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Health Care and the Balance Billing Problem: The Solution is the Common Law of Contracts and Strengthening the Free Market for Health Care

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I. Introduction

Courts across the country are beginning to understand that hospital bills based on list or chargemaster prices are exorbitant and unfair because they reflect prices that are set to be discounted and not paid. As a result, courts are becoming aware of the fact that the list prices or chargemaster rates that hospitals claim are usual and customary are instead exorbitant amounts arbitrarily set by hospitals as a starting point for negotiating huge discounts with insurers. Much attention has been focused by commentators on the

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2 See e.g., Stanley v. Walker, 906 N.E. 2d 852, 856-867 (Ind. 2009) (noting that based on the realities of healthcare finance, we are unconvinced that the reasonable value of medical services is necessarily represented by either the amount actually paid or the amount stated on the original medical bill); Cape Reg’l Med. Ctr. V. Sanchez, No. CPM DC 109-11, at *9 (N.J. Super. Ct. Law Div. Mar. 26, 2012) (on file with the _____ Law Review) (noting that most patients upon entering the hospital sign an "Authorization for Treatment," a "statement of Financial Responsibility," and/or another similar
ironic unfairness of the fact that uninsured patients, that is those least likely to be able to afford to pay for health care even at a reasonable price, are often expected to pay these exorbitant rates in full. However, while this attention is certainly well deserved, focusing only on the uninsured misses the fact that it is not just the uninsured that are burdened by obscenely high chargemaster rates. A large and growing group of insured patients is also being unfairly burdened by hospitals’ exorbitant chargemaster prices. The burden is brought to bear on these patients through a process known as balance billing. When a patient’s insurance company has not negotiated a contract with the hospital that provides an open-ended agreement pursuant to which the patient purports to agree to pay for all medical goods and services provided by the hospital at the hospital’s list (chargemaster) prices, but in reality, this type of agreement amounts to a blank check given by the patient to the hospital with the amount to be unilaterally filled in by the hospital at a later date. However, not all courts have yet come to this realization, especially in the balance-billing context. See e.g., Allen v. Clarian Health Partners, Inc., 980 N.E.2d 306, 310-11 (Ind. 2012) (rejecting a central premise of this article that hospitals’ chargemaster rates should not be used as a basis for pricing on contracts for healthcare services).


4 See e.g., Steven Brill, Bitter Pill: How Outrageous Pricing and Egregious Profits are Destroying our Health Care, TIME, Mar. 4, 2013 (discussing outrageous bills imposed on insured patients who receive care from providers are outside of the patient’s insurance network); Uwe E. Reinhardt, The Many Different Prices Paid to Providers and the Flawed Theory of Cost Shifting: Is It Time for a More Rational All-Payer System?, 30 HEALTH AFF. 2125, (2011) (discussing the high prices faced by insured patients who receive care outside of their insurers network). See e.g., Caroline Chen, Surprise Medical Bills Lead to Protection Laws: Health, at www.bloomberg.com/news/articles/2014-04-04/surprise-medical-bills-lead-to-protection-laws-health, Bloomberg Business April 4, 2014 citing Elisabeth Benjamin, vice president of health initiatives at the Community Service Society of New York as saying: “It’s important to protect the consumer now [since the passage of the ACA], because there’s a little more chaos in the system and a lot more people, ... and that balance-billing is the most-common payment problem seen at her nonprofit advocacy organization, which handled 65,000 health-care cases last year. See generally, Jack Hoadley, Kevin Lucia and Sonya Schwartz, Unexpected Charges: What States Are Doing About Balance Billing, prepared for California Healthcare Foundation and available at: www.chcf.org/~/media/MEDIALIBRARYFiles/PDF/U/PDFUnexpectedchargesStatesandBalanceBilling.pdf (hereinafter “Unexpected Charges”).
services to the patient the patient is considered out of network, OON in hospital speak, and as a result the discounts that the hospital has negotiated with other insurers do not apply to the OON patient. The patient’s insurer pays the hospital the amount that the insurance company is obligated to pay for the services received, but this amount, being reasonable, is always far less than the unreasonably high list price set by the hospital. Because the OON patient’s insurer has no contract with the hospital, the hospital is not obligated to accept the payment from the insurance company as full payment and therefore the hospital is permitted to bill the patient for the balance that is the difference between the obscenely high hospital list price and the reasonable amount that the insurance company paid. Moreover, for a variety of reasons hospital networks are becoming narrower as hospital systems contract with fewer insurers, and as a result, more and more patients are receiving balance bills. In addition, not only do the price and collection limitations included in the Affordable Care Act, Obamacare, not prevent balance billing, the Act allows for the sale of narrow network health insurance, enshrines exorbitantly high chargemaster rates, and encourages balance billing. Finally, the practice of balance billing puts upward pressure on health care prices in general. That is,

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5 See, Unexpected Charges supra note 4 at 3-5.
6 See e.g., George A. Nation III, Determining the Fair and Reasonable Value of Medical Services: The Affordable Care Act, Government Insurers, Private Insurers and Uninsured Patients 65 Baylor Law Review 425, 434 (2013) (hereinafter Nation, Determining) (based on actual hospital pricing a hypothetical gall bladder surgery would have a list price of $14,000, a price for HMO’s of $5,600, for Blue Cross/Blue Shield of $4,700, for Aetna a price of $5,000, for Medicare a price of $2,590 and for Medicaid a price of $1,260 – for the same exact services).
7 See e.g., Reed Abelson, More Insured, but the Choices are Narrowing, N.Y. TIMES, May 12, 2014 at A1 (noting that because many health insurance policies sold on the ACA exchanges use narrow networks, out-of-network care and balance-billing are becoming more frequent).
8 See infra notes 23-82 and accompanying text.
9 See Ge Bai and Gerard F. Anderson, Extreme Markup: The Fifty U.S. Hospitals with the Highest Charge-to-Cost Rations, 34 HEALTH AFF. 922, 925 (2015) (noting that high markups [charge master rates] may add to private insurance premiums and play a role in the rise of overall healthcare spending); Robert Murray, Hospital Charges and the Need for a Maximum Price Obligation Rule for Emergency Department and Out-of-Network Care, HEALTH AFF. Blog [blog on the Internet] May 13,
this practice leads to higher prices across the board for the uninsured, the out-of-network insured and even the in-network insured.\textsuperscript{10}

I have written about the balance-billing problems in other work and have suggested there the adoption of government regulations directed at hospitals that would both address the balance-billing problem and would improve the functioning of the free market for healthcare by providing price transparency.\textsuperscript{11} A few states have attempted to address this problem legislatively with mixed success.\textsuperscript{12} The focus of this article is on the practice of balance billing and what courts can do now under existing law to address this problem and on the type of legislation that will provide a long term solution to the broader problem of market failure regarding the sale of healthcare. This article argues that more government price-fixing is not the solution. The primary goal of health care policy in the United States should not be to increase access and control the price of healthcare; rather it should be to develop the best health care in the world at the lowest

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\textbf{Charges Do Matter – They Matter a Great Deal.} Counter to the belief of both hospital industry representatives and many of my colleagues, hospital charge levels and rapidly escalating charges matter a great deal. While individual states and the Affordable Care Act (ACA) have instituted limits on the amounts low-income uninsured patients pay hospitals, insured patients that receive care at hospitals that are “Non-Par” or “out-of-network” are still victims of hospital’s exorbitant charging practices. When patients receive emergency services at an out-of-network hospital, the patient and/or insurance company (depending on insurer cost sharing for out-of-network care) pay full charges.

High and increasing hospital charges, combined with increasing proportions of cases admitted through the hospital Emergency Department (ED), are major factors behind the ever-declining negotiating leverage of private health insurers. This situation, coupled with the increased pricing power of the ever-more-concentrated provider industry, will be a major contributor to the almost certain rapid escalation in total U.S. health care costs in coming years. \textit{Id.}

\textsuperscript{10} See supra note 9 and accompanying text.


\textsuperscript{12} See e.g., Unexpected Charges supra note 4 at 6-9. (Noting that nine states have enacted legislation in an attempt to deal with the balance billing and problem of these efforts have met with mixed results.)
price.\textsuperscript{13} The only mechanism we have for doing that is the free market.\textsuperscript{14} While there is additional government regulation that would be helpful in strengthening the free-market for health care,\textsuperscript{15} I argue here that we do not have to wait for such regulation; the common law of contracts contains the tools necessary to allow courts to provide a free-market solution to the balance-billing problem now.\textsuperscript{16}

Part I provides background concerning the problem of balance billing. Part II provides analysis of the problem and suggests that part of the solution to the lack of competition in the sale of healthcare (of which the balance billing problem is a symptom) requires, inter alia, government regulation designed to require meaningful price disclosure by hospitals, along with other steps to further strengthen the free-market for healthcare in the United States. Part IV discusses what courts can do now with the tools currently available to them to solve the problem of balance billing in a way consistent with a strong free-market for healthcare. Part V concludes.

II. Background: The Problem

In a recent newspaper article a journalist recounted the story of a 50-year-old construction worker who experienced chest pains and was admitted to St. Francis Hospital in Bartlett Tennessee in 2014.\textsuperscript{17} His wife said they were not told either at the time of admission or during their visit that the hospital did not accept their health

\begin{footnotesize}
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  \item[13] See, George A. Nation III, \textit{Non-Profit Charitable Tax-Exempt Hospitals – Wolves in Sheep’s Clothing: To Increase Fairness and Enhance Competition in Health Care All Hospital Should be For-Profit and Taxable}, 42 \textit{Rutgers Law Journal} 141 at 198-209 (2010) (arguing that the definition of the word “better” as in better health care is key to policy formulation).
  \item[14] Id. at 180-184 (arguing that the non-profit tax-exempt business model is not appropriate for hospitals and that only free market competition can accomplish health care goals).
  \item[15] See infra notes 98 - 121 and accompanying text.
  \item[16] See infra notes 83 - 131 and accompanying text.
\end{itemize}
\end{footnotesize}
The couple received a bill from the hospital for $22,945.\textsuperscript{19} As the article points out, under the ACA a family’s out-of-pocket expenses (this would include charges for things like co-pays, co-insurance, etc.) for 2014 were capped at $12,700.\textsuperscript{20} However, this limitation under the ACA does not apply to non-emergency room charges provided by an out-of-network hospital.\textsuperscript{21} That is, the limitation does not protect patients from balance billing, and thus the family received a bill for $22,945. In this case, as discussed in the article, the family was lucky because they appealed the charges and the hospital eventually reduced them to $600, but only after the bill had been sent to a collection agency, which the family worries will hurt their credit rating.\textsuperscript{22}

