138-159 and accompanying text.}\)
\(^{94}\text{See supra} \text{ notes 138-159 and accompanying text.}\)
\(^{95}\text{See supra note 11.}\)
\(^{96}\text{See, e.g., Stephanie Armour, Health Law Hits Free Clinics: Expanded Insurance Under Affordable Care Act Hurts Funding, Causes Closures, WALL STREET JOURNAL Dec. 13-14, 2014 at A3 (some free clinics closing because directors feel there is no longer a need following the roll out of health law, and donations are dropping for the same reason, though a May 2013 report by the Congressional Budget Office reports there will still be 31 million Americans without health insurance after the health law); Melanie Evans, Hospitals Split on Ending Aid to Uninsured Obamacare-Eligible, Modern Healthcare Dec. 6, 2014 (discussing the fact that hospitals are divided over whether to deny financial aid to}
estimates from the Congressional Budget Office (CBO) there will still be 31 million Americans without health insurance by 2023.\textsuperscript{97} In addition, while the ACA mentions chargemaster prices it does very little to solve the problem of insanely high chargemaster prices or the pernicious consequences they cause.\textsuperscript{98} In fact, the ACA's references to hospital chargemaster rates are likely to have the perverse effect of making hospitals even more reluctant to reform the chargemaster pricing system.\textsuperscript{99}

\section*{A. Unfair And Cruel To Self-Pay Patients}

Exorbitantly high chargemaster prices cause a great deal of suffering and despair for self-pay patients notwithstanding the fact that even after bankruptcy and/or foreclosure most self pay patients cannot and do not pay the amounts they are charged.\textsuperscript{100} The fact that this suffering is often inflicted by hospitals that claim to be charities represents the height of hypocrisy and is an affront to the credulity of human nature.\textsuperscript{101} Even if these consequences are unintended, this fact does not make the suffering and despair any less real. I have written before about the ridiculously high level of chargemaster prices and the pernicious consequences they

\begin{itemize}
\item uninsured patients who are eligible for subsidized insurance under Obamacare but did not purchase a plan). \textit{Id.} at 1.
\item \textsuperscript{97} See Armour, supra note 96 (CBO reports 31 million uninsured Americans after ACA).
\item \textsuperscript{98} See Nation, \textit{Fair & Reasonable}, supra note 3 at 467-470 (unfortunate that ACA locks in exorbitent chargemaster prices) \textit{Id.} at 469.
\item \textsuperscript{99} \textit{Id.}
\item \textsuperscript{100} See supra notes 15-16 and accompanying text.
\item \textsuperscript{101} See Nation, \textit{Wolves}, supra note 15 at 180-184 (In the worst case, a non-profit tax-exempt hospital’s mission is to keep its tax exemption in order to maximize profits and use their non-profit structure as camouflage to hide both their profit-maximizing activities on behalf of doctors and administrators and/or their elitist, secretive (perhaps fraudulent) cross-subsidization of certain types of healthcare and wealth redistribution (notes omitted).
\end{itemize}
visit on self-pay patients.\textsuperscript{102} I do not intend to repeat that work here, but permit me two examples to make the point.

First, consider the case reported by New York Times reporter Elisabeth Rosenthal of Orla Roche, a young child who fell from a couch splitting open her forehead on a table.\textsuperscript{103} The little girl was taken to the California Pacific Medical Center’s emergency room where the wound was cleaned, numbed and mended with a dab of skin glue, all in under an hour.\textsuperscript{104} The billed charges, at California Pacific’s chargemaster rates, were $1,696.\textsuperscript{105} The unbundled, itemized, bill included charges for: “supplies and devices” for $529, which consisted of gauze, apparently priced at $142.43 (the gauze was wrapped around Orla’s head to cover the wound), a vial of skin glue for $181, a tube of antibiotic cream for $125.84 and a vile of local anesthetic for $79.73.\textsuperscript{106} These items, according to Rosenthal, may be purchased on the Internet for $1, $15.99, $36.99 and $5, respectively, though hospitals which buy wholesale and in bulk pay far less.\textsuperscript{107} In addition, the bill also included a $1,167 Facility Fee, the price to walk in the door.\textsuperscript{108} The Facility Fee was classified at Level 3, the middle of the scale, though Orla’s treatment is one of the most common and simple emergency room procedures.\textsuperscript{109}

The second example also involves California Pacific Medical Center.

According to the Medicare database California Pacific charges $43,679 for

\begin{footnotes}
\item[102] See generally, Nation, Fair & Reasonable, supra note 3; Nation, Wolves, supra note 15; Nation, Obscene Contracts, supra note 14.
\item[103] Rosenthal supra note 3 at 1.
\item[104] Id. at 4.
\item[105] Id.
\item[106] Id.
\item[107] Id.
\item[108] Id.
\item[109] Id.
\end{footnotes}
hospitalization to treat a simple pneumonia and $96,642 to treat a stroke.\textsuperscript{110} The Medicare payments for these illnesses are $8,046 and $9,583 respectively.\textsuperscript{111} These charges reflect the fact that the chargemaster rates at California Pacific are roughly 5 ½ to over 10 times the Medicare reimbursement rate.