A. Narrow Networks

In 2015, under the ACA, out-of-pocket costs are capped at $6,600 dollars for an individual and $13,200 for a family.\textsuperscript{23} But again these caps do not apply to out-of-network providers who charge patients for the portion of their bills that their insurance does not pay.\textsuperscript{24} Moreover, this balance-billing problem is getting worse because networks are becoming narrower.\textsuperscript{25} A network consists of the hospitals with which an insurer has contracted.\textsuperscript{26} Pursuant to those contracts hospitals agree to dramatically discount their list

\begin{footnotes}
\item[18] \textit{Id.}
\item[19] \textit{Id.}
\item[20] \textit{Id.}
\item[21] \textit{Id.}
\item[22] \textit{Id.}
\item[23] \textit{Id.}
\item[24] \textit{Id.}
\item[25] \textit{Id.} (noting that plans with narrow networks make up about half of all health law exchange networks and about two-thirds of the networks in large cities); \textit{See, Abelson supra note 7} (balance-billing becoming more frequent).
\item[26] \textit{See, “Unexpected Charges” supra note 4 at 3-5.}
\end{footnotes}
prices.\textsuperscript{27} If a provider is not in-network, that means that the insurance company has no contract with the hospital and patients who are insured by that company are not entitled to the huge discounts and instead are, according to the hospital, responsible for the full undiscounted, obscenely high, list price for the services they receive. A network is narrow if it only includes a few hospitals.\textsuperscript{28} A wide network includes many hospitals. Wide networks give patients more choice as to where to seek care. A poll conducted by the Kaiser Family Foundation found that more than half of Americans believe that it is important to make sure that health plans have sufficient networks to provide a wide choice of doctors and hospitals.\textsuperscript{29} However, according to a 2015 report by McKinsey & Company, plans with narrow networks make up half of all of the insurance networks offered through the ACA, and narrow networks make up about two-thirds of the insurance networks offered through the ACA in the largest cities.\textsuperscript{30}

\textsuperscript{27} See Nation, Chargemaster Insanity, supra note 11 at 19-23 (noting that self-pay patients billed chargemaster rates are asked to pay are at least 2.5 times the amount paid by health insurers for the same exact care); Nation, Determining supra note 6 at 429-30 stating:

Another important characteristic of healthcare is that chargemaster or list prices are not fair or reasonable. They are grossly inflated because they are set to be discounted rather than paid. Hospitals, in general, do not expect to recover these inflated prices, but they are very reluctant to reduce them for self-pay patients. Nevertheless, hospitals and other providers maintain that the grossly inflated list prices contained in their chargemasters are “reasonable and customary,” in part because every patient, insured or uninsured, receives a detailed itemized bill reflecting chargemaster prices. As a result, hospitals sometimes claim that all patients are billed at chargemaster rates. However, while all patients are billed chargemaster rates, all patients are not expected to pay the billed charges. *** For insured patients, the billed (chargemaster based) amount is dramatically (at least 50%) discounted. Thus, while hospitals claim that the chargemaster rates reflect their usual and customary charge for services, they certainly do not represent the usual price actually paid for the listed goods and services (notes omitted).

\textsuperscript{28} See Armour supra note 17 (Health plans offered by employers also have been reducing the number of doctors and hospitals in their networks, but what have come to be known as narrow networks are more prevalent in plans offered on the ACA exchanges).

\textsuperscript{29} Id.

\textsuperscript{30} Id.
networks become narrower more patients are burdened with exorbitant hospital debt pursuant to balance billing.  

The reason that networks are becoming narrower is the desire on the part of hospital systems to increase profits. For example, in some cases insurance companies cannot afford the reimbursement levels being demanded by hospital systems in order to become in-network. Some hospital systems choose to purposely limit the size of their networks because they feel that this strengthens their financial bargaining position and allows them to recoup higher payments from insurers and patients. An important cause of this is the increased concentration that has occurred on the provider side of the market. As

31 Id.
32 See Murray supra note 9 at 3 where he states:
   More importantly, the already astronomical and rapidly escalating hospital charge levels also have a less obvious impact on the rise in overall health care costs. High and increasing charges fundamentally undermine the negotiating leverage of private payers relative to hospitals, both big and small. This dynamic, which has been playing out in negotiations between private insurers and hospitals for years, goes something like this:
   When hospitals negotiate with health plans they have one of two options: 1) they can take a lower negotiated rate (around 135 percent of cost, which is the average payment level nationally as shown by the AHA statistics) and receive higher volumes of patients by virtue of being "in-network"; or 2) they can decline to be in-network and receive an average profit of 220 percent of costs on smaller patient volumes admitted through their EDs. The higher the profit on ED patients that pay out-of-network rates, the stronger the incentive for the hospital to drive hard bargains with insurers over negotiated prices.
   Recent analyses of private-sector pricing trends show stronger-than-average growth in hospital prices for Emergency Department services. The Health Care Cost Institute (HCCI), which monitors spending trends by private insurers, found that from 2009 to 2011, unit prices for ED services increased by 16.3 percent, compared to 9.9 percent and 8.1 percent increases in prices for inpatient and ancillary services, respectively. The profit-making opportunity to raise prices for services with highly inelastic demand curves is clearly not lost on the hospital industry.
   However, even under Scenario 1, with markups at 320 percent or higher, the hospital has relatively little incentive to negotiate with a health plan that cannot promise substantial volumes. The bottom line conclusion, then, is that high markups and heavy and growing use of the ED as a source of admission act to substantially reduce insurer market power, even for providers with relatively small market share. Those who negotiate on behalf of commercial insurers are well aware of how the ability of hospitals to raise charges completely undermines their own negotiating leverage. [Table 1 omitted]

33 Id.
34 Id.
35 Id. at 5-6 stating:
hospitals consolidate, more large healthcare systems are created and these dominant systems do not feel any competitive pressure to contract with insurance companies at reasonable reimbursement rates.  

B. No Notice, No Control & Unfair Surprise

Even patients who are aware of the risks of balance billing, and who, given their medical condition, are in a position to make a choice regarding where to seek treatment, find it difficult if not impossible to prevent balance billing. This is because it is often

It is a well-documented fact that provider consolidation – which research shows leads to higher prices – is already extreme and once again on the rise (citing Provider Market Power in the U.S. Health Care Industry: Assessing its Impact and Looking Ahead, Catalyst for Payment Reform, 2012) available at http://www.catalyzepaymentreform.org/2013-03-03-06-22-58.2913-03-04-03-29-59/market-power. *** As Barak Richman from the Duke School of Law has discussed, health care providers with market power enjoy substantially more pricing freedom than monopolists in other industries because of the presence of U.S. style health insurance, which largely insulates consumers from the full implications of monopoly pricing. This dynamic results in much greater potential for revenue generation and much greater distribution of wealth than would result from monopoly power in markets where consumers face the prices and price increases directly. [See Barak Richman at Concentration in Health Care Markets: Chronic Problems and Better Solutions available at http://www.aei.org/files/2012/06/12/concentration-in-health-care-markets-chronic-problems-and-better-solutions_171350288300.pdf. Thus, the prospects for cost control are greatly diminished as long as providers are allowed to exercise their monopoly power, particularly where they face a highly inelastic demand curve – namely for emergency department services.] The ability to hold a gun to the head of private insurers in this fashion is a by-product of provider consolidation, the enhanced pricing flexibility of health care monopolies, and the increasing proportions of admissions through hospital EDs.

36 Id.; Elizabeth Rosenthal, As Hospital Prices Soar, A Stitch Tops $500, N.Y. TIMES, Dec. 2, 2013 citing Glen Melnick, a professor of health economics at the University of Southern California, regarding California Pacific Medical Center, which is owned by Sutter Health Inc., whose chargemaster rates are 5 ½ to over 10 times the Medicare reimbursement rate. According to Professor Melnick, Sutter is a leader – a pioneer – in figuring out how to amass market power to raise prices and decrease competition. Id. 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 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.); 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).

37 See e.g., Chen supra note 4; Armour supra note 17. See generally, Unexpected Charges, supra note 3.
extremely difficult for a patient to determine whether the provider from whom they are seeking medical services is in-network or out-of-network. Moreover, the mere fact that a patient seeks medical services from an in-network hospital does not ensure that the doctors treating the patient are also in-network. That is, it is very common for in-network hospitals to employ physicians who are not in that network. As a result, patients treated at an in-network hospital may receive balance bills from the out-of-network physicians who treated them. This is confusing and unfair to patients.

C. Exorbitant Obscenely High Charges

The problem of balance billing would not be of nearly as much concern if the balance bills were not so outrageously high. That is, if hospitals and other healthcare providers set their list prices at a fair and reasonable level to begin with, the balance bills would not represent a crippling financial burden for patients. Rather, they would simply represent the difference between a reasonable list price and a likewise reasonable reimbursement amount set by the insurance company. In this economically sensible world, (one that a properly functioning free-market would create) balance bills would often be zero or a minimal amount. Unfortunately this does not represent the current reality the hospital billing as illustrated by the fact that in the case cited above once the hospital reduced it charges the bill went from $22,945 down to $600!

38 See Chen supra note 4 (quoting Karen Pollitz, a senior fellow at the Menlo Park, California-based Kasier Foundation as follows: “It’s a pretty good bet that if you’re hospitalized or having any kind of surgery, somebody along the way who touches you or your slides or films, will not be in network”).
39 Id.
40 Id.
41 Id.
42 See e.g., Nation, Determining, supra note 6 at 427.
43 Id.
44 See supra notes 17 - 22 and accompanying text.
What makes the problem of balance billing so pernicious is that the bills not only surprise patients, but the amount of the bills is often financially devastating to patients.\textsuperscript{45} I have written before about outrageously high charge master prices that hospitals insist are usual and customary and I do not wish to repeat that work here.\textsuperscript{46} It is sufficient to note here that the amounts reflected on balance bills, when based on chargemaster prices, are outrageously high, bear no relationship to the hospital’s cost, are set to discounted and not paid, and if they are paid yield truly enormous profits to the hospital.\textsuperscript{47}

D. Balance Billing Increases The Overall Cost Of Health Care

Because the profit maximizing conduct of hospitals, both for-profit and not-for-profit, are unrestrained by competitive market forces the overall cost of healthcare in the United States is inflated.\textsuperscript{48} The lethal combination of exorbitantly high chargemaster prices and the practice of balance billing combine to put upward pressure on prices for health care across the board.\textsuperscript{49} These practices not only directly increase the cost of healthcare for the uninsured and out-of-network patients; they also indirectly increase the

\textsuperscript{45} See e.g., Melissa B. Jacoby & Mirya Holman, \textit{Managing Medical Bills on the Brink of Bankruptcy}, 10 \textit{Yale J. Health Pol'y. L. & Ethics} 239, 247 (2010), (medical debt makes it difficult to get further healthcare); Christopher Tarver Robertson et al., \textit{Get Sick, Get Out: The Medical Causes of Home Mortgage Foreclosures}, 18 \textit{Health Matrix} 65, 66-68 (2008) (23\% of home foreclosures were caused by unmanageable medical bills); Melissa B. Jacoby & Elisabeth Warren, \textit{Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress}, 100 \textit{Northwestern U.L. Rev.} 535, 548 (2006) about 46\% - 56\% of personal bankruptcies were caused by a medical reason for their bankruptcy).

\textsuperscript{46} See generally, Nation, \textit{Obscene Contracts supra} note 3; Nation, \textit{Determining, supra} note 6; Nation, \textit{Wolves supra} note 13, Nation, \textit{Chargemaster Insanity}, supra note 11.

\textsuperscript{47} See e.g., Reinhardt, \textit{U.S. Hospital Services, supra} note 3 at 63 (chargemaster prices if paid would yield truly enormous profits).

\textsuperscript{48} See Nation, \textit{Chargemaster Insanity, supra}, note 11 at 26-30 (high chargemaster prices lead to overall higher prices for healthcare); Nation, \textit{Wolves}, supra note 13 at 154 (primary reason that the non-profit business model has dominated the hospital industry is that it provides camouflage and autonomy for the real profit seeking motives and/or elitist weak transfer motives of these in de-facto control and affords a tax deduction that enhances profits).

\textsuperscript{49} See \textit{supra} note 9.
cost of healthcare for everyone. While government insures whom pay for more than half of the healthcare provided in the U.S. no longer set reimbursement rates based directly on chargemaster rates; higher chargemaster rates do indirectly put upward pressure on government reimbursement amounts. However, more importantly and the focus of this article, is the fact that the combination of obscenely high chargemaster rates and the practice of balance billing increase the cost of healthcare for both uninsured and privately insured patients.

It is obvious why uninsured and out-of-network patients pay more because the dysfunctional market for health care allows hospitals’ to set unreasonably high chargemaster rates and insist on balance billing out-of-network, uninsured and other self-pay patients. What is less obvious is why this also increases the cost of healthcare for in-network patients. Remember that patients are considered to be in-network if their insurance company has entered into a contract with the hospital providing medical services and as a result, in network patients typically cannot be balance billed. However the negotiation of the contract that makes a patient “in-network” is affected directly by exorbitant chargemaster rates and the practice of balance billing. For example, when a hospital or hospital system and an insurance company negotiate reimbursement rates the hospital system’s bargaining power is increased by the fact that if the insurance company fails to agree to the reimbursement rates desired by the hospital system then all

50 See supra note 9.
51 See Nation, Determining supra note 6 at 454 (main reason chargemaster prices are so high is that the higher chargemaster prices lead to higher revenues, though not dollar for dollar, for hospitals from government and private insurers as well as from self-pay patients); Nation, Chargemaster Insanity supra note 11 at 26-30 (exorbitant chargemaster prices case higher overall prices for healthcare).
52 See supra note 9.
53 See supra notes 23 - 47 and accompanying text.
54 See supra notes 4 - 10 and accompanying text.
of the insurance company’s customers, that is the insured patients, will be charged the provider’s exorbitant chargemaster rates and balance billed for the difference between these ridiculously high rates and the amount the insurance company pays for the services provided to the patient.55 This threat: "agree to our reimbursement rates or your insureds’ will face huge charges for health care" is strengthened each time the hospital raises its chargemaster rates.56 This threat based bargaining power is irresistible in the case of a hospital or hospital system that is dominant in its’ market.57 Insurers simply cannot sell health insurance policies if those who buy them will be punished with exorbitant balance bills if they receive care from the dominant provider in the market.58 As a result, many insurers have no option but to agree to the high reimbursement rates requested by the hospital system and pass these costs along to their customers/insureds in the form of higher prices for health insurance.59 As a result, the price of insurance (what insured patients pay for health care) goes up.60

An alternative for insurance companies is to simply sell very narrow network policies to uninformed customers and let these patients be shocked and surprised by the balance bills they receive. Narrow network policies are, of course, cheaper and the low price often attracts customers who do not fully understand the risks posed by narrow

55 See Bai and Anderson supra note 9 at 3 (noting that high chargemaster rates motivate insurers to include hospitals in their networks to reduce the likelihood of having subscribers pay high out-of-network prices); Murray supra note 9 at 3 (high chargemaster rates undermine the negotiating leverage of private insurers relative to hospitals).
56 See Murray supra note 9 at 3.
57 See, e.g., Nation Chargemaster Insanity supra note 11 at 22 (discussing California Pacific Medical Center owned by Sutter Health and the fact that its amassed market power allows it to charge 5 ½ to over 10 times the Medicare reimbursed rate).
58 See Nation Chargemaster Insanity supra note 11 at 28 (private insurers, even these with significant market power are forced to agree to high contractual reimbursement rates with must have hospitals in their market).
59 Id.
60 Id.
network policies. As noted supra, the majority of policies sold on ACA exchanges are narrow network policies. In addition, several newspaper articles have focused on the frustration, shock and surprise of patients who receive huge balance bills.

Make no mistake, even non-profit tax-exempt, so called “charitable” hospitals act exactly like their for-profit competitors when it comes to setting obscenely high chargemaster prices and balance billing their patients. I have written before about the very uncharitable conduct of so-called charitable hospitals and there is no need to repeat that work here; it is sufficient to note here that there is no meaningful difference between the conduct of non-profit and for-profit hospitals when it comes to conducting their financial affairs, except of course that the non-profits make more money because they pay no taxes. Moreover, while the pricing and collection limitations included in the ACA apply only to non-profit hospitals these provisions do not solve the balance-billing problem even in the context of non-profit hospitals as discussed at the next section. Thus, there is very little to be gained from simply applying the ACA’s ineffective price and collection limitations to for-profit hospitals.

E. The ACA Actually Encourages Balance Billing

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61 See Armour supra note 17 (customers who purchased coverage through the ACA are surprised by balance bills).
62 Id.
63 See supra note 4.
64 See Nation, Wolves supra note 13 at 174-179 (“The many instances in which non-profit hospitals seem to place the pursuit of profit over charity care has led the Commissioner of the IRS to observe that there is now very little difference between for-profit and not-for-profit hospitals”) [notes omitted] Id. at 179. Cf. Bai and Anderson supra note 9 (finding that 98% of the top 50 hospitals with the highest chargemaster rates were for-profit). These findings are misleading with respect to the difference between for and non-profit hospitals. The sample is small at 50, most of the top 50 were owned by just two for-profit systems, but most importantly the average chargemaster rate for all hospitals was 3.4 times Medicare allowable cost. Id at 923.
65 See generally, Nation, Wolves supra note 13.
66 See infra note ____ - ____ and accompanying text.
The ACA started out with laudable goals, however much got lost in the translation into legislation. As noted above, the ACA contains limits on what patients may be asked to pay out-of-pocket if they are covered by a qualified health insurance policy, but these limits do not apply to non-emergency charges of out-of-network providers. In other words, the out-of-pocket limits established by the ACA do not apply to balance billing. The ACA also establishes limits on the amount that indigent uninsured patients may be charged for health care, and also limits the type of collection techniques that may be used to recover health care debt. It is important to note however, that these limitations apply only to not-for-profit tax-exempt hospitals; they do not apply to for-profit hospitals. For-profit hospitals make up approximately 20% of the hospitals in the United States, and while not directly relevant here; I have argued elsewhere that all hospitals should be for-profit and taxable.

In any event, an indigent patient eligible for a (not-for-profit, tax-exempt) hospital’s financial assistance policy or FAP may not be charged more than the hospital’s generally billed amount (GBA). GBA is a reasonable amount established under the ACA and may be based on either the average amount the hospital bills private insurance and Medicare

68 See ACA § 1302 (c), codified at 42 U.S.C. § 18022 (c); Bai and Anderson supra note 9 at 923 (ACA requires non-profit hospitals to provide discounts to eligible uninsured patients. However, the same provision lets individual non-profit hospitals determine their own eligibility standards does not address the levels of the markup faced by out-of-network patients and casualty and workers’ compensation insurers, and does not apply to for-profit hospitals [notes omitted]).
69 See supra note 66.
70 See supra note 66.
71 See generally, Nation, Wolvers supra note 13.
for the services provided, or on the perspective Medicare reimbursement rate alone.\textsuperscript{73}

Moreover, these hospitals and their collection agencies are forbidden from using extraordinary collection techniques to collect hospital debt from FAP-eligible patients.\textsuperscript{74}

However, these provisions fail to solve the balance-billing problem even for not-for-profit, tax-exempt hospitals for several reasons. First, these hospitals are free to define who is eligible for their financial assistance programs.\textsuperscript{75} Many hospitals define FAP eligibility according to income levels based on the Federal Poverty Guidelines. The problem is that in addition to the FPG limits most of these hospitals also limit eligibility for their FAP’s to those who are uninsured.\textsuperscript{76} Obviously, this offers no protection for patients subject to balance billing, who by definition are insured but have received care outside of their network.

Second, the recently finalized regulations implementing the ACA’s limitations on hospital charges for FAP-eligible patients, specifically allow balance billing of patients who qualify for financial assistance.\textsuperscript{77} That is, if under a specific hospital’s FAP an insured patient is eligible for financial assistance and therefore the amount the hospital may charge is limited to the hospital’s GBA, the hospital is specifically permitted to recover this amount from \textit{both} the insurance company and the patient.\textsuperscript{78} That is, the

\begin{itemize}
  \item \textsuperscript{73} \textit{Id.}
  \item \textsuperscript{74} I.R.C. § 501 (r)(6).
  \item \textsuperscript{75} I.R.C. § 501 (r)(4)(A). Additional Requirements for Charitable Hospitals, 26 C.F.R. § 1.501 (r) ("Neither the (ACA) nor these regulations establish specific eligibility criteria that a FAP (financial assistance policy) must contain").
  \item \textsuperscript{76} \textit{See, e.g.,} Cleveland Clinic Foundation Summary of Financial Assistance available at my.clevelandclinic.org/cdf/media/files/patients/financial-assistance-app.pdf (stating: we provide financial assistance … if you are a resident of the state in which you are seeking care, \textit{do not have insurance}, and your family income does not exceed four times the FPG).
  \item \textsuperscript{77} \textit{See,} 26 C.F.R. § 1.501(r)-5(b)(2) (it is no violation of the Regulations if the total amount paid by the individual and the health insurer exceeds the AGB so long as the individual's portion including co-payments, co-insurance and deductibles, does not exceed the AGR).
  \item \textsuperscript{78} \textit{Id.}
\end{itemize}
hospital may balance bill the FAP-eligible patient for an amount up to the GBA amount even though the hospital has already collected the GBA amount, an amount deemed to be the reasonable value of the services provided according to the ACA, from the insurance company!\(^79\)

Finally, the ACA specifically refers to a hospital’s “gross” charges\(^80\) clearly indicating their chargemaster rates. While the ACA does this with good intentions, specifically requiring not-for-profit tax-exempt hospitals to charge less than their list prices two FAP-eligible patients (the ACA does not say how much less), nevertheless the effect of these references to chargemaster rates is to effectively require that chargemasters with their exorbitant prices stay in existence. In addition, hospitals continue to have the same incentives to continually right raise their chargemaster rates.\(^81\) As noted above, high chargemaster rates contribute significantly to the severity of the balance-billing problem.\(^82\)

III. Analysis: The Solution

It is very important to recognize that our goals with respect to healthcare are not only to control prices and to provide access to all Americans to basic healthcare; but first and foremost our goal is to develop the best health care in the world.\(^83\) The best healthcare is that which can cure or treat the greatest number of diseases and ailments.