California Pacific Medical Center is owned by Sutter Health, which operates more than two-dozen community hospitals in Northern California. California Pacific Medical Center is the state’s largest private nonprofit hospital and also earned the highest net income in California.\textsuperscript{112} Due to its nonprofit status California Pacific reaps millions of dollars in tax benefits yet it’s main campus spent only 1.27\% of their more than one $1.1 billion in net patient revenues in 2011 on free care for indigent or uninsured patients.\textsuperscript{113} This amount was lower than the state average of 2.07\%.\textsuperscript{114} Moreover, California Pacific is a good example of the fact that even though most hospitals are nonprofit charities they are nonetheless often flush with revenue and guilty of overspending.\textsuperscript{115} Sutter, based in Sacramento, employs 28 officials who make more than $1 million a year and four of them are among the top paid hospital executives in California.\textsuperscript{116} Sutter’s Chief Executive Officer makes more than $5 million. Evidently, working for a nonprofit can be quite profitable!\textsuperscript{117} In addition,
California Pacific, Sutter’s main campus in upscale Pacific Heights, just broke ground on a $2.7 billion renovation, which includes a new flagship hospital. According to Dr. Warren Browner, the Chief Executive Officer of California Pacific Medical Center, there are good reasons that hospitals charge what they do. For example, Dr. Browner mentions that hospitals must have highly trained professionals available 24 hours a day, seven days a week, and they must constantly upgrade to the latest equipment and building standards to meet patient’s expectations and state mandates. He also stated: “we take every penny of the revenue we earn and use it to build new and better facilities for everyone in the city.” Of course, Dr. Browner means every penny left after the payment of administrative expenses including salaries and other perks for hospital administrators and staff. Dr. Browner, a distinguished physician who spent much of his career in academics, made more than $1.2 million in 2011 according to tax documents.

According to Glenn Melnick, a professor of health economics at the University of Southern California, Sutter is a leader - a pioneer- in figuring out how to amass market power to raise prices and decrease competition. Research shows that today’s hospital mergers tend to drive up prices. For example in the case of Sutter, it operates the only hospital in some California cities. As a result employers have limited ability to fight back against Sutter’s high fees. Professor Melnick, notes

118 Id.
119 Id. at 3.
120 Id.
121 Id.
122 Id. at 6.
123 Id. at 2.
124 Id. at 9.
that hospital’s sent prices to maximize revenue and they raise prices as much as they can. In addition, professor Melnick notes that chargemaster prices are basically arbitrary, not connected to underlying cost or market prices; hospitals can set them at any level they want. There are no market constraints. Hospitals are the most powerful players in the healthcare system and there is little or no price regulation in the private market.

In addition, the problem of insanely high chargemaster rates appears to be getting worse not better. For example, Rosenthal states: “Hospital charges represent about a third of the $2.7 trillion annual United States healthcare bill, the biggest single segment, according to government statistics, and are the largest driver of medical inflation.” In 2004 for example, for every $257 a hospital charged based on its chargemaster rates, it actually collected $100; self-pay patients who are charged chargemaster rates are being asked to pay at least $2 times the average amount paid by health insurers for the same exact care. Moreover, these discounts are well known in advance by the hospital and are planned for in the hospital’s budgeting. The huge discounts that hospitals negotiate with insurers are factored into its inflated chargemaster rates and are a very large part of the reason that the chargemaster rates are so unreasonably high. No one, not hospital administrators, not government insurers, not private insurers expect the

\[125\] Id. at 2.
\[126\] Id.
\[127\] Id. at 1.
\[128\] See Anderson, Soak the Rich, supra note 9 at 782.
\[129\] See Nation, Fair & Reasonable, supra note 3 at 429 (chargemaster rates are greatly inflated because they are set to be discounted not paid).
chargemaster rates to be paid. Rather, they expect them to be significantly
discounted. The problem is that these exorbitant rates are not always discounted.\(^{130}\)

Self-pay patients include: the uninsured, international visitors who receive
medical care in the U.S., people insured by health plans that do not have contracts
with the hospitals providing their treatment, including self-insured patients. As
noted above, notwithstanding the ACA the United States is expected to continue to
have a large number of uninsured people.\(^{131}\) In addition, the third category of self-
pay patients is larger than one might first expect. The people in this category are
subject to what is known as balance billing. Balance billing refers to the practice of a
hospital billing the patient for the difference between the hospital’s ridiculously
high billed charges, calculated at chargemaster rates, and the amount paid by the
patient’s insurer.\(^{132}\) Balance billing applies anytime a patient’s insurer does not have
a negotiated contract with the provider or hospital. This category includes patients
who rely on automobile insurance or Worker’s Compensation to cover their medical
bills, because auto insurers rarely have contracts with hospitals and Worker’s
Compensation pays a flat fee depending on the injury and does not negotiate
contracts with hospitals.\(^{133}\) Without a negotiated contract, the huge discounts
applicable to other insurers do not apply.

More significant in number are patients who, for one reason or another (e.g.
the need for emergency or specialized care), are forced to seek treatment outside of

\(^{130}\) See supra note 24.
\(^{131}\) See supra note 96 (citing at CBO report expecting 31 million uninsured Americans even after the
ACA).
\(^{132}\) See Nation, Fair & Reasonable, supra at 443-446 (discussing balance-billing).
\(^{133}\) Id.
their provider network. For example, it is very common, especially in HMO type insurance, for insured patients to be limited to certain providers and hospitals (i.e. the ones that their insurers have contracted with). If these patients seek care outside of this network of providers and hospitals, no discounts are applicable and the patient is liable for the difference between the exorbitant billed charges and the amount paid by the insurance company.\textsuperscript{134} These patients are not uninsured, they have insurance, but their insurance companies do not have a negotiated contract with the providers or hospitals that have provided care and thus no discount from chargemaster rates applies. Finally, high deductible insurance, a type of insurance that is becoming increasingly popular, sometimes provides that coverage does not begin until after the insured has paid the deductible amount, (e.g. $1,000 to $10,000) out-of-pocket for medical care. In this case the insured is responsible for the full undiscounted billed charges until the deductible is met.\textsuperscript{135}

What makes matters even worse is that hospitals are often adamant about trying to collect these outrageous chargemaster rates from self-pay patients. They, or the debt collectors to whom they have sold the debts’ of patients who have not paid in full, often employ aggressive collection tactics that sometimes include wage garnishment, body attachment (which can result in the jailing of patients who fail to pay the full amount of their billed charges), “parking” hospital charges on patients credit reports even before they are past-due in order to scare patients into paying their bills, making use of hospital/medical provider lien statutes that are available in many states and allow hospitals to attach a lien to a patient’s tort recovery in the full

\textsuperscript{134} Id.
\textsuperscript{135} Id.
amount of the hospital’s billed charges, liens on a patient’s home and foreclosure pursuant to the lien, seizure of property, and the use of high interest rates. The fact that these debt collection tactics are often employed even by so-called charitable hospitals, belie any charitable motivation that one might expect from tax-exempt nonprofit charitable hospitals.