\(^79\) Id.
\(^80\) See, 26 C.F.R. § 1.501(r)-1(b)(16). ("Gross Charges" is defined as the chargemaster rate ("a hospital facility's full, established price for medical care that the hospital facility consistently and uniformly charges patient before applying any contractual allowances, discount, or deductions). Id.
\(^81\) Higher chargemaster rates mean greater revenue though not dollar for dollar. See supra note 48.
\(^82\) See supra notes 42 - 47 and accompanying text.
\(^83\) See Nation, Wolves supra note 13 at 151-155.
with the greatest success.\textsuperscript{84} A thriving free market for healthcare will accomplish our goals with regard to pricing and the development of the best health care.\textsuperscript{85} I have written before about the dangers associated with incorporating the access goal to tightly with the goal of developing the best healthcare and I don’t want to repeat that work here.\textsuperscript{86} The point is, that the issue of how to provide access to basic healthcare for low-income populations is separate and distinct from the issue of how to develop the best healthcare.\textsuperscript{87} To develop the best healthcare and to control costs we must enhance the free-market for healthcare.\textsuperscript{88} Also, a robust free-market economy is the best remedy for poverty and its effects including lack of access to healthcare.

A. More Price Fixing Will Not Help

There is no question that when hospitals’ seek to collect their chargemaster rates they are acting unreasonably and especially in the case of charitable hospitals unfairly.\textsuperscript{89} But, hospitals are also responding predictably, which is to say a somewhat reasonably though certainly not charitably, to existing market forces.\textsuperscript{90} The solution is to change the market conditions, such as the current lack of price transparency, that are preventing the free market for healthcare from functioning properly.\textsuperscript{91} Price-fixing does not strengthen the free-market it destroys it and replaces it with central planning. Not only does prior

\textsuperscript{84} Id. at nt. 33.
\textsuperscript{85} Id. at nt. 34.
\textsuperscript{86} See generally, Nation Wolves supra note 13.
\textsuperscript{87} Id. at 207-209.
\textsuperscript{88} Id. at 154-155.
\textsuperscript{89} See supra notes 41-46 and accompanying text.
\textsuperscript{90} See Nation Chargemaster Insanity supra note 11 at part II (discussing the evolution of higher chargemaster rates).
\textsuperscript{91} See e.g., Bai and Anderson supra note 9 at 925 (discussing policy implications to the market failure caused by a lack of price transparency).
experience suggest that this will ultimately fail to control prices, it will also destroy quality.

The US healthcare market already has too much price-fixing. Government insurers such as Medicaid and Medicare are price fixers.\(^9^2\) Moreover, they represent a large share of the US healthcare market.\(^9^3\) Price-fixing whether in the form of a single-payer system or in the form of full-blown government healthcare is not the solution because it ignores the real goal, which is to develop a properly functioning free-market for health care because this is the only way to develop the best healthcare.

**B. Enhancing The Free Market For Health Care**

Enhancing the free-market for healthcare will require that the government work to prevent and reduce market concentration and ensure relatively equal bargaining power of both providers and consumers (or insurance companies as the consumers’ representatives).\(^9^4\) In addition, a properly functioning free-market requires price and quality transparency so that consumers can actively choose the best value in healthcare.\(^9^5\) That is, the best healthcare at the cheapest price. When consumers have this information then providers are forced to compete with regard to quality and price. This is the essence of a free-market and it is from this that all of its benefits flow. Other than observing that certain provisions of the ACA are, unfortunately, encouraging concentration in an already overly concentrated provider side of the market, I focus in this part on how to increase

\(^9^2\) See e.g., Reinhardt, “U.S. Hospital Service,” *supra* note 3 at 60 (discussing price setting by Medicare).

\(^9^3\) See Nation *Wolves supra* note 13 at nt. 237 (noting that government is responsible for pay for more than 50% of U.S. healthcare via various programs, principally Medicare and Medicaid).

\(^9^4\) See *supra* note 34–35 and accompanying text.

\(^9^5\) See e.g., Bai and Anderson *supra* note 9 at 924-25 (discussing lack of transparency in market failure).
price transparency.\textsuperscript{96} It is also important to note, that this article seeks to strengthen the free market for healthcare and that necessarily includes recognizing that providers should be free to set their prices at any level they wish, with the exception of services provided in the emergency department.\textsuperscript{97} However, a properly functioning free-market will force them to set reasonable prices.

C. Increasing Price Transparency Using The Common Law of Contracts

One of the most significant problems in the market for healthcare is a lack of price transparency.\textsuperscript{98} Patients do not know at the time of contracting how much they are agreeing to pay for the services that will be provided to them.\textsuperscript{99} As a result, it is virtually impossible for patients to compare hospitals based on price.\textsuperscript{100} This in turn, means that hospitals are not forced to compete on price. As mentioned above, it is also important for hospitals to compete on quality, but in the current market environment it is much easier for patients to get an idea of the relative quality of hospitals than it is for them to get an idea of how much they will be responsible for paying for the services that they receive.\textsuperscript{101} My focus here is on increasing price transparency.

Not only is price transparency critical for the proper functioning of the free market, not surprisingly basic principles of contract law require that the parties clearly establish the terms of their agreement or, if the court is convinced the parties intended a contract but did not clearly established some terms, including the price, the court will

\textsuperscript{96} See infra note 98 - 121 and accompanying text.
\textsuperscript{97} See supra note 66. Also, infra notes 122-130 discussing contract prices.
\textsuperscript{98} See e.g., Nation Determining supra note 6 at 426-429 (discussing the lack of price transparency in healthcare contracts).
\textsuperscript{99} Id.
\textsuperscript{100} Id.
\textsuperscript{101} There are many ranking services available regarding the relative quality of healthcare. See e.g., U.S. News and World Report ranking hospitals at ________
imply a reasonable price to the contract consistent with the parties’ presumed intent.\textsuperscript{102} At
the heart of the common law requirements for the creation of a contract is its recognition
of the freedom of individuals to knowingly and freely enter into enforceable
agreements.\textsuperscript{103} The problem with healthcare contracts that are entered into directly with
patients is that they are not knowingly and freely entered into with respect to price.\textsuperscript{104} As
discussed in more detail in the next section, courts can use the common-law principles of
contracts now to rein in the abusive balance billing practices of hospitals.\textsuperscript{105} In this
section I renew a suggestion I have made previously for regulation that will enhance the
functioning of the free-market by increasing price transparency.\textsuperscript{106} In addition, I
recommend here specific patient disclosures designed to ensure healthcare contracts
entered into directly with patients are knowingly and freely entered into with respect to
price.\textsuperscript{107}

My recommendation regarding price disclosure are similar to Regulation Z\textsuperscript{108}
(Regulation Z, is issued by the Board of Governors of the Federal Reserve System to
implement the federal Truth in Lending Act, which is contained in Title I of the
Consumer Credit Protection Act, as amended (15 U.S.C. 1601 et seq.), which applies to
customer lending and ensures that consumers know and understand the credit terms of

\textsuperscript{102} See infra notes 165 - 168 and accompanying text.
\textsuperscript{103} See infra notes 149 - 168 and accompanying text.
\textsuperscript{104} See supra note 97.
\textsuperscript{105} See infra notes 223 - 230 and accompanying text.
\textsuperscript{106} See Nation, Chargemaster Insanity supra note 11 at 36-44.
\textsuperscript{107} See infra notes 108 - 121 and accompanying text.
\textsuperscript{108} Regulation Z is issued by the Board of Governors of the Federal Reserve System to implement the
the loan they are agreeing to.\textsuperscript{109} Similarly in the context of healthcare contracts the government’s role should be to require disclosure of the relevant pricing information.

In order to provide patients with the relevant information that they need regarding price in order to enter into an enforceable contract with a hospital regulation requiring the following would be very helpful. First, all providers should be required to adopt the same pricing system, but not the same prices.\textsuperscript{110} Second, a number of disclosures including the following need to be made to the patient prior to the creation of the contract. First, the patient should be told the total amount that the hospital will charge (including amounts charged to the patient’s insurance or any other third-party payer) for the care to be provided. Second, the patient should be told the maximum amount in dollars and cents that the patient will be expected to pay for the services for which they are contracting.\textsuperscript{111} Third, the hospital must disclose the amount, in dollars and cents that the hospital receives from Medicare for the same services and the average amount the hospital receives from private insurers for the same services. Fourth, hospitals must tell the patient explicitly that the hospital accepts these amounts, from private and government insurers, as full payment for these services. Fifth, the hospital must disclose explicitly, again in dollars and cents, how much more the hospital is asking the individual patient to pay for these exact same services. Sixth, the hospital should also inform the patient that it negotiates rates with private insurers and, if the hospital in fact does so, with self-pay patients on a case-by-case basis. Finally, a prominent space should be provided on the

\textsuperscript{109} Id. See also, Keith T. Peters, What Have We Here? The Need for Transparent Pricing and Quality Information in Health Care: The Creation of an SEC for Health Care, 10 J. HEALTH CARE L. AND POL’Y 363, 364 (2007) (noting that with proper information healthcare consumers can make rational decisions).

\textsuperscript{110} This is a recommendation that I and others have made before. See Nation, Chargemaster Insanity supra note 11 at 39; Bai and Anderson supra note 9 at 927 (regarding legislation requiring all reimbursements to be based on the same system such as DRG’s (diagnostic related groups)).

\textsuperscript{111} I have previously argued that a reasonable price for medical services is no more than 115\% of the Medical reimbursement rate. See Nation, Determining supra note 6 at 460-465.
disclosure form for the total negotiated price the patient and the hospital have agreed to and the amount of discount received by the patient.\textsuperscript{112}

These regulations should be written, similar to Regulation Z, so that a single consistent and easily read and understood form is used by all hospitals to convey this pricing information to the patient. Not only will this type of regulation ensure that patients are knowingly and freely entering into contracts with hospitals, but it would also facilitate the comparison of prices between hospitals by patients. This in turn will result in price control via market forces.

If these disclosures regarding price are not made prior to contracting for any reason, then the court must decide if the parties intended to contract, which would clearly be the case if the patient received any treatment from the hospital, and if a contract was created the court must provide a reasonable price term for the parties.\textsuperscript{113} For example, a hospital may continue to use its price-ambiguous “Authorization for Treatment”, “Statement of Financial Responsibility”, or some other similar open-ended agreement pursuant to which the patient purports to agree to pay for all medical goods and services provided by the hospital at the hospital’s chargemaster prices.\textsuperscript{114} But if these open price type agreements are used the patient would not be liable to the hospital for any more than a reasonable amount as decided by the court.\textsuperscript{115} That is, whenever the provider does not make the required disclosures, the court will apply a reasonable price to the contract.

\textsuperscript{112} This is similar to the disclosure box required by Regulation Z. See \textit{supra} note 107.
\textsuperscript{113} Cf. Article 2 of Uniform Commercial Code § 2-207 (3).
\textsuperscript{114} See \textit{supra} notes _____ - _____ and accompanying text.
\textsuperscript{115} See \textit{supra} note 110.
based on, as I have argued elsewhere, the average price paid for the same services by private insurers plus a modest percentage between 1 and 15%.^{116}

As discussed more fully in the next section, even in the absence of legislation requiring these price disclosures, courts should not interpret typical admission forms signed by patients such as an “Authorization for Treatment”, “Statement of Financial Responsibility”, or some other similar open-ended agreement, which purport to establish a formula based on the hospital’s chargemaster for arriving at the price the patient has agreed to pay for the services the hospital may provide as establishing a definite price.^{117} Rather, these types of forms 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.^{118} This is not at all consistent with common-law of contract principles requiring that the parties knowingly and freely enter into contracts.^{119} As a result, the court should not find that these writings are binding with respect to establishing the price for the goods and services provided by the hospital to the patient.^{120} Simply put, under the common law of contracts, the hospitals that fail to fully disclose relevant pricing information, as discussed above, may recover no more than the fair market value of the goods and services provided.^{121}

D. Price Setting Freedom In A Free Market

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^{116} See supra note 110.
^{117} See Nation, Determining supra note 6 at 426-27.
^{118} Id.
^{119} See infra note 147 and accompanying text.
^{120} See infra notes 223 - 230 and accompanying text.
^{121} See infra notes 223 - 230 and accompanying text.
One of the hallmarks of a free market is freedom of contract. That is, individual market participants are free to enter into contracts on any terms that they knowingly and freely agree to within the parameters established by the common law. These parameters include requirements such as capacity and legality, and compliance with normal contract policing tools such as fraud, duress, undue influence, and unconscionability. Thus, in a free-market businesses are typically free to establish their prices at any levels they see fit, and of course, potential customers are free to reject prices that they consider to be too high. In order to come to an agreement the parties negotiate the terms, including the price, of the contract.

Because the purpose of the recommendations made here are to strengthen the operation of the free market, this article takes the position that providers of medical goods and services must be free to set their prices as they see fit. That is, direct government price controls are not only inconsistent with the idea of freedom of contract that underlies the free market; they also disrupt the functioning of the free market and prevent it from achieving its ultimate goal of efficient resource allocation. Moreover, a properly functioning free-market will control prices. In addition, as discussed in the next section, I argue that the common law of contracts includes sufficient flexibility to allow judges to apply its principles to ensure that hospitals cannot engage in unfair pricing practices.

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122 See infra notes 149 - 168 and accompanying text.
123 See infra notes 149 - 168 and accompanying text.
124 See infra notes 231 - 236 and accompanying text.
125 If prices are set too high, the excess profits attract more sellers and in turn the increased supply cause prices to come down. As a result, the proper level of resource allocation is achieved and maintained.
126 See supra note 124.
127 See infra notes 147 - 236 and accompanying text.
The common law of contracts also leaves hospitals and other provider’s sufficient pricing flexibility to charge extremely high rates to patients who are able and willing to pay them. Commentators as well as hospital administrators often recount the “Arab Sheik” scenario. This scenario involves an Arab Sheik, invariably extremely wealthy, arriving at the hospital seeking medical services; the Sheik is able and willing to pay any price, according to this scenario, that the hospital demands. Hospital administrators, clearly misunderstanding the common law of contracts, fear that without their exorbitant chargemasters they would not be able to charge the Sheik an exorbitant, overpriced amount for the hospital’s services. Why it is acceptable to overcharge a wealthy Arab Sheik, especially in the case of a so called charitable hospital, which is an implicit assumption in this scenario is unclear to me. Freedom of contract and the rules established by the common law of contracts allow hospitals to charge any patient, any amount the hospital wishes as long as the patient and the hospital freely and knowingly agree. The frequency with which one encounter the Arab Sheik scenario would seem to suggest that it is quite common, however even without the advantage of empirical evidence, I am tempted to conclude that it may represent more wishful thinking than reality. In any event, to maintain such a ridiculous and pernicious chargemaster pricing system in the vein hope for the arrival of an Arab Sheik certainly seems to be an example of the tail wagging the dog.

E. The Just Say No Approach

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128 See e.g., Rosenthal supra note 36 at 6.
129 Id.
130 Id.
131 See infra notes 147 - 168 and accompanying text.
Some companies that self-insure for health insurance and their third party administrators have created health insurance plans that dispense with networks altogether.132 Under these direct pay type plans no contracts are entered into with any providers.133 Employees insured under these plans are free to go to any provider they like.134 When the bill is presented the company pays an amount determined to be reasonable based on reference to the amounts paid by other payers.135 For example, the company may reimburse the hospital at the Medicare reimbursement rate plus a percentage such as 25 or 30%. The hospitals of course are not required to accept this amount as full payment because they have not entered into a contract with the company/insurer. Moreover, the hospital may balance bill the patient/employee for the difference between the hospital’s chargemaster amount and the amount paid by the company/employer.136

However, companies offering such plans and their third-party administrators typically flight such balance billing efforts on behalf of the employee/patient.137 The few companies offering such plans report great success so far.138 One such third-party administrator is ELAP Services, a small benefits consulting firm, based in Chester Springs, Pennsylvania.139 According to an ELAP spokesperson, when ELAP clients are sued by hospitals in pursuit of balance bills the company fights back with lawyers and

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132 See e.g., Jay Hancock, Playing Hardball on Soaring Hospital Bills, THE MORNING CALL, June 9, 2015 (Life 2). (When hospitals send invoices with jaw-dropping charges, ELAP Services tells its clients (generally medium-sized employers) to just say no.
133 Id. (under ELAP’s approach neither employers nor their claims administrators sign contracts with hospitals).
134 Id. (there is no network – so there is no limitation on which provider can be used).
135 Id. (ELAP estimates costs based on the hospital’s financial reports filed with Medicare, then adds a cushion so the hospital can make a modest profit).
136 Id. (When this happens to ELAP clients, ELAP fights back with lawyers and several arguments).
137 Id.
138 Id.
139 Id.
several arguments: how can hospitals justifiably charge employers and their workers so much more than they charge Medicare?\textsuperscript{140} How can Hospitals bill $30 for a gauze pad?\textsuperscript{141} How can patient’s consent to prices they never see you until they have been discharged?\textsuperscript{142} ELAP reports that eventually, “overwhelmingly, the providers just accept the payment” and leave patients alone.\textsuperscript{143} Whether this approach will be upheld in court against hospitals’ balance billing claims against patients is unknown.

ELAP was named as a defendant in a federal District court case in Georgia, which was decided in 2012 in ELAP’s, and the employer’s favor, but the issue in that case was limited to whether the administration of the direct payment plan was consistent with ERISA.\textsuperscript{144} The court held that it was, but as the provider was acting in the place of the insured pursuant to an assignment of the insured’s rights to benefits under the plan the case did not involve balance billing.\textsuperscript{145} That is, no state law claims, the balance-billing claim would be a contract claim, were part of the proceeding.\textsuperscript{146}

IV. What Courts Can And Should Do Now

Courts can use the common law of contracts to rein in abusive balance billing practices. As this section discusses the common law of contracts is based on the premise that courts will enforce agreements that are entered into knowingly and freely by individuals.\textsuperscript{147} Contracts entered into between healthcare providers and patients are not

\textsuperscript{140} Id.
\textsuperscript{141} Id.
\textsuperscript{142} Id.
\textsuperscript{143} Id.
\textsuperscript{144} See, Floyd Medical Center v. Warehouse Home Furnishings Distributors Inc., Case No. 4:11-CV-15 (CDL) U.S. District Court for the Middle District of Georgia, Columbus Division, April 25, 2012.
\textsuperscript{145} Id. at 15-16.
\textsuperscript{146} Id.
\textsuperscript{147} See e.g., Mark Klock, Unconscionability and Price Discrimination, 69 TENN. L. REV. 317 (2002).
knowingly and freely entered into with respect to price and therefore the ridiculous prices reflected in these contracts should not be enforced by the courts.148

The consideration can be as nominal as a peppercorn for the agreement to be legally enforceable. Courts do not inquire into the distribution of benefits between the parties. This legal fact is deeply rooted in a strong faith in the efficiency of free markets. Individuals do not voluntarily enter into agreements that they expect to make them worse off than before the agreement. If the agreement was made voluntarily, everyone is presumed to have been made better off by the agreement. This presumption can be justified by economic thought which, given a few simple axioms, demonstrates that markets will channel resources to their most valued use and maximize society's wealth when all market participants are permitted to freely make their own decisions. Government intervention cannot improve the allocation of resources and can even impede it. Id. at 343-44 (citations omitted); John D. Calamari and Joseph M. Perillo, The Law of Contracts §§ 1-3, 1-4 (discussing freedom of contract and the philosophical foundation of contract law respectively); See e.g., Ellsworth Dobbs, Inc. v. Johnson, 236 A.2d 843 (N.J. 1967). The case involved a real estate broker who found a buyer for the seller. The seller and buyer entered into a contract for sale, but the contract was never performed due to breach by the buyer. The broker brought suit against the seller, alleging that, based on the express terms of the listing agreement, the commission was earned upon execution of the contract between buyer and seller. The court ruled that any contractual provision in the listing agreement that required the seller to pay the commission even though the buyer of the land was unable to arrange financing and therefore breached the contract of sale, was "so contrary to the common understanding of men, and also so contrary to common fairness, as to require a court to condemn it as unconscionable." Id. at 857. In so ruling, the court applied the following reasoning that is equally applicable to the hospital admission contracts discussed here:

Courts and legislatures have grown increasingly sensitive to imposition, conscious or otherwise, on members of the public by persons with whom they deal, who through experience, specialization, licensure, economic strength or position, or membership in associations created for their mutual benefit and education, have acquired such expertise or monopolistic or practical control in the business transaction involved as to give them an undue advantage. Grossly unfair contractual obligations resulting from the use of such expertise or control by the one possessing it, which result in assumption by the other contracting party of a burden which is at odds with the common understanding of the ordinary and untrained member of the public, are considered unconscionable and therefore unenforceable. Id. at 856 (citation omitted).

The perimeter of public policy is an ever increasing one. Although courts continue to recognize that persons should not be unnecessarily restricted in their freedom to contract, there is an increasing willingness to invalidate unconscionable contractual provisions which clearly tend to injure the public in some way.

Id. at 857.