B. Exorbitant Chargemaster Prices Cause Higher Overall Prices For Healthcare

Based on the available evidence, in addition to causing a great deal of heart ache and suffering for self-pay patients, insanely high chargemaster prices lead to over all higher prices for healthcare across the entire market. That is, they lead to higher prices for insured patients as well as self-pay patients. High chargemaster prices indirectly increase both government and private reimbursement rates. Moreover, the main driver of the most exorbitant chargemaster prices is market share. Hospitals with the greatest market share tend to have the highest chargemaster rates. Higher chargemaster rates do not buy better, higher quality, healthcare they simply produce exorbitant profits.

136 See Nation, Wolves, supra note 15 at 144 (referring to harsh and “draconian” collection tactics); Paul Muschick, What Hurts? Medical Bills Do Apparently, THE MORNING CALL, Dec. 14, 2014 at NEWS 11 (referring to medical providers who “park” debt on credit reports.)
137 See generally, Nation, Wolves, supra note 15.
138 See Anderson, It’s the Prices Stupid, supra note 5 at 102 (market concentration by providers leads to higher prices for health care in the U.S.).
139 Id.
140 See Martin Gaynor and Robert Town, The Impact of Hospital Consolidation – Update, Robert Wood Johnson Foundation 2 (June 2012), (hospital bargaining leverage main determinant of relative expensiveness within the same hospital market).
141 See supra note 7.
Government insurers, Medicare and Medicaid set their own reimbursement rates, but to some extent these rates are nevertheless based indirectly on chargemaster rates. As noted, Medicare and Medicaid reimburse based on flat bundled rates for an entire episode of care based on diagnosis.\textsuperscript{142} For inpatient hospital care Medicare uses 746 Medicare Severity Adjusted Diagnoses Related Groups or MS–DRGs.\textsuperscript{143} Each DRG is weighted according to how resource intensive treatment for the diagnosis tends to be compared to the average admission. An annually adjusted base representing the cost for labor and other hospital operations, adjusted by geographic region, is multiplied by the DRG weight. For outpatient hospital care Medicare uses the APC (ambulatory payment classification) System, which is similar to the DRG system.\textsuperscript{144} However, Medicare’s payment for the facility component of outpatient services is directly based on charges.\textsuperscript{145} Also, while Medicare does not directly base it’s inpatient payment rates to a particular hospital on that specific hospital’s charge data, it does use aggregate hospital chargemaster data as a proxy for resource intensity, which is used to calculate the DRG weights.\textsuperscript{146} Moreover, many states calculate their Medicaid reimbursement rates as a percentage of the Medicare DRG reimbursement, or as a percentage of the APC reimbursement.\textsuperscript{147} Thus, higher chargemaster rates are still associated with, albeit indirectly, higher net hospital revenues from government insurers. That is, higher chargemaster rates mean that government insurers pay higher prices, not for better

\begin{footnotes}
\item[142] See Uwe E. Reinhardt, \textit{How Medicare Sets Hospital Prices: A Primer}, N.Y. Times Economix Blog (Nov. 26, 2010, 6:00 AM)
\item[143] Id.
\item[144] Id.
\item[145] See Nation, \textit{Fair & Reasonable, supra} note 3.
\item[146] Id.
\item[147] Id.
\end{footnotes}
quality healthcare, but to increase the profits of hospitals, especially market-dominant hospital systems.

Higher chargemaster rates also mean higher reimbursement from private insurers. Private insurers usually calculate their reimbursement rates using one of three methods discussed below. Private insurers with sufficient market power negotiate with hospitals for bundled rates based on either per a diem-based amount or a procedure based amount. Similar to government insurers, these methods are bundled. Hospitals, of course, prefer to begin negotiations with insurers from their chargemaster prices and negotiate down, while insurers that have sufficient market power prefer to begin with Medicare reimbursement rates and negotiate up. Private insurers without sufficient market power, or even large insurers when negotiating with “must-have” hospitals in their market are often forced to negotiate a percentage discount from unbundled chargemaster rates. While only in the latter case do increases in chargemaster prices result in dollar-for-dollar increases in reimbursement rates, higher chargemaster rates do indirectly produce higher hospital revenues from all private insurers.

One reason for this is that chargemaster rates are more relevant to reimbursements for private insurers, including those that reimburse on a per diem or case basis, than first appears because a significant portion of hospital services are

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148 Id.
149 A “must have” hospital is one that a certain community demands access to because of perceived reputation, availability of the latest equipment, or the ability to perform certain procedures. Thus, insurers must be able to provide their employers with access to the hospital to get their business and therefore the insurers must contact with the hospital even if the hospital demands high reimbursements. See Anderson, It's the Prices Stupid, supra note 5 (discussing concentration on the provider side of the market).
150 Rosenthal supra note 3 at 6.
not covered by the bundled reimbursement rates and are reimbursed by the insurance company based on a percentage discount from billed charges, that is chargemaster rates.\footnote{See Nation, Fair & Reasonable, supra note 3 at 455-56.} Moreover, chargemaster rates are also relevant to determining 20 to 30\% of per diem and case based reimbursement rates for private insurers as a result of contract language that uses chargemaster prices as a reference points for discounts and to derive fixed payment amounts.\footnote{Id.} The fact that many contracts with private insurers refer to chargemaster prices, even nominally, encourages hospitals to keep chargemaster rates high.\footnote{Id. at 455 (citing Tompkins et al, supra note 3 at 50.)} As noted supra, this is another problem with the ACA’s approach because the ACA also references chargemaster prices.\footnote{Id. at 469.}

In addition, some common provisions in contracts between hospitals and private insurers have the pernicious effect of making hospitals very reluctant to reduce their chargemaster prices. For example, one common provision provides that notwithstanding any other provision in the contract, the insurer will be charged no more than the lowest paying customer.\footnote{See Tompkins et al., supra note 3 at 53.} Another common provision, with a similar but somewhat less pernicious effect, sometimes referred to as a “most favored nation” clause, provides that if the hospital offers a lower (negotiated) payment rate to any of the insurer’s competitors then the hospital must offer the

\footnote{151 See Nation, Fair & Reasonable, supra note 3 at 455-56.}
\footnote{152 Id.}
\footnote{153 Id. at 455 (citing Tompkins et al, supra note 3 at 50.)}
\footnote{154 Id. at 469.}
\footnote{155 See Tompkins et al., supra note 3 at 53.}
same rate to the favored insurer.\textsuperscript{156} Such provisions, as might be expected, have raised antitrust concerns.\textsuperscript{157}

Because extremely high chargemaster rates raise the overall cost of medical care they affect all participants in the marketplace insured and uninsured. As discussed above, the effect of these insanely high prices on self-pay patients, especially the uninsured is particularly troubling.\textsuperscript{158} However, the insured are also affected. To the extent that insurers, both private and government, pay higher reimbursements than would be necessary to purchase the same quality medical care, this, of course, translates to unnecessarily higher premiums for participants in those plans. Moreover, insured patients are also burdened with higher co-pays, and coinsurance payments. While deductible amounts remain nominally the same they purchase less healthcare than they should. Many of the problems mentioned here are typically associated with monopoly as opposed to free markets, and as discussed \textit{infra}, this provides an important clue as to the remedy for insanely high chargemaster pricing.\textsuperscript{159}

\textbf{C. Distortions In Markets Tangentially Related To Healthcare}

Insanely high charge master prices and their upward pressure on overall medical costs have negative consequences in several tangentially related markets. In the context of tort law, for example, courts have been forced to struggle with the

\begin{footnotesize}
\textsuperscript{156} See, \textit{e.g.}, Complaint at 1, United States v. Blue Cross Blue Shield of Mich., 809 F.Supp.2d 665 (E.D. Mich. 2010)(No. 2: 10-CV-14155)(anti-trust lawsuit related to “most favored nation” clause)(Case dropped when Michigan passed law prohibiting the use of such classes by insurers).

\textsuperscript{157} \textit{Id.}

\textsuperscript{158} See \textit{supra} notes 100-137 and accompanying text.

\textsuperscript{159} See, Clark Havighurst and Barak Richman, \textit{The Provider Monopoly Problem in Health Care}, 89 Or. L.Rev. 847, at 860 (2011); \textit{infra} notes 186-227 and accompanying text.
\end{footnotesize}
application of the Collateral Source Rule in order to prevent plaintiffs from receiving a windfall by recovering their medical expenses at the billed charge or chargemaster rate from the defendant or the defendant’s insurer.\textsuperscript{160} The problem, as discussed \textit{supra}, is that billed charges are fictitious, phantom, or illusory because these charges are set to be discounted, and hospitals’ routinely accept much less in full payment.\textsuperscript{161} In addition, in the same context as just discussed, exorbitant chargemaster rates distort the application of hospital lien statutes, which most jurisdictions have enacted to allow hospitals to recover \textit{fair} payment for their services.\textsuperscript{162} Finally, high chargemaster rates also cause trouble in the consumer finance market. Not only does medical debt cause havoc with the credit ratings of many consumers,\textsuperscript{163} medical debt also forces many consumers into personal bankruptcy\textsuperscript{164} and is the cause of about 25\% of home foreclosures.\textsuperscript{165} Also, insanely high chargemaster rates create problems for both consumers and consumer finance companies who often purchase hospital debt and strive to collect the hospital’s billed charges from the patient.\textsuperscript{166} Assuming that discount rates are constant, the

\begin{itemize}
\item \textsuperscript{160}See, \textit{e.g.}, Howell \textit{supra} note 1 (discussing the problem of chargemaster rates in the context of the Collateral Source Rule).
\item \textsuperscript{161}See \textit{supra} notes 24-93 and accompanying text; Nation, \textit{Reasonable & Necessary, supra} note 3 at 438-443 (discussing the Collateral Source Rule in connection with chargemaster rates and noting that as Court’s begin to understand that chargemaster rates are set to be discounted not paid they are limiting the application of the Collateral Source Rule).
\item \textsuperscript{163}See \textit{supra} note 15.
\item \textsuperscript{164}See \textit{supra} note 15.
\item \textsuperscript{165}See \textit{supra} note 15.
\item \textsuperscript{166}See, \textit{e.g.}, Brill \textit{supra} note 6. (discussing specific cases of harsh collection tactics throughout the article); Nation, \textit{Wolves, supra} note 15 at 174-180 (similar); Nation, \textit{Obscene Contracts, supra} note 14 at 174-180 at 115-124 (similar).
\end{itemize}
higher a hospital’s chargemaster rates the more money the hospital receives on the 
sale of its debt.