148 See supra notes 42 - 47 and accompanying text. See e.g., Tunkl v. Regents of the University of California, 383 P.2d 441 (Cal. 1963) (court rejected contract with exculpatory clause noting that patients are in no position to reject the offered agreement, to bargain with the hospital, or in lieu of a agreement to find another hospital) Id. at 447; Wheeler v. St. Joseph Hospital, 133 Cal. Rptr. 775 (Cal. Ct. App. 1976) (rejected agreement to arbitrate noting that the hospital admission agreement possessed all of the characteristics of a contract of adhesion (contracts offered on a take it or leave it basis with no realistic opportunity to bargain and such that the goods or services cannot be acquired without agreeing to the terms offered) and that admission to hospital is an anxious, stressful, traumatic experience as a result the patient cannot reasonably be expected to read the printed agreement in detail much less to fully comprehend its terms) id. at 786; Phoenix Baptist Hospital and Medical Center, Inc. v. Aiken, 877 P.2d 1345 (Ariz. Ct. App. 1994)(husband signed admission
A. Common Law of Contracts

1. Law of Voluntary Agreements: Freedom of Contract

A contract may be defined as a promise the courts will enforce. The concept of freedom of contract, which plays a central role in the law of contracts, reflects the idea that individuals should be free to enter into contracts on any terms they wish. There are, of course, limits to the doctrine of freedom of contract, which reflect other policy

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149 See Restatement (Second) of Contracts § 1 (1981).
150 See Calamari and Perillo supra note 147 at § 1-3:

The crux is that as England changed from a relatively primitive backwater to a commercial center with a capitalistic political reforms, freedom of contract was the ideological principle for development of the law of contract. In Maine’s classic phrase, it was widely believed that “the movement of the progressive societies has hitherto been a movement from Status to Contract.” Williston adds: “Economic writers adopted the same line of thought. Adam Smith, Ricardo, Bentham and John Stuart Mill successively insisted on freedom of bargaining as the fundamental and indispensable requisite of progress; and imposed their theories on the educated thought of their times with a thoroughness not common in economic speculation.”

In the twentieth century the tide has turned away from the nineteenth century tendency toward unrestricted freedom of contract. While the parties’ power to contract as they please for lawful purposes remains a basic principle of our legal system, it is hemmed in by increasing legislative restrictions.

Apart from legislative restrictions on freedom of contract it seems likely that in the future there will be greater restrictions imposed by courts in the exercise of their function of developing the common law. There has been increasing recognition in legal literature that the bargaining process has become more limited in modern society. In purchasing a new automobile, for example, the individual may be able to dicker over price, model, color and certain other factors, but, if he wishes to consummate the contract to purchase, he usually must sign the standard form prepared by the manufacturer (although he is contracting with an independent dealer). He has no real choice. He must take that form or leave it. Such contracts, called contracts of “adhesion,” constitute a serious challenge to much of contract theory.

Most of Contract law is premised upon a model consisting of two alert individuals, mindful of their self-interest, hammering out an agreement by a process of hard bargaining. The process of entering into a contract of adhesion, however “… is not one of haggle or cooperative process but rather of a fly and flypaper.” Courts, legislators and scholars have become increasingly aware of this divergence between the theory and practice of contract formation, and new techniques are evolving for coping with the challenges stemming from this divergence (notes omitted).
concerns of our legal system.\textsuperscript{151} For example, one cannot enter into an enforceable contract to sell illegal drugs.\textsuperscript{152} However within the broad parameters established by the legal system, the doctrine of freedom of contract is a fundamental principle of contract law. Moreover, the principle of freedom of contract is very consistent with the idea of a free-market economy, and one of the most important functions served by contract law is to facilitate the operation of the free market.\textsuperscript{153} That is, buyers and sellers may use contract law to create agreements on whatever terms they see fit.\textsuperscript{154} In addition, the principle of freedom of contract counsels that the role of the courts is to enforce the agreement created by the parties.\textsuperscript{155} Courts are not to create contracts for the parties, nor are courts required to approve the agreement the parties create, except to ensure that it falls within the broad parameters of contract law principles.\textsuperscript{156} The parties must create their own contracts because it is only through the aggregate interactions (contracts) of market participants that the market can determine the appropriate allocation of resources.\textsuperscript{157}

However, the doctrine of freedom of contract does not mean that the courts do not play a role in the contract formation process; on the contrary courts play a very important role by both establishing and enforcing the rules that must be followed to create a contract.\textsuperscript{158} For example, courts apply these rules to ensure that only agreements knowingly and freely entered into by the parties are enforced.\textsuperscript{159} Courts require that

\textsuperscript{151} Id.
\textsuperscript{152} Id.
\textsuperscript{153} Id.
\textsuperscript{154} Id.
\textsuperscript{155} Id.
\textsuperscript{156} Id.
\textsuperscript{157} Id.
\textsuperscript{158} Id.
\textsuperscript{159} See e.g., supra note 147.
contracts be knowingly and freely entered into because to agree both parties must know what they are agreeing to and voluntarily agree.\textsuperscript{160}

It is not possible to agree to nothing; similarly it is not possible to agree to allow the other party to charge any amount he wishes.\textsuperscript{161} Such terms are not contracts or even agreements they are the opposite of an agreement; they are simply an exercise of power by the stronger party against the weaker party.\textsuperscript{162} The doctrine of freedom of contract allows parties to agree to whatever terms they wish but it does require that the parties agree.\textsuperscript{163} Freedom of contract does not allow for the enforcement of the law of the jungle in the guise of a contract. If one party purports to agree to allow the other party to charge any amount he wishes as the price of the contract, such an agreement is not likely a contract because it was not likely knowingly and freely entered into.\textsuperscript{164} Who would knowingly and freely agree to such a term? No one! Yet, as discussed infra, this is precisely what hospitals claim.

Traditionally courts have required the parties to specifically agree to all necessary terms in order to create a contract.\textsuperscript{165} However, modern courts are more willing to supply missing terms for the parties if the court is convinced that the parties in fact intended to enter into a contract even if the words or writings of the parties do not clearly established all necessary terms.\textsuperscript{166} When the court fills in this term for the parties they provide terms

\textsuperscript{160} See supra note 148.
\textsuperscript{161} See Calamari and Perillo supra note 147 at §§ 2-1 and 2-13 (Mutual Assent and Indefiniteness respectively); RESTATEMENT (SECOND) OF CONTRACTS § 77 (illusory promises unenforceable).
\textsuperscript{162} See e.g., supra note 147.
\textsuperscript{163} See supra notes 148 and 160.
\textsuperscript{164} See supra note 148.
\textsuperscript{165} See supra note 160.
\textsuperscript{166} See Calamari and Perillo supra note 147 at 2-13.

There is an important distinction between cases in which the parties have purported to agree on a contractual provision and have done so in a vague and indefinite manner and cases in which they have remained silent as to a material term or have discussed the term
that are consistent with the reasonable expectations of the parties.\textsuperscript{167} For example, if the court is called upon to fill in the price term of the contract it will seek to determine a fair and reasonable price, because this is what reasonable contracting parties would intend.\textsuperscript{168}

2. Objective Intent and The Essential Requirements of Contract

While a contract is a promise the courts will enforce and all contracts are promises, not all promises are contracts. The common law of contracts uses the concept of objective intent and from it has derived the essential requirements of contract in order to determine which promises are contracts and which are not.\textsuperscript{169} Objective intent is very different than subjective intent.\textsuperscript{170} Objective intent makes no attempt to pick the brain of the person whose intent is in question.\textsuperscript{171} Rather, to determine objective intent we do not

\begin{footnotesize}
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\item \textsuperscript{167} Id.
\item \textsuperscript{168} Id.
\item \textsuperscript{169} See e.g., Calamari and Perillo supra note 147 at § 2-2 (objective and subjective intention). A party’s intention will be held to be what a reasonable man in the position of the other party would conclude his manifestations to mean. By testing the meaning to be given to a party’s words from the point of view of the reasonable man in the second party’s position, the subjective element of this party’s particular knowledge is incorporated into the objective test. In other words, the test considers what the second party knows or should know about the intention of the first party.
\item The objective theory is strongly supported by those who place the basis of contract law upon the promisee’s justified reliance upon a promise or upon the needs of society and trade. An objective test is believed to protect “the fundamental principle of the security of business transactions.” Even those who espouse intention as the basis of contract obligations are generally willing to hold a promisor to the reasonable meaning of his words, basing such liability on a theory of negligence but are inclined to wish that the objective theory be held on a short leash, and to allow subjective intention a high degree of relevance in the resolution of many contractual issues (notes omitted).
\item \textsuperscript{170} Id.
\item \textsuperscript{171} Id.
\end{itemize}
\end{footnotesize}
focus at all on the person whose intent we are trying to determine, instead we focus on a hypothetical reasonable person in the position of the other party; that is, the party interacting with the person who's intent we are trying to determine.\textsuperscript{172} The hypothetical reasonable person is used by the law to determine the objective intent of the other person based on the other person’s objective manifestations.\textsuperscript{173} Objective manifestations are the things done and said, in this context by the person who’s intent we are trying to determine, that may be perceived by others.\textsuperscript{174} Thus, for contract law purposes a person’s intent is deemed to be that which is consistent with the perceptions of a hypothetical reasonable person in the other party’s position.\textsuperscript{175}

Using an objective standard to determine intent for contracts provides certainty, which is especially important given the role that contract law plays in facilitating business transactions. Under the doctrine of freedom of contract, whether the parties have entered into a legally enforceable agreement, a contract, is and should be based on the intent of the parties involved. However, the intent we are concerned with is their objective intent. As a result, the essential requirements of contract reflect what we would expect hypothetical reasonable people to do if they intended to enter into an enforceable exchange of promises. Specifically, the essential requirements of contract are; offer and acceptance, consideration, legal abject and capacity. In particular, the specific requirements for the offer and acceptance reflect the objective intent idea.\textsuperscript{176}

\textsuperscript{172} Id.
\textsuperscript{173} Id.
\textsuperscript{174} Id.
\textsuperscript{175} Id.
\textsuperscript{176} See e.g., Calamari and Perillo supra note 147 at § 2-1 (Mutual Assent) (Usually an essential prerequisite to the formation of an informal contract is agreement; a mutual manifestation of assent to the same terms).
3. Offer and Acceptance: Knowingly and Freely Agreeing

In order for an offer to be made three requirements must be satisfied. The first is intent to contract.\textsuperscript{177} That is the person making the offer, the offeror, must indicate a willingness to exchange one thing for another.\textsuperscript{178} The second requirement is that the terms of the offer must be reasonably definite and certain.\textsuperscript{179} Not only does this requirement indicate that the parties have fully developed their agreement, it also as a practical matter is necessary in order to allow the court to determine if a breach has occurred and if so an appropriate remedy.\textsuperscript{180} The third requirement is that the offer must be communicated to the person who is trying to accept it.\textsuperscript{181}