In the context of personal injury litigation, the plaintiff is permitted to recover the value of her reasonable, customary, and necessary medical expenses as part of her damages from the defendant/tortfeasor. While a full discussion of the Collateral Source Rule is beyond the scope of this article, I will briefly review its application here in the context of a hospital’s billed charges. The Collateral Source Rule states that if an injured party receives some compensation for his injuries from a source wholly independent of the tortfeasor, such payment should not be deducted from the damages, which the plaintiff would otherwise collect from the tortfeasor. In the context of medical expenses, the Collateral Source Rule prohibits the defendant from telling the jury that the plaintiffs medical expenses were paid for by the plaintiffs medical insurance company. This ensures that the payments made by the plaintiffs insurance company for medical expenses do not redound to the benefit of the tortfeasor by reducing the tortfeasor’s liability for the medical expenses caused by the injury inflicted by the tortfeasor. The rule accomplishes two goals important to the legal system. First, it ensures that the tortfeasor will pay the full expense associated with his tortious conduct and this will serve the deterrent function of tort law. Second, the rule ensures that the plaintiff and not the defendant/tortfeasor will receive the benefit of the plaintiff’s decision to

167 See, e.g., Howell supra note 1 at 1133 (citing RESTATEMENT (SECOND) OF TORTS § 920 (A) ed.).
168 Id. at 1135.
169 Id.
170 Id. at 1145.
carry insurance and thereby encourages individuals to carry insurance.\textsuperscript{171} Insurance policies typically provide the insurance company with a right of subrogation that allows the insurance company to recover the amounts that it paid on behalf of the insured either directly from the tortfeasor or out of any tort recovery by the plaintiff/insured.\textsuperscript{172}

Insanely high chargemaster rates create a problem in this context when the plaintiff seeks to submit it’s unbundled invoice from the hospital reflecting the hospitals chargemaster rates as proof of the reasonable, customary, and necessary medical expenses that the tortfeasor’s conduct caused. Tortfeasor’s and their insurers object to this, claiming that the billed charges based on chargemaster rates are really phantom charges because the hospital routinely accepts much lower amounts as full payment for the same exact services as those rendered to the plaintiff.\textsuperscript{173} The difficulty caused by these high chargemaster rates is, as noted supra, that some patients are legally responsible to pay them, while many other patients, those with insurance from companies who have contracted with the hospital, are not expected to pay them. However, traditional application of the Collateral Source Rule would prohibit evidence of the actual amounts paid by the plaintiffs insurance company and accepted as full payment by the hospital.\textsuperscript{174} This in turn often results in an unjustified windfall to the plaintiff. That is, if the plaintiffs insurance company paid substantially less than the billed charges, a situation that is very common but

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\textsuperscript{171} Id.  \\
\textsuperscript{172} See Nation, \textit{Fair & Reasonable}, supra note 3 at 439 (the insurer may recover this amount from the plaintiff via subrogation, but noting that many insurers do not pursue subrogation).  \\
\textsuperscript{173} See Howell \textit{supra} note 1 at 1133-34 (Defendant moved to exclude evidence of medical bills that neither plaintiff nor her health insurer had paid).  \\
\textsuperscript{174} Id. at 1134 (noting that the Court of Appeals used the Collateral Source Rule to allow the plaintiff to recover full billed charges).
\end{flushleft}
not universal, and the plaintiff is permitted to recover the full billed charges then the plaintiff is recovering for a loss the plaintiff never incurred.\textsuperscript{175}

Courts in many jurisdictions have struggled with this issue,\textsuperscript{176} but many seem to be working their way toward an application of the Collateral Source Rule that ensures that the plaintiff will only be able to recover for medical expenses actually paid by or on behalf of the plaintiff.\textsuperscript{177} Ironically, in these jurisdictions, plaintiffs suffering the exact same injuries and receiving the exact same medical treatment may recover vastly different amounts depending on the insurance that the plaintiff had.

The application of hospital lien statute has been distorted for the same reasons. Hospital lien statutes give hospitals that provided treatment to a patient/plaintiff a lien on any tort recovery by the plaintiff to ensure payment of any unpaid medical expenses owed by the plaintiff to the hospital.\textsuperscript{178} The purpose of hospital lien statutes is to ensure that hospitals are able to receive \textit{fair} payment for their medical services.\textsuperscript{179} The problem in this context caused by insanely high chargemaster rates is that some hospitals claim a lien in the amount of their billed

\textsuperscript{175} Id. at 1133 (Court holds plaintiff may not recover full billed charges because plaintiff did not suffer any economic loss in that amount, but only in the amount paid and accepted by the hospital on behalf of the plaintiff by the plaintiff's insurer).


\textsuperscript{177} See e.g., Howell, \textit{supra} note 1; Haygood \textit{supra} note 176; Moorhead, \textit{supra} note 176; \textit{Butler supra} note 176; Kastick \textit{supra} note 176. \textit{But see}, Leitinger \textit{supra} note 176; Covington, \textit{supra} note 176; Acuar \textit{supra} note 176.

\textsuperscript{178} See, e.g., Daughters of Charity Health Services of Waco v. Linnstaedter, 226 S.W.3d 409 (Tex. 2007) (involving the Texas hospital lien statute, TEX. PROP. CODE. ANN. § 55.007 (West 2007)).

\textsuperscript{179} See Daughters of Charity \textit{supra} note 178 at 412 (refused to enforce the lien against the difference between hospital's charges and the amount they accepted as full payment under Workers Comp. noting that Worker's Comp. provides fair and reasonable reimbursement for healthcare providers).
charges (based on their chargemaster rates) notwithstanding the fact that they routinely accept much less from private and government insurers.\textsuperscript{180}

The effect of insanely high charge master prices has been especially cruel with regard to consumer finance issues. Medical debt is responsible for more than 50\% of personal bankruptcies\textsuperscript{181} and 25 \% of home foreclosures.\textsuperscript{182} Moreover, medical debt frequently appears on the credit reports, often unfairly, and damages a consumer’s credit rating.\textsuperscript{183} A study by the Consumer Financial Protection Bureau found that half of all overdue debt on consumer credit reports is medical debt.\textsuperscript{184} This in turn increases interest rates the consumer pays across the board and may reduce the level of credit available to the consumer. The report notes that medical debt is confusing for consumers in part because of its unexpected nature, that is medical events arise without warning, and in part because of the confusing nature medical billing.\textsuperscript{185} That is, for insured patients the timeframe is often very long between the medical event and the time when the patient knows how much they are individually responsible to pay. And, for uninsured patients they get sent an unbundled bill that is indecipherable and huge both the number of pages and dollar amount.

\textsuperscript{180} Id. at 410.
\textsuperscript{181} See supra note 15.
\textsuperscript{182} See supra note 15.
\textsuperscript{183} See supra note 15.
\textsuperscript{184} See Muschick supra note 136.
\textsuperscript{185} Id.
IV. A Proposed Solution

One of the most significant reasons that U.S. healthcare is so expensive is that U.S. hospitals overcharge patients and insurers.\textsuperscript{186} Another, more positive reason is that U.S. healthcare is the best in the world.\textsuperscript{187} Hospitals overcharge because they can.\textsuperscript{188} That is, hospitals, including nonprofit tax-exempt charitable hospitals, which are no longer true charities, are businesses.\textsuperscript{189} As businesses, hospitals charge what the market will bear. The problem is that the competitive forces that typically hold prices check in a free-market have failed with regard to the chargemaster prices set by hospitals.\textsuperscript{190} Many of the reasons for this failure relate to the third-party reimbursement systems of government and private insurers discussed supra.\textsuperscript{191} As a result, the remaining market forces are insufficient to hold chargemaster prices in check. The result, predictably, has been skyrocketing chargemaster prices. Not only do these insanely high chargemaster prices contribute significantly to rising prices

\textsuperscript{186} See supra notes 100-159 and accompanying text.
\textsuperscript{187} See Nation, Wolves, supra note 15 at 196-206 (noting that high prices alone are not the problem, that is, if high prices reflect better healthcare then pricing may be fine, but when prices are higher than necessary in order to excessively reward market participants such as hospital administrators and providers (see Rosenthal supra note 3 at 3, quoting James Robinson, a professor of health policy at the University of California Berkeley as saying “There is an infinite amount of stuff to buy – amenities, machines, new wings, higher salaries, more nurses – but to deliver good health care what do you need?) then to that extent prices are a problem. The only way to restore sanity to hospital pricing without threatening the quality of U.S. healthcare is to separate the goals of increasing access to healthcare form the goal of developing the best healthcare and to increase free market competition in healthcare).
\textsuperscript{188} See supra notes 140-141 and accompanying text (market share largest determinant of high chargemaster prices).
\textsuperscript{189} See Nation, Wolves, supra note 15 at 180-184 (arguing that the non-profit business model is not appropriate for hospitals); see, e.g., California Pacific Medical Center discussed supra at notes 112-122.
\textsuperscript{190} See supra notes 123-127 and accompanying text.
\textsuperscript{191} See supra notes 24-93 and accompanying text.
for healthcare throughout the healthcare market as discussed supra, they are also especially cruel and unfair when applied to self-pay patients.

The reason for the market failure with regard to chargemaster pricing, is a lack of robust competition for healthcare, especially that provided by hospitals. The best way to restore sanity to the hospital pricing is to restore a fully functioning free market for hospital services. This is the best solution because it will ensure that the high quality of U.S. hospital care is preserved even as prices are brought under control. One important part of restoring competition is to make pricing transparent, known in advance, and comparable among hospitals. The solution I offer here is designed to improve price competition among hospitals.

Another important part of a properly functioning free market is to have a large number of market participants on both the demand and supply side of the market. Unfortunately, with regard to supply, the hospital market has been moving in just the opposite direction. Moreover, due to various provisions of the ACA this trend promises to continue. It is beyond the scope of this article critique the ACA's approach to accomplishing in its noble goals of expanding insurance coverage, improving the overall efficiency of U.S. healthcare delivery and ultimately the overall health of the U.S. population. I simply point out that the ACA's managed

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192 See supra notes 123-127 and accompanying text.
193 See supra notes 100-137 and accompanying text.
194 See supra notes 123-127 and accompanying text.
195 See Nation, Wolves, supra note 15 at 206-211 (arguing that the best way to increase competition is to make all hospital for profit and taxable).
196 See Anderson, Soak the Rich, supra note 9 (noting that most patients cannot understand the hospital bill they receive due to its length and complexity).
197 See, e.g., Rosenthal supra note 3 at 9 (hospital mergers are increasing and drive up prices).
competition approach built around large coordinated hospital systems will further disrupt the proper functioning of free-market competition for hospital services. The managed-care concept needs to be revisited and made to work with smaller more competitive hospitals.

At present, the most competitive market for hospital services exists with regard to private healthcare insurers. The solution I offer below is designed to protect self-pay patients, but would also help to bring overall hospital pricing under control. While I favor free-market competition, the solution that I suggest involves government intervention in the marketplace. However, it is important to point out that the government intervention I suggest is designed to restore the robust functioning of the free-market and not to replace it with a government directed market. Also, I am not advocating an “all-payer” system in which hospitals must charge the same price to all customers. My solution is in three parts:

1. Hospitals should be required to price their services based on Medicare MS-DRG and APC codes, but not at Medicare rates. That is, hospitals would be prevented from billing for unbundled services for any patient, including self-pay patients.

2. Hospitals should be required to publish annually the average amount accepted (AAA) from private insurers as full payment for each DRG/APC code.

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199 See Reinhardt, U.S. Hospital Services, supra note 1 at 61-62 (each private insurer negotiates the dollar level of payments with each hospital every year).