For example, if one party, a new car dealer, says to another “I would like to sell this car”, and the other party after test driving the car and fully examining it says, “I would like to buy it”, no contract has yet been formed because the parties have not specified the terms of the contract with reasonable certainty. That is, we do not know the price the seller is willing to accept or the price the buyer is willing to pay. Moreover, without this information it seems unlikely that the parties have actually entered into a contract, rather they seem to be still in the process of negotiation.\textsuperscript{182} However, a problem arises where the parties act as though they have a contract, even though their words or writings have not spelled out all of the terms.\textsuperscript{183}

In the above example, this situation would be illustrated if the seller had delivered the car to the buyer and the buyer accepted it notwithstanding the fact that they had not

\textsuperscript{177} Id.
\textsuperscript{178} Id. at § 2-5 (a commitment to do or refrain from doing some specified thing in the future).
\textsuperscript{179} Id. at § 2-13 (performances to be rendered by both parties must be reasonably certain).
\textsuperscript{180} Id.
\textsuperscript{181} Id. at § 2-15 (generally offeree must know of offer to accept).
\textsuperscript{182} See supra notes 165-178 and accompanying text.
\textsuperscript{183} Id.
agreed on a specific price.\textsuperscript{184} Given the actions of the parties it is clear that they both thought that they had a contract; why else would the car has been delivered and accepted.\textsuperscript{185} However, if the parties cannot agree on a specific price, for example, the seller sends a bill to the buyer, which is higher than the buyer is willing to pay, then a court may be called upon to determine the price.\textsuperscript{186} In doing so, the court will seek to determine a reasonable price, that is one which reasonable contracting parties would agree to.\textsuperscript{187} While reasonable people may differ somewhat, by a few hundred dollars plus or minus, concerning what constitutes a fair price, one thing is clear the MSRP or manufacturer’s suggested retail price of the car is not a reasonable price because it is set to be discounted not paid.\textsuperscript{188} The same is true of list prices in health care except that in healthcare the list price is set much higher as a percentage of reasonable value than in the case of an automobile.\textsuperscript{189}

4. Types of Contracts

There are various types of contracts including express, implied-in-fact, and implied-in-law.\textsuperscript{190} All real contracts (as discussed below implied-in-law contracts are not real contracts) must satisfy the same essential requirements for contract discussed above. The difference between an express contract and implied-in-fact contract is the way in which the parties create the contract.\textsuperscript{191} An express contract is created by the use of

\textsuperscript{184} See e.g., Uniform Commercial Code Article 2 § 207(3).
\textsuperscript{185} Id.
\textsuperscript{186} See supra notes 165-178 and accompanying text.
\textsuperscript{187} Id.
\textsuperscript{188} Id.
\textsuperscript{189} See supra notes 42 - 47 and accompanying text.
\textsuperscript{190} See Calamari and Perillo supra note 147 at § 1-12 (Express and Implied Contracts – Quasi Contracts).
\textsuperscript{191} Id.
words, either written or oral.\textsuperscript{192} For example, a typical type of express contract is an Agreement of Sale for real estate. This contract is formed by words, the words written in the Agreement of Sale and agreed to by the parties as evidenced by their signature at the end of the agreement. An implied-in-law contract is created by the actions of the parties. For example, assume that Joe often visits Jane’s Candy Store on his lunch break and usually buys a candy bar for one dollar. One day during his lunch break Joe visits Jane’s candy store selects a candy-bar but observes that Jane is busy with a customer and has several other customers waiting. Joe catches Jane’s attention shows her the candy bar and walks out of the store.\textsuperscript{193} Based on these facts Jane and Joe have entered into a contract pursuant to which Joe is legally obligated to pay for the candy bar.\textsuperscript{194} The contract is based on the actions of the parties.\textsuperscript{195} Specifically, Jane has made an offer by setting up her store, inviting the public to shop there, and placing the candy out for sale. Joe has accepted by taking the candy bar, acknowledging it to Jane and leaving the store. The requirement of consideration is satisfied because the candy is being exchanged for the money. There is nothing illegal about buying and selling candy, and as long as both parties have capacity to contract, all of the essential requirements for a contract have been satisfied and enforceable contract has been formed. In this case the price, like the other terms of the contract, is established by the conduct of the parties.\textsuperscript{196} Specifically, in this case their prior dealings establish one dollar as the price.\textsuperscript{197} Of course in a free-market Jane is free to change her prices at any time. However, in order for a changed price to

\begin{flushleft}
\textsuperscript{192} Id. \\
\textsuperscript{193} See RESTATEMENT (SECOND) OF CONTRACTS § 4 (Illustration 2) (1981). \\
\textsuperscript{194} Id. \\
\textsuperscript{195} Id. \\
\textsuperscript{196} Id. \\
\textsuperscript{197} Id.
\end{flushleft}
become part of the contract the other party must agree to it. For example, if Jane had decided to raise her prices the night before Joe came into the store would Joe be bound to pay the new price? The answer depends on whether the parties intended (objective) the new price to apply. In this case, if Jane had clearly marked the new price on the candy then the new price would become part of the contract. That is, if the new price were clearly marked a reasonable person in Joe’s position would only have taken the candy bar if he were willing to pay the posted price. On the other hand, if Jane had failed to take actions necessary to bring the new price to the attention of a reasonable person in the buyer’s position then the new price would not apply to the contract.

An implied-in-law contract, also called a quasi-contract, is not a real contract and therefore does not depend upon the essential requirements of contract for its enforceability. The requirements for a quasi-contract are that a benefit has been given by one party to the other, the party receiving the benefit has kept it, that is refused to return it, and the court finds that allowing the party to keep the benefit without payment is unfair. When a court decides that a quasi-contract exists, it will require the benefitted party to pay the amount necessary to remedy the unfairness. A quasi contract is not a real contract because it is not based on the agreement of the parties; rather it is based on the equitable policy of furthering justice by preventing an unjust enrichment. Moreover, since there is no agreement between the parties the court has to provide the appropriate

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198 See supra notes 148-178 and accompanying text.
199 See supra note 168.
200 Id.
201 Id.
202 Id.
203 See Calamari and Perillo supra note 147 at § 1-12.
204 Id.
205 Id.
amount to be paid.\textsuperscript{206} In most cases of real contracts the court enforces the amount that the parties have agreed upon.

A fair question at this point is what does all of this have to do with contracting for health care? The principles just discussed apply to contracting in general and thus apply to contracting for health care. Moreover, some commentators get confused regarding the distinction between implied-in-law contracts and implied-in-fact contracts especially in the healthcare context.\textsuperscript{207} This may be due in part to a very common law school example involving healthcare services. The law school example involves a doctor, licensed and in good professional standing under the applicable state law, happening upon an injured motorist on the side of the highway who has been in an accident.\textsuperscript{208} The injured person is unconscious and in need of medical attention.\textsuperscript{209} The doctor provides medical attention and then sends a bill to the patient.\textsuperscript{210} May the doctor recover for the services he provided?\textsuperscript{211} There is certainly no real contract between the doctor and the patient since there was never any agreement between them due to the fact that the patient was unconscious. However, under the doctrine of, implied–in–law contract also known as quasi contract, the doctor may recover the fair value of his services from the patient.\textsuperscript{212} It is reasonable to assume that most patients in this situation would want the doctors

\textsuperscript{206} Id.
\textsuperscript{208} Id.
\textsuperscript{209} Id.
\textsuperscript{210} Id.
\textsuperscript{211} Id.
\textsuperscript{212} Id. See also, Calamari and Perillo supra note 147 at § 1-12 (similar example).
services and the patient will receive an unjust enrichment unless you were required to pay the doctor.\textsuperscript{213}

When it comes to the question of how much the doctor should be paid, obviously this cannot be based on the agreement of the parties, so the court must fill in the amount.\textsuperscript{214} In setting the price the court uses the fair market value of the services because it is fair.\textsuperscript{215} While this scenario may be relevant to an emergency department situation, it is not directly relevant to the balance-billing context. As discussed in the next section, in typical balance billing contacts there is no question that the parties have entered into an agreement for medical services, and one pursuant to which the patient expects to pay for the medical services received.\textsuperscript{216} The problem in the balance billing context is that the parties have not specifically agreed to a price; as noted above, hospitals typically require patients to sign some agreement pursuant to which the patient purports to agree to pay for the services received at the hospital’s chargemaster, usual, or customary prices.\textsuperscript{217} The problem, as discussed above, is that chargemaster prices are not usual or customary; they are exorbitant, grossly unfair and are set to be discounted not paid.\textsuperscript{218} In other words, in the balance-billing context it is as though the parties have entered into a contract for medical services but have not specified a specific price.\textsuperscript{219}

5. Good Faith

\textsuperscript{213} Id.
\textsuperscript{215} Id.
\textsuperscript{216} See \textit{infra} notes 223 - 225 and accompanying text.
\textsuperscript{217} See \textit{supra} notes 1 - 16 and accompanying text.
\textsuperscript{218} See \textit{supra} notes 42 - 47 and accompanying text.
\textsuperscript{219} See \textit{supra} notes 177 - 189 and accompanying text.
The common law of contracts recognizes an obligation of good faith in every contract.\(^{220}\) Good faith is generally defined as honesty in fact and the observance of reasonable commercial standards of fair dealing.\(^ {221}\) As a result, all parties to a contract must act in good faith in the performance and enforcement of every term of a contract. The obligation to act in good faith strengthens the conclusion reached \textit{supra}. That is, in cases where a patient has agreed, by signing a statement of financial responsibility or some other open-ended financial agreement at the time of admission to the hospital, to pay the hospital based its chargemaster or similar rates, the common law requires that this provision be performed and enforced in good faith. Good faith, as noted, requires observance of reasonable commercial standards of fair dealing. As a result, it would be inconsistent with the common law of contracts to allow the hospital to recover based on its chargemaster rates. Rather, the observance of reasonable commercial standards of fair dealing would require that the hospital be permitted to recover no more than a reasonable price for its services.\(^{222}\)

B. Contracting for Health Care

1. Promise To Pay Regular, List, Customary, Or Chargemaster Rates

In the balance-billing context however, the hospital argues that the parties have established a formula based on the hospital’s chargemaster for arriving at the ultimate price that the patient will pay for the services provided, and therefore the court must use

\(^{220}\) See \textit{Restatement (Second) of Contracts} § 205 (1981) (imposing a duty of good faith on the parties to a contract).