200 See Nation, Fair & Reasonabl, supra note 3 at 451-52 (discussing problems with “All-Payer” systems).
3. Hospitals should be restricted to charging no more than 115% of the AAA amount to any patient who self-pays in whole or in part, including uninsured, under-insured, and out-of-network patients subject to balance billing.

An important impediment to the functioning of a free market for hospital services is that most self-pay patients do not know at the time of purchase how much the services they are purchasing will cost.\textsuperscript{201} Hospitals typically have their patients sign some type of patient agreement often an “Authorization For Treatment” or a “Statement Of Financial Responsibility” or both.\textsuperscript{202} These are open-ended agreements pursuant to which the patient agrees to pay for all medical goods and services provided by the hospital at the hospital’s usual and customary rates, which means chargemaster rates.\textsuperscript{203}

These agreements have been compared to a blank check given by the patient to the hospital with the amount to be unilaterally filled in by the hospital at a later date.\textsuperscript{204} This is like going to purchase a television but not knowing until a month or two later how much you agreed to pay for it. And, months later when you get the bill, it does not reflect the price of the television as a unit, rather it states a price for each component in the television and the labor to install it. After this experience if you go to buy another television you still will not be able to compare prices. It’s easy

\textsuperscript{201} See Nation, Fair & Reasonable, supra note 3 at 429 (discussing that consumers may be effective advocates for lower prices if they have usable pricing information).
\textsuperscript{202} Id at 426-427 (discussing these agreements).
\textsuperscript{203} Id.
\textsuperscript{204} Id.
to see then that there is no competition between hospitals based on price and thus no pressure on hospitals to keep their chargemaster rates reasonable.\footnote{205 See Rosenthal, supra note 3 at 3 (Professor Melnick states that hospitals can set chargemaster prices at any level they want because there are no market constraints).}

Moreover, requiring hospitals to publish their chargemasters so that the prices for each of the thousands of items listed on the charge master are publicly known offers no solution to this problem.\footnote{206 See Nation, Fair & Reasonable, supra note 3 at 428-429 (noting that even if patients had access to a hospital’s chargemaster they could not use it to calculate the price they will owe for treatment).} A hospital’s chargemaster, even if it were available to the patients, would be virtually meaningless.\footnote{207 Id.} For example, a patient that requires a hernia repair procedure may have discussed the various procedure options in detail with his/her doctor, but the patient would still not know what he/she is purchasing in a way that would allow the patient to use the chargemaster to calculate the price.\footnote{208 Id.} Even a patient who is very well informed regarding hernia repair options will have no idea how many pairs of surgical gloves, operating room hours, or suture material, etc. will be needed to perform the procedure.\footnote{209 Id.} Without this information calculating a price based on a chargemaster is impossible.\footnote{210 Id.}

However, bundled charges, which set a price for an entire episode of care or the entire procedure are much easier for patients to understand and compare. The advantages associated with bundled pricing are reflected in the fact that government insurers as well as large private insurers, participants with great market power, use procedure based, rather than a la cart, unbundled chargemaster-
based pricing. Requiring hospitals to publish procedure based prices and to apply them to individual self-pay patients will allow patients to effectively compare prices and therefore force providers to compete on price. This will restore some market forces that will function to keep prices reasonable.

The second part of my proposed solution requires hospitals to publish, annually, the average amount accepted (AAA) from private insurers as full payment for each MS-DRG/APC code. With this information self-pay patients will be able to compare hospitals on the basis of price and therefore force hospitals to compete on the basis of price. This will restore market pressure to keep prices competitive and reasonable. As noted above, there currently is very little market pressure brought to bear on chargemaster prices.

I have argued elsewhere in favor of using private insurer rates as a basis for calculating the fair amount to be paid by self-pay patients, and I do not want to repeat that work here. I will briefly summarize the arguments in favor of using private insurers as a base. As discussed above, it is clearly not appropriate to use chargemaster prices as a base. An unbundled bill from a hospital calculating charges at a chargemaster rates is a complete fiction and should not be used by courts or others to establish the fair and reasonable value of medical services.

On the other hand, the lowest rates that a hospital accepts as full payment are those provided by Medicare and Medicaid, with Medicaid representing the

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211 See supra notes 24-93 and accompanying text.
212 See supra note 205.
213 See generally, Nation, Fair & Reasonable, supra note 3.
214 Id. at 458-459 (chargemaster prices are set to be discounted not paid, if paid they would yield truly enormous profits).
lowest rates. Many have argued that Medicaid rates are actually too low, that is below hospital cost.\textsuperscript{215} Some have even made that argument with regard to the Medicare rates,\textsuperscript{216} suggesting that they may represent only 94\% of the hospitals costs. Evaluating these claims is beyond the scope of this article. However, what is clear is that government insurers are rate fixers and thus their rates are not the result of market competition. The prices paid by private insurers however represent the best approximation we have a free market pricing.\textsuperscript{217}

As noted, private insurers renegotiate their rates on a regular basis with the hospitals and thus these rates are continually updated to reflect market conditions.\textsuperscript{218} A market-based rate is clearly preferable and I believe it is attainable. That is, hospitals have such information readily available and thus can easily calculate their AAA.\textsuperscript{219} In addition, a benefit to using an average is that no proprietary information of any particular insurer or of the hospital is required to be disclosed. On the other hand, some have argued for using the Medicare reimbursement rate as a base as this is readily available from an independent source, the government.\textsuperscript{220} The Medicare reimbursement rate is complicated but transparent. However, my preference for reasons I have previously outlined, is for a

\textsuperscript{215} \textit{Id.} at 459-460 (government insurers’ reimbursement rates are said to be below fully allocated costs).
\textsuperscript{216} \textit{Id.} Rosenthal, supra note 3 at 6 (a hospital spokesmen suggest that Medicare reimburses only 70\% of the actual cost of care).
\textsuperscript{217} \textit{See Nation, Fair & Reasonable, supra} note 3 at 460-61.
\textsuperscript{218} \textit{See supra} note 199.
\textsuperscript{219} \textit{Cf. Nation, Fair & Reasonable, supra} note 3 at 467-470 (discussing the ACA use of “amounts generally billed” or AGB for tax exempt hospitals to use in calculating permissible charges to patients eligible for financial assistance).
\textsuperscript{220} \textit{See Nation, Fair & Reasonable, supra} note 3 at 463-464 (discussing a proposal by Dr. Gerand Anderson to calculate the price for self-pay patients at the Medicare reimbursement rate plus 25 percent).
market-based rate.\textsuperscript{221} As discussed below, this rate is only a beginning point and requires further adjustment to arrive at the proper rate to be paid by self-pay patients.