\(^{221}\) \textit{Id.}

\(^{222}\) See \textit{supra} notes 1-2 and accompanying text.
this formula to determine the amount the patient owes.\textsuperscript{223} But, have the hospital and the patient really agreed on a price? The answer is clearly no, as the supposed chargemaster based formula is illusory; all aspects of it remain completely within the control of the hospital.\textsuperscript{224} As I have noted elsewhere, the problem of inexact price information at the time of contracting is not unique to the sale of healthcare, but healthcare is the only area in which the parties purport to use a blank check as payment.\textsuperscript{225} For example, many professionals such as lawyers base their charges on an hourly rate and it is often not possible to know at the time of engagement how many hours a matter will take. However, unlike the health care situation, the hourly rate is agreed to at the time of engagement and cannot be changed unilaterally by the lawyer. In contrast, hospitals often do not provide any price information, not a copy of their chargemaster, or any other specific information to the patient at the time of contracting, and worse hospitals retain the right to change their chargemaster rates at any time.\textsuperscript{226}

This situation with the hospital more closely resembles that of an auto mechanic and a customer when the customer takes his car to the mechanic because it is having some unspecified problem and the mechanic refuses to give an exact price to repair the car because the mechanic does not yet know how much repair will be necessary. If the car owner and the mechanic agree that the mechanic will work on the car and then determine the price, an express contract has been entered into even though no specific price has been agreed upon. However, the law does not grant the mechanic the right to

\textsuperscript{223} See e.g., Allen v. Clarian \textit{supra} note 2.
\textsuperscript{224} See e.g., \textit{supra} note 36 (Professor Melnick notes that hospitals may set chargemaster rates at any level they want and set them to maximize revenue). Nation, \textit{Chargemaster Insanity supr}a note 11 at 1-18 (similar).
\textsuperscript{225} See Nation, \textit{Determining supr}a note 6 at 426-432.
\textsuperscript{226} See Anderson \textit{supr}a note 3 at 786 (noting that hospitals may change their chargemaster rates at any time).
charge whatever price he will, rather the obligation of good faith discussed *supra* requires that the mechanic exercise his/her discretion to set the price in good faith;\textsuperscript{227} that is, the mechanic must set a commercially reasonable price.\textsuperscript{228} The mechanic cannot charge any more than the fair market value for the work the mechanic has performed. If the mechanic and customer cannot agree as what a reasonable price is then the court will set the price.\textsuperscript{229} Similarly, in the case of contracting for healthcare the court must step in and provide the price for the parties since it is clear, based on both the conduct and words of the patient and the hospital that they intend to have a contract, but they have failed to specify a clear price. The court should reject the hospital’s claim that it should be free to calculate the price, based on its elusive and ever-changing chargemaster rates, and should, consistent with the common-law principles of contract, imply a term into the contract that requires the patient to pay a reasonable price, determined as discussed *infra*, for the services received.\textsuperscript{230}

2. Patients Required To Pay Prior To Treatment

Where the hospital requires an upfront payment of all or a certain percentage of the overall amount that the patient will be liable for, the parties have effectively established a specific price for the services that will be provided by the hospital. In this case, usually there is still a good argument to be made that under contract law principles the patient should be liable for no more than the reasonable value of the services received. This argument focuses on the common law requirement the contracts be

\textsuperscript{227} See *supra* notes 220 - 222 and accompanying text.
\textsuperscript{228} Id.
\textsuperscript{229} See *RESTATEMENT (SECOND) OF CONTRACTS* § 204. (a term e.g., price] which is reasonable in the circumstances is supplied by the court).
\textsuperscript{230} See *infra* notes 237 - 259 and accompanying text.
knowingly and freely entered into.\textsuperscript{231} Chargemaster prices are simply unreasonable and no reasonable person would knowingly and freely agree to pay such exorbitant rates.\textsuperscript{232} That is, if the hospital had informed the patient that they were being asked to pay at least 2 $\frac{1}{2}$ times the amount that in-network patients pay, and that the hospital gladly accepts this lower amount as full payment for the same exact services, no reasonable patient who had a choice would agree to pay the exorbitant chargemaster rates.\textsuperscript{233} As a result, there is a good argument to be made that an agreement to pay chargemaster prices is unconscionable.\textsuperscript{234} That is, the patient either did not make an informed choice to pay these prices or the patient had no choice but to agree because he did not have the ability to acquire the services elsewhere and therefore the contract is procedurally unconscionable; and the chargemaster rates are grossly unfair and therefore the contract is also substantively unconscionable.\textsuperscript{235} Thus, the contract should not be enforced.\textsuperscript{236} Other common-law theories might also be applicable in this context including fraud in the inducement or undue influence. Ultimately, what gives all of these arguments strength is the truth of the basic facts underlying the transaction. Specifically, chargemaster prices are exorbitant and unfair and no sane person properly informed would agree to pay them.

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\textbf{C. Determining The Reasonable Price of Health Care}
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\item \textsuperscript{231} See supra notes 147 - 189 and accompanying text.
\item \textsuperscript{232} See supra notes 42 - 47 and accompanying text.
\item \textsuperscript{233} See supra notes 42 - 47 and accompanying text; Bai and Anderson supra note 9 at 923 (noting that in 2012 on average U.S. hospital charges were 3.4 times the Medicare-allowable cost).
\item \textsuperscript{234} See Nation, Obscene supra note 3 (arguing that contracts with hospitals pursuant to which patients purportedly agreed to pay chargemaster rates are unconscionable).
\item \textsuperscript{235} Id. at 124-128.
\item \textsuperscript{236} Id. at 128-131.
\end{itemize}
I have written previously and in detail about how courts should determine the reasonable price for healthcare.\textsuperscript{237} It is sufficient here to note that I strongly support using, when possible, a price set by the free-market as a basis from which to establish the reasonable price. When this is not possible, it may be necessary as an alternative to use the Medicare price as a basis.

1. Rejecting Usual, Customary & Necessary

How do we determine the fair and reasonable price for health care? Hospitals would prefer to frame the question in its traditional manner which was; what is the usual and customary charge for the necessary medical services provided. Hospitals of course answer this question with reference to their chargemasters. They support this argument with a deceptive statement that “all patients are billed chargemaster rates”, and therefore those rates are their usual and customary rates.\textsuperscript{238} However, while all patients may be billed chargemaster rates all patients are not expected to and does not in fact pay chargemaster rates.\textsuperscript{239} Moreover, the hospital knows, accepts and plans on the majority of its patient’s pain less, much less, then chargemaster rates.\textsuperscript{240} Chargemaster rates are a fiction, they are not set to be paid; they are set to be discounted.\textsuperscript{241} Statements by hospital administrators to the contrary are disingenuous. Once the relevance of chargemaster rates are rejected, then the question can be phrased properly; that is, what is the value as established by the market of the services provided by the hospital. In other words, what is the fair market value of the services the hospital has provided? Thus, the focus is on what

\textsuperscript{237} See generally, Nation, Determining supra note 6.
\textsuperscript{238} Id.
\textsuperscript{239} Id.
\textsuperscript{240} Id.
\textsuperscript{241} Id.
is actually paid and accepted for the services, and not on some phantom chargemaster-based billed charges that very few ever pay and that no one should be expected to pay.\textsuperscript{242}

2. Prices Based On Fair Market Value

The fair and reasonable value of medical expenses must be based on the usual amount actually paid to the provider, not by the amount billed by the provider.\textsuperscript{243} A hospital invoice of itemized billed charges at chargemaster rates is, when it comes to measuring fair value, a complete fiction and should not be used by courts or others to establish the fair and reasonable value of medical services.\textsuperscript{244} Hospitals engage in price discrimination. That is, hospitals charge different amounts to different patients for the same exact services depending upon the identity of the party paying the bill.\textsuperscript{245} Government insurers pay the least, private insurers pay more and self-pay patients, including individuals with private insurance that receive balance-bills, pay the most.\textsuperscript{246} As a result of the perceived unfairness of this price discrimination, some commentators have called for an all-payer system.\textsuperscript{247} Under an all-payer system various methods may be used to arrive at a particular price for a good or service.\textsuperscript{248} For example, the government may set prices or each hospital may set its own price. However, regardless of how prices are set, once set that price must be posted for public view and apply to all patients without discrimination.\textsuperscript{249} Although I recognize that it is unfair to allow hospitals to charge any patient chargemaster rates, I have argued against all-payer systems because a

\begin{itemize}
\item \textsuperscript{242} Id.
\item \textsuperscript{243} Id. at 457-465.
\item \textsuperscript{244} Id. at 446-457.
\item \textsuperscript{245} Id.
\item \textsuperscript{246} Id.
\item \textsuperscript{247} Id.
\item \textsuperscript{248} Id.
\item \textsuperscript{249} Id.
\end{itemize}
part of what appears to be price discrimination is really market-driven discounting designed to purchase value from specific buyers.250 Because of this, imposing an all-payer system would be disruptive to the market and create inefficiency.251

Hospitals charge lower rates to insurers because insurers provide certain benefits to hospitals.252 These benefits include an increased volume of business through access to patients who are insured by the insurance company, assurance of quick and full payment of discounted charges from the insurance company, as well as marketing and advertising benefits that result from being listed as “in-network” by the insurance company.253 These benefits are valuable to hospitals and result in a portion, but only a portion, of the discount from chargemaster rates that private insurers receive. It is likely that the most important of these benefits to hospitals is the increased volume of business that results from entering into a contract with a large insurer.254 After all, any patient who pays with a credit card provides an assurance of payment similar to that provided by the insurance company. Because individuals do not bring the extra benefits, such as an increased volume of business, which insurance companies bring to hospitals, individual should pay more than the amount paid by insurers.255

As I have argued elsewhere the best way for courts and others to determine the fair and reasonable value of medical services is to start with the average amount the hospital would be paid by private insurers and then add to this an amount between 10 and

\[250 \text{Id.}\]
\[251 \text{Id.}\]
\[252 \text{Id.}\]
\[253 \text{Id.}\]
\[254 \text{Id.}\]
\[255 \text{Id.}\]
15% to account for the value of the benefits private insurers provide to hospitals.\textsuperscript{256} It’s important to note that the system I recommend, while it may be described as a form of price-fixing, is different than a government controlled all-payer system. The formula I suggest to determine a fair and reasonable price is based on a price freely set by the market.\textsuperscript{257} No individual market participant, provider or ensure, may control the base.\textsuperscript{258} Encouraging a freer and more transparent market for the sale of healthcare is the only approach that will result in appropriate pricing while simultaneously encouraging the development of the best healthcare in the world. More price-fixing will only make the problem worse.\textsuperscript{259}

V. Conclusion

The chargemaster rates set by hospitals are exorbitant because they are set to be discounted not paid. As a result, it is grossly unfair to enforce these rates against any patient; this is why balance billing is such a pernicious problem. There are many reasons for the development of exorbitant chargemaster rates, but the most important reason that they continue to cause problems is a lack of price transparency in contracting for healthcare. Regulation, as suggested in this article, to provide price transparency and make sure that patients knowingly and freely agree to the price term in contracts for healthcare would help to eliminate the chargemaster/balance-billing problem.

However, courts can and should begin now to rein in the balance-billing problem. As this article explains, the common law of contracts provides the necessary tools for courts

\textsuperscript{256} Id. at 460-465.
\textsuperscript{257} Id.
\textsuperscript{258} Id.
\textsuperscript{259} Id.
to use to enforce fair and reasonable prices in contracts for health care. When an individual contracts with a hospital for healthcare, courts should use these common-law tools to ensure that the patient is not liable to pay any more than a fair and reasonable price for the services received. Moreover, a fair and reasonable price should be based on the average amount the hospital receives from private insurers for the services provided to the patient.