It is not appropriate to have self-pay patients pay rates as low as those paid by private insurers, because private insurers bring value to hospitals that self-pay patients do not provide.\textsuperscript{222} Private insurers bring large groups of profitable patients to the hospital, in essence preapproving all of these patients in terms of credit worthiness.\textsuperscript{223} Private insurers offer quick and assured payment, increased volume of business and marketing advantages by making the hospital known to its insureds. Self-pay patients do not provide any of these benefits.\textsuperscript{224} As I have discussed elsewhere, I believe that adding 10 to 15\% to the AAA amount represents the proper amount for self-pay patients to pay, based on an analogy to credit card issuers.\textsuperscript{225} Another commentator, using different methodology and arriving at a different formula nonetheless arrives at a similar amount as representing a fair reimbursement amount for self-pay patients.\textsuperscript{226}

Commentators have reported that hospitals receive anywhere from 10 to 50\% of their chargemaster rates from insurance companies. Thus, based on the formula I suggest above self-pay patients will be responsible to pay approximately 11\% to 57.5\% of billed charges based on chargemaster rates. However, it’s important to remember that hospitals have increased their chargemaster rates at a

\textsuperscript{221} Id. at 460-461.
\textsuperscript{222} Id. at 461-463.
\textsuperscript{223} Id.
\textsuperscript{224} Id.
\textsuperscript{225} Id. at 463-464.
\textsuperscript{226} Id.
greater percentage than the reimbursement rates increase. Thus, it’s important to base self-pay reimbursement amounts not on chargemaster rates but on the AAA amount. In addition, due to the high and increasing levels of concentration in many markets especially on the supply side, the lower range of 10%, or in some extremely concentrated markets even less, over AAA may be appropriate and, eventually if concentration continues to increase there may be no choice but to base rates on Medicare reimbursement amounts. I am hopeful that the trend toward concentration can be reversed before this becomes necessary and pricing can be based on competitive market forces. In addition, it’s important to recognize that the formula I suggest does call for self-pay patients to pay a larger amount for their medical care than private insurers pay. As discussed above, the reason for this is that self-pay patients do not provide the same benefits to hospitals as private insurers.

V. Conclusion

Chargemaster prices are insanely high and this results in many negative consequences, including cruel treatment of self-pay patients and higher overall U.S. healthcare prices. However, these insanely high prices are a symptom and not the real problem. The problem also is not hospitals or even hospital administrators; they are responding like any businessperson would to the market. The symptom of high prices is caused by a lack of competition; a lack of competitive market forces

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227 See Anderson, Soak the Rich, supra note 9 at 783 (noting that form 1984 to 2004, for example, chargemaster prices increased 10.7% per year, which was faster than Medicare allowable costs (6.3%) or hospital net revenues (6.6%).

228 See supra notes 138-159 and accompanying text.
applicable to healthcare in general and hospitals specifically is the real problem. Without competitive market forces to impose discipline on decision-making, price setting lacks sufficient market restraint. Hospitals are not the enemy; U.S. hospitals do a great job, whenever I have required medical care there was no hospital in the world I would have rather been in than a U.S. hospital. Overall the quality of care provided by U.S. hospitals is the best in the world.\textsuperscript{229} I do however fault nonprofit, charitable, tax-exempt hospitals for pretending to be charities when they are in fact, and act like, for-profit businesses.\textsuperscript{230}

The insanely high chargemaster prices set by hospitals result from hospital administrators making good and rational decisions from there specific perspectives, but which, in aggregate, create an inflated and bloated overall hospital system characterized by insanely high chargemaster prices, high and increasing market concentration, too large and perhaps too highly compensated administrative staffs, too much construction and expansion, etc.\textsuperscript{231} There is too much of many things and the primary reason for this is that hospitals and the broader healthcare market that they are part of, are unrestrained by proper competitive forces.\textsuperscript{232} A lot has been written about cost shifting by hospitals, but government insurers and their relatively low reimbursement rates represent only a small cause of high prices.\textsuperscript{233} Cost shifting likely accounts for only a small part of price increases; it is not the main driver. Hospitals raise their prices because they can, because of unrestricted market

\textsuperscript{229} See supra notes 22-23 and accompanying text.
\textsuperscript{230} See generally, Nation, Wolves, supra note 15.
\textsuperscript{231} See supra notes 24-93 and accompanying text.
\textsuperscript{232} See supra notes 138-159 and accompanying text.
\textsuperscript{233} See supra notes 87-91 and accompanying text.
power. In fact, it is my suspicion that any market experiencing a failure of competitive forces would tend in the same direction.

Thus, the solution to the problem lies in restoring proper competitive forces to healthcare overall and hospitals in particular. This article argues for the adoption of regulations that take a small but important step in the direction of restoring proper competitive forces. A dog will pull on a leash until taught to heel; a seller will raise prices higher and higher until brought to heel by market forces. It is time we empower the market by providing self-pay patients with the information and protection they need to ensure competition between hospitals and fair prices, this will allow market forces to bring the healers’ price setting to heel.

See supra notes 138-159 and accompanying text